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Developing Mahi Oranga: A Culturally Responsive Measure of Māori Occupational Stress and Wellbeing.

A thesis presented in partial fulfillment of the requirements for the degree of
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He Whakamārama (Abstract)

Occupational stress is a growing problem worldwide, resulting in poor health for individuals, reduced organisational performance, and financial costs to society because of increases in health service costs. Despite occupational stress research spanning 30 years, none has yet examined whether indigenous groups such as Māori experience it differently to their mainstream counterparts. Neither has anyone critiqued the appropriateness of using Western developed occupational stress assessments with Māori. Using a Māori-centred approach, this research aimed to identify whether Māori health workers in Aotearoa New Zealand experience occupational stress differently, and then to develop a culturally responsive, reliable and valid psychometric assessment (called Mahi Oranga).

Consultation with thirteen Māori health workers investigated the need for this research, and gained feedback and support for developing Mahi Oranga. Following consultation Mahi Oranga was developed, informed by Māori models of health and wellbeing, feedback from consultation, the limited literature related to Māori experiences of occupational stress, mainstream occupational stress literature and Western developed measures of occupational stress. Mahi Oranga was designed to measure workplace demands (cultural safety, organisational constraints, role overload and interpersonal conflict), coping strategies (including wairua/spiritual, hinengaro/psychological, tinana/physical and whānau/extended family components), and strain outcomes (for the individual and the organisation). Once developed, Mahi Oranga was made available online to Māori health workers, receiving 130 responses. Statistical analyses included exploratory factor analysis and bivariate correlations. Respondents represented urban and rural work settings, plus kaupapa Māori and mainstream work environments. Thematic analysis was conducted on qualitative responses.

Organisational strain was higher in urban rather than rural work settings. Cultural safety, organisational constraints, role overload and interpersonal conflict were all higher in kaupapa Māori rather than mainstream work environments. Coping strategies were lower in mainstream rather than kaupapa Māori work environments. Thematic analysis revealed occupational stress experiences related to organisational constraints, role overload and

interpersonal conflict were common to all staff, but that experiences of institutional racism and a lack of cultural safety were unique to Māori.

Limitations included the small sample size, and implications for practice include the need to increase awareness of these issues and knowledge of how to address them.

Rārangi Kupu Māori (Glossary of Māori Words)

Kupu Māori/ Māori Words	English Translation
Aotearoa	the Māori name for New Zealand, meaning 'Land of the Long White Cloud'
aroha	love or compassion
awhi	help
hā a Koro mā a Kui mā	the 'breath of life' from forebears
hapū	sub-tribe
hinengaro	thoughts and feelings, psychological, the mind
Hua Oranga	the name for a Māori measure of mental health outcomes
hui	meeting(s) or conference(s)
iwi	tribe
iwi katoa	societal context
kapa haka	Māori performing arts
karakia	prayer
karanga	call
kaumātua	male elder
kaupapa	philosophy
kaupapa Māori	Māori philosophy
kawa	marae protocol
kete	basket
kōhanga reo	Māori preschool, language nests
korero te reo	speak in the Māori language
kotahitanga	solidarity
kuia	female elder
kupu Māori	Māori words
mahi	job, work
mahi ki te tangata whaiora	work with Māori patients or clients
Mahi Oranga	Healthy Work Questionnaire
mana	prestige or dignity
mana ake	uniqueness
mana Māori	Māori wellbeing and integrity which emphasises the wholeness of social relationships
mana Whakahaere	CEO
manaakitanga	care for, show respect for, or hospitality
Māori	indigenous people of Aotearoa New Zealand
Māoridom	the Māori people

Kupu Māori/ Māori Words	English Translation
marae	central area of a village and its buildings
mātauranga Māori	Māori knowledge
mauri	life principle or ethos
mauriora	access to te ao Māori
mihimihi	exchange of greetings
mokopuna	grandchild, grandchildren
nga manukura	leadership
Ngā Pou Mana	The Four Supports
Pākehā	non-Māori, European
papakāinga	home base
pepeha	a recital of the speaker's whakapapa (genealogical) connections
pono	honesty
poroporoakī	farewell, closing ceremony
pōwhiri	formal Māori welcome
pūtea	Money, budget
rangatiratanga	Māori self determination
raranga	weaving
rohe	territory, area
rongoā Māori	Māori medicine, usually derived from traditional herbs
rongoā practitioners	traditional Māori healers
rōpū	group
taha hinengaro	the thoughts and feelings side
taha tinana	the physical side
taha wairua	the spiritual side
taha whānau	the extended family side
taiao	physical environment
tamariki	children
tangata Māori	Māori person
tangata whaiora	Māori patient or client
tangi	funeral
taonga tuku iho	cultural heritage
tauirā Māori	Māori student(s)
tauiwi	foreigner
te ao Māori	the Māori world
te ao tūroa	the physical environment
te mana whakahaere	autonomy
te oranga	participation in society

Kupu Māori/ Māori Words	English Translation
Te Pae Māhutonga	The Southern Cross
Te Pōwhiri Poutama	The Steps of Welcome
te reo Māori	the Māori language
Te Taitokerau	the Northland region of Aotearoa New Zealand
Te Whare Tapa Whā	The Four Cornerstones
Te Wheke	The Octopus
tika	integrity
tika/pono/aroha	integrity/honesty/compassion
tikanga	customs and protocols
tikanga Māori	Māori customs and protocols
tikanga Pākehā	non-Māori or European philosophy
tinana	physical body
Tiriti o Waitangi	Treaty of Waitangi
tohunga	expert, specialist or priest
toiora	healthy lifestyles
tūpuna	ancestors
tūrangawaewae	land base
waiata	song, singing
waiora	total wellbeing
waiora	environmental protection
wairua	spirit, spiritual
wairuatanga	spirituality
wero	challenge
whakamā	embarrassed
whakamua	forward
whakaoranga	respect of life
whakaotinga	completion or new beginnings
whakapapa	genealogy or cultural identity.
whakapuaki	letting wellness flow
whakaratarata	expression of openness and trust
whakatauāki	proverb
whakawhanaungatanga	relationship building
whakawhetaitanga	acknowledgements
whānau	family, extended family
whānau ora	family health
whanaungatanga	family, the extended family and group dynamics or relationship building that is mana enhancing
whatumanawa	the emotional aspect

Pepeha and Whakatauaāki

Pepeha (Introduction)

*Ko Aotea u tanga nui, Matātua, me Te Arawa ngā waka
Ko Matua te Mana/Ruapehu, Whakaraia, me Tongariro ngā maunga
Ko Wanganui rawa ko Tākau ngā awa
Ko Taupō-Nui-A-Tia te moana
Ko Te Ātihaunui a Paparangi, Ngāpuhi, me Tūwharetoa ngā iwi
Ko Ngāti Kurawhatia ki Pipiriki, Ngāti Rehia ki Tākau Bay, me Ngāti Rongomai
ngā hapū
Ko Paraweka, Te Whetumarama O Te Ao Hou, me Rongomai Turangi ngā marae
Ko Lisa Stewart tōku ingoa*

Aotea u tanga nui, Matātua, and Te Arawa are my ancestral canoes
Matua te Mana/Ruapehu, Whakaraia, and Tongariro are my mountains
Wanganui and Tākau are my rivers
Taupō-Nui-A-Tia is my lake
Te Ātihaunui a Paparangi, Ngāpuhi, and Tūwharetoa are my tribes
Ngāti Kurawhatia ki Pipiriki, Ngāti Rehia ki Takau Bay, and Ngāti Rongomai are my sub
tribes
Paraweka, Te Whetumarama O Te Ao Hau, and Rongomai Turangi are my marae
Lisa Stewart is my name

Whakatauaāki (Proverb)

<i>Ki te kāhore he whakakitenga</i>	Without foresight or vision
<i>ka ngaro te iwi</i>	the people will be lost

Whakawhetaitanga (Acknowledgements)

I could not have embarked on this thesis project without the help and support of so many people I am blessed to have in my life. First and foremost, this thesis was guided and overseen by my tūpuna in the spiritual realms, who communicated the need for this research to be done for our people. My research interests lay in a slightly different direction, but having got to the end of this project, I see clearly why my tūpuna would not leave me alone until I agreed to take up this wero (challenge). Kia ora.

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In closing, the whakataūāki (proverb) below is a true reflection of this thesis.

Ehara taku toa, he taki tahi, he tōā taki tini.

My success should not be bestowed on to me alone, as it was not individual success,
but the success of a collective.

Tena koutou, tena koutou, tena koutu katoa.

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Chapter 1 – Introduction

Whakatauāki (Proverb)

<i>He aha te mea nui o te ao?</i>	What is the most important thing?
<i>Maku e ki atu</i>	I say to you
<i>He tangata, he tangata, he tangata</i>	It is people, it is people, it is people

The world of work has changed significantly over the past 50 years, with the introduction of new technology such as computers in the workplace during the 1960s and 1970s, globalization and the resulting increase in competitiveness in the international market during the 1980s, followed by restructuring, downsizing and delaying during the 1990s (Sparks, Faragher & Cooper, 2001). As a result of changes to work, occupational stress has become recognised as a significant problem globally, and incidences of occupational stress are increasing along with the negative consequences to individuals and organisations (McGowan, Gardner & Fletcher, 2006). However, as Marchand, Demers and Durand (2005) rightly point out, it is not work itself that causes stress, but the way work is organised.

The goal of this research was to develop a Māori-specific psychometric measure of occupational stress and wellbeing, called Mahi Oranga (Healthy Work). The rationale for doing so is provided in this chapter, along with an explanation of why Māori working in the health and disability sector were the population of interest. This research was conducted with the philosophy of a Māori-centred approach that started with the question ‘What is important to Māori?’, and built from there to ensure Māori experience, values and aspirations were paramount. In the spirit of this philosophy, where it is possible to do so in this thesis, the researcher will allow the voices of participants and respondents to be heard by using summaries of their discussions or direct quotes to tell their story.

This chapter provides some background to and definitions of occupational stress. Next it will identify some of the consequences of occupational stress, followed by a discussion of the relationship between job satisfaction, psychological wellbeing,

occupational stress, and job performance. This will be followed by a discussion about Māori and psychometric assessments, including cultural differences and historical contextual considerations. In light of these cultural differences and historical contextual considerations, the rationale for developing Mahi Oranga will be explained. The final section of this chapter provides an overview of this thesis.

1.1 Background and Definitions

According to the literature, Dr Hans Selye has been credited as the “Father” of the stress concept which began with his experiments on animals in 1936. Since then, stress has been researched in a range of diverse fields including medicine, the behavioural sciences and philosophy (Selye, 1979). Selye proposed the General Adaptation Syndrome to explain stress in terms of three stages: alarm, resistance and exhaustion. During the alarm stage, the body becomes aware of a threat or stressor, and adrenaline is produced to induce the ‘fight-or-flight’ response. The resistance stage occurs if the threat or stressor persists, which means the body has to find a way to cope. Although the body can and will adapt during the resistance stage, it will not be able to do so indefinitely, and the body’s resources begin to deplete. By the time the exhaustion stage is reached, the body’s resources are depleted and illnesses can occur. Examples of physical illnesses include ulcers, diabetes and cardiovascular disease, and examples of psychological illness include depression and burnout.

Although fledgling research into occupational stress was being conducted in the late 1960s to mid-1970s, once Beehr and Newman (1978) published their review and analysis of the literature, occupational stress became recognised as an important area to research and began to flourish. According to Cotton and Hart (2003) the dominant approach to research during the 30 years that followed Beehr and Newman’s (1978) review was the stressors and strain approach. The stressor and strain approach assumes that strain results when work stressors contribute to poor physical or psychological health (Spector & Jex, 1998). The problem with this approach is that it does not consider the organisational context within which occupational stress occurs, and according to Hurrell and Murphy (1996), it also tends to reinforce the view that occupational stress is an employee problem

rather than a systemic problem within the organisation that management has the ability (and responsibility) to correct. In more recent years, research attention has turned to positive work experiences and occupational wellbeing.

In addition to the focus on stressors and strain, occupational stress has been studied from the perspective of individual differences, environmental factors, or a combination of the two (Parker & de Cottiis, 1983). It has also been treated as a stimulus, an outcome, an attribute of an individual, a characteristic of the environment, and an interaction between an individual and the environment (Beehr & Newman, 1978). Whether occupational stress is viewed as a process or an outcome, what is already clear is that it is a complex phenomenon.

The term 'stress', in the occupational context, is usually associated with psychological stress (Cooper, 1998), but researchers have so far failed to agree on a single definition of occupational stress. For example, Hurrell and Murphy (1996) suggest that occupational stress is "a situation in which characteristics of, or events related to, the workplace lead to the workers' ill health or welfare" (p. 338). Schuler (1980) developed a comprehensive definition that attempts to move away from the negative connotation of stress, to a more neutral or even positive connotation as follows:

Stress is a dynamic condition in which an individual is:

- a. confronted with an opportunity for being/having/doing what (s)he desires and/or
- b. confronted with a constraint on being/having/doing what (s)he desires and/or
- c. confronted with a demand on being/having/doing what (s)he desires and for which the resolution is perceived to have uncertainty but which will lead (upon resolution) to important outcomes. (p. 189)

Lazaus and Folkman (1984) define occupational stress as "... a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 21). However, the National Institute for Occupational Safety and Health (1999) includes a physical and emotional component in their definition of occupational stress, which they say is "the harmful physical and emotional responses that occur when job requirements do not match the workers capabilities, resources, and needs" (p. 6). These disparate definitions that regard stress as

either a process or an outcome reflect the lack of a widely accepted single definition of occupational stress (Parker & de Cotiis, 1983) and reflects the complexity of the issues involved. For the purpose of this thesis research, a combination of Lazaus and Folkman's (1984) and the National Institute for Occupational Safety and Health (1999) definitions, plus a Māori cultural perspective is preferred, so as to acknowledge that occupational stress involves a relationship between the person and the environment, an appraisal by the person that his or her resources are exceeded, and which endangers his or her wairua (spiritual), hinengaro (psychological), tinana (physical) or whānau (extended family) wellbeing.

1.2 Consequences of Occupational Stress

Although having some degree of 'challenge' within a role can induce feelings of achievement, thereby increasing a person's feeling of self-efficacy, confidence and esteem, when those challenges exceed a person's ability to cope, there is a number of negative consequences both for the individual and the organisation (Fletcher, 1988). At the individual level, negative consequences of occupational stress may include physical illness such as hypertension, coronary heart disease and mental illness such as depression (Cotton & Hart, 2003; Godin & Kittel, 2004; Gupta & Beehr, 1979; Wright, Bonett & Sweeney, 1993), maladaptive coping behaviour such as alcoholism and drug-taking (Wright et al., 1993), and can involve physiological, psychological and behavioural components (Schuler, 1980).

Examples of the negative consequences of stress to the organisation include absenteeism (Cotton & Hart, 2003; Godin & Kittel, 2004; Gupta & Beehr, 1979; Parker & de Cotiis, 1983), employee turnover (Chiu, Chien, Lin & Hsiao, 2005; Cotton & Hart, 2003; Gupta & Beehr, 1979; Parker & de Cotiis, 1983), job dissatisfaction (Beehr, Walsh, & Taber, 1976; Cotton & Hart, 2003; Denton, Zeytinoglu, Davies & Lian, 2002; Parker & de Cotiis, 1983), and complaints about the quality of customer service (Cotton & Hart, 2003).

These negative consequences to individuals and organisations come at a financial cost as well. Individuals have to pay to receive health services to address their physical and psychological ill health. In many cases, organisations still have to pay the wages and salaries of employees who have taken sick leave or stress leave, as well as paying for

counselling or other Employee Assistance Program (EAP) interventions. In those few cases that have ended up with the Employment Relations Authority or Employment Court, organisations pay the legal costs of representation, as well as potential financial compensation to affected employees. In addition, decreases in productivity caused by occupational stress issues, the financial cost of replacing staff who have left due to job dissatisfaction, and the costs of dealing with customer complaints about the quality of customer service (because of poor job performance) all cut into profits. Furthermore, there is a cost to society due to rising health care costs provided to individuals with physical and mental health issues related to occupational stress (Schuler, 1980; Spector & Jex, 1998; Wright et al., 1993).

1.3 The Relationship Between Job Satisfaction, Psychological Wellbeing and Occupational Stress, and Job Performance

Research over the years has evolved in a number of directions. The three directions discussed in this section of the chapter are the relationship between job satisfaction and job performance, the happy-productive worker thesis, and the relationship between occupational stress and job performance.

According to Judge, Thoresen, Bono and Patton (2001) it was during the 1930s, and as a result of the Hawthorne studies, that the potential linkage between employee attitudes and job performance was considered. Interest in the relationship between job satisfaction and job performance was stimulated further during the human relations movement that followed the Hawthorne studies. However, despite organisational researchers being intrigued for so long by potential links between job satisfaction and job performance, the relationship still remains empirically elusive. Indeed, research such as Iaffaldano and Muchinsky (1985) and Bowling (2007) found no persuasive evidence of a direct relationship between job satisfaction and job performance.

Rather than try to establish a direct link between job satisfaction and job performance, Thomas Wright, Russell Cropanzano and others (see Cropanzano & Wright, 1999; Wright & Cropanzano, 2000; Wright & Cropanzano, 2004; Wright, Cropanzano & Bonett, 2007) focussed their research efforts on the moderating role of psychological

wellbeing in the relationship between job satisfaction and job performance. According to Wright and Cropanzano (2000) psychological wellbeing has three characteristics. First, psychologically well people are happy when they believe themselves to be happy. Second, psychologically well people are more prone to experiencing positive emotions and less prone to experiencing negative emotions. Third, psychological wellbeing is a global evaluation and is therefore not limited to the occupational context. Wright, Cropanzano and others found that assuming employees have the requisite knowledge, skills and abilities to do the job, positive wellbeing adds more to job performance than job satisfaction alone. Furthermore, they found that psychological wellbeing rather than job satisfaction predicts job performance, and that psychological wellbeing may even be the cause of job performance.

The concept of psychological wellbeing also features in research related to the happy-productive worker thesis. According to Zelenski, Murphy and Jenkins (2008) the happy-productive worker thesis has also generated research interest since the 1930s, and proposes that happy workers are more productive workers. However, despite 70 years of research there is still uncertainty about whether happy workers are in fact more productive. Part of the problem lies with inconsistencies in how 'happiness' is defined and therefore measured. For example, happiness indicators could include job satisfaction, quality of work life, life satisfaction, or positive and negative affect (Zelenski et al., 2008), whereas Wright and Cropanzano (2000) define happiness as psychological wellbeing. Another part of the problem lies with inconsistencies in how productivity or job performance is defined and therefore measured. For example, Barrick and Mount (1991) measured job performance as job proficiency, training proficiency and personnel data, whereas Motowidlo, Packard and Manning (1986) measured job performance using supervisor and co-worker ratings on interpersonal performance elements (including sensitivity, consideration, warmth and tolerance of others), and cognitive or motivational performance elements (including concentration, composure, perseverance, and adaptability).

Despite the issues surrounding definitions and measurement of happiness and job performance, some research does support the happy-productive worker thesis. For example, Staw, Sutton and Pelled (1994) found that positive job attitudes and positive emotions had favourable work outcomes in terms of supervisor evaluation and co-worker

support. And of course the research of Wright, Cropanzano and others found that employees who had higher levels of psychological wellbeing received higher ratings of job performance from their supervisor.

Research demonstrating a direct link between work stressors and job performance is more clear cut, although there is a lack of agreement about whether the relationship between work stressors and job performance is a positive linear one (stress is good), a negative linear one (stress is bad), or an inverted u one (some level of stress is good for optimal performance, but levels below and above this are detrimental) (Muse, Harris & Feild, 2003). Acknowledging that the effects of low stress levels (such as boredom) on job performance have not attracted as much research attention as the effects of high levels of stress, the evidence is overwhelming that stress negatively impacts job performance. Friend (1982) found that subjective workload and time urgency impair job performance. Jamal (1984) found that among nurses, job stressors (such as role ambiguity, role overload, role conflict and resource inadequacy) negatively impacted their job performance (as measured by motivation and patient care skill) and increased withdrawal behaviours such as absenteeism, tardiness and anticipated turnover. Motowidlo et al. (1986) found a significant correlation between self-reported perceptions of stressful events such as work overload, criticism, negligent co-workers, and a lack of support from supervisors, and interpersonal and cognitive job performance indicators. Gilboa, Shirom, Fried and Cooper (2008) examined the relationship between role ambiguity, role conflict, role overload, job insecurity, work-family conflict, environmental uncertainty and situational constraints on job performance, and found that role ambiguity and situational constraints were negatively correlated with job performance. Interestingly, Kousar, Dogar, Ghazal and Khattak (2006) found there was no significant relationship between overall stress and job performance, but there was a significant negative correlation between workload and job performance. This finding highlights that it is specific work stressors, rather than overall stress that negatively impact job performance.

1.4 Why Should Managers Care about Occupational Stress?

Why should managers in organisations care about the impact of occupational stress? Sethi and Schuler (1984) provide four reasons:

- ◆ The financial impact on organisations
- ◆ Organisational effectiveness
- ◆ Legal obligations to provide safe and healthy places of work, and
- ◆ Concern for employee health and wellbeing

With respect to the financial impact on organisations, section 1.2 of this chapter presented some of the literature that details this issue. When it comes to organisational effectiveness, section 1.3 of this chapter provided a clear link between occupational stress and job performance, confirming that maximum effectiveness is not possible when staff experience high levels of stress. In terms of the legal obligations to provide safe and healthy places of work, Chapter 3 will provide more details of the legislative context in Aotearoa New Zealand. This legislation confirms that compliance is an issue that managers and organisations are required to address. With respect to concerns about employee health and wellbeing, in the spirit of social relations, motivation and employee satisfaction of the Human Relations Movement (Rudman, 2002), and the whakatauāki (proverb) that opened this chapter, taking care of staff is morally the right thing to do.

1.5 Psychometric Assessments and Māori

1.5.1 Psychometric Assessments: What they are and why they're used

In the context of the workplace, psychometric assessments are measurement instruments such as questionnaires and tests that have been developed to measure a psychological phenomenon such as knowledge, abilities, attitudes and personality. They are most often used in the field of recruitment and selection, and aid decision-makers to predict which candidate will perform best on-the-job, and therefore to choose the right person for a position. However, psychometric assessments are also used with incumbents to measure existing levels of a particular psychological property such as an ability (for

example leadership) to see whether an individual meets a particular standard considered necessary by an organisation.

1.5.2 Construction Issues: Reliability and Validity

Psychometric assessments must meet strict scientific and technical requirements before they are considered appropriate for use. Two key concepts must be adequately addressed: reliability and validity. A reliable assessment consistently measures the psychological property of interest (such as occupational stress) across time, individuals and situations. A valid assessment measures what it claims to measure, for example occupational stress rather than everyday stress. A psychometric assessment must be both reliable and valid, but while an assessment cannot be valid unless it is reliable, reliability by itself is not sufficient to achieve validity (Coolican, 1999).

According to Miller, McIntire and Lovler (2011), three types of reliability are test-retest, internal consistency and scorer reliability. Test-retest examines reliability over time, and involves comparing scores taken from the same set of test-takers, but taken at different times. Internal consistency examines how well the test questions are related to each other, and can be calculated statistically. Scorer reliability examines the consistency of judgements made by those that score an assessment, and involves comparing the judgements that two or more scorers make about answers on an assessment to see how much they agree.

When it comes to validity Miller et al. (2011) discuss current views related to gathering evidence, including evidence based on test content, response processes, internal structure, relations with other variables, and consequences of testing. Gathering evidence based on test content (content validity) involves evaluating the psychometric assessment's format, wording and the processes that test-takers must go through to determine whether the content is relevant to and representative of the psychological property of interest. Gathering evidence based on response processes involves observing test-takers while they are taking the assessment, or interviewing them after they have taken the test to understand the mental processes they use when they respond to the assessment. Evidence based on internal structure (construct validity) involves using statistical techniques such as factor analysis to determine how many underlying concepts or factors account for the variance in

test-taker's scores. Evidence based on relations with other variables (construct validity) involves performing statistical analysis to determine whether the psychological property of interest is correlated with other similar concepts (convergent validity), and whether it is not correlated with different concepts (discriminant validity). Evidence based on the consequences of testing involve examining whether an assessment maybe biased in favour of one group over another, resulting in unintended consequences to test-takers for which the bias has caused a disadvantage. Clearly, the more evidence that is gathered for all these forms of validity of a psychometric assessment, the more credibility it will have with the professionals who administer that assessment, and the test-takers who are the focus of the process.

1.5.3 Score Interpretation: Criterion and Norm Referencing

When interpreting a test-taker's scores on a psychometric assessment, those scores are compared against a particular benchmark in order to identify how a test-taker ranks (or is referenced) against other test-takers. Two types of such comparison are criterion referencing and norm referencing (Morrow, Jackson, Disch & Mood, 2011). Criterion referencing is when, for example, a certain standard of leadership performance has been predetermined by an organisation as necessary to do a particular job effectively. If a test-taker has not met the required criterion, then professional development initiatives can be put in place to assist that person to improve their performance. Norm referencing is when the test-takers scores are compared with the average scores of other people in the same population. In the occupational context, some of those populations may be individuals doing the same type of work (for example executive managers in the finance industry) or from the same demographic background as the test-taker (for example Māori managers in the health and disability sector). Most psychometric assessments are developed in such a way that they can be interpreted by comparing against both a particular criterion and a particular norm group.

1.5.4 Are Western Developed Psychometric Assessments Valid for Māori?

Many of the psychometric assessments used in Aotearoa New Zealand, including those designed to measure occupational stress, have been developed in overseas Western countries, and norm reference data gathered from sample groups in Aotearoa New Zealand. This process of norm referencing assessments in the Aotearoa New Zealand context is thought to ensure any underlying cultural differences between the country the test was developed in and Aotearoa New Zealand, have been adequately and fairly addressed to ensure test-takers, including Māori, are not disadvantaged by those differences. However, in the process of norm referencing in this situation, insufficient thought has been given in Aotearoa New Zealand as to whether norm referencing alone ensures the validity of a particular assessment when it comes to the Māori population.

With respect to construct validity, Messick (1980) makes a very important distinction between whether a particular assessment measures the psychometric properties it is interpreted to assess (the classic understanding of construct validity) and whether it should be used to measure those psychometric properties. The first question can be answered based on the scientific and technical evidence around the construction of that assessment, but the second question is an ethical one which is based on appraising the potential social consequences of using the assessment in the proposed way. Messick (1980) argues that to achieve construct validity, a psychometric test must be **both** scientifically valid (reliable and valid in the technical psychometric sense) **and** socially valid (no unintended consequences for any social groups). The reason for considering unintended consequences for social groups is because what is considered ‘good’ or ‘bad’ when it comes to psychological properties depends on the values underpinning the assessment. Those values are based on what is considered important within a cultural context – specifically the culture for which the psychometric assessment was originally developed. Therefore, when considering whether to norm reference a psychometric assessment developed overseas for the Māori population, we first need to ask if the values of the originating culture align with the values of the Māori culture. If not, norm referencing may have unintended consequences for Māori test-takers, and may not therefore be ethically sound.

1.5.5 Cultural Differences: Māori in Aotearoa New Zealand

Geert Hofstede (1984) identified four dimensions around which cultures differ. These are power distance, uncertainty avoidance, individualism versus collectivism and masculinity versus femininity. Power distance is the extent to which less powerful members of society accept that power is distributed disproportionately. Uncertainty avoidance is the extent to which uncertainty and ambiguity is tolerated. Individualism versus collectivism is the extent to which individual or collective values are encouraged. Masculinity versus femininity is the extent to which power and assertiveness are valued.

According to Hofstede (1984) the dimension that has the most influence on human values and behaviour is individualism versus collectivism. Individualistic cultures are characterised by an individual's focus on their own and their immediate family's best interests, and emphasise individual expressions, initiative and independence. By contrast, collectivist cultures are characterised by their focus on the group's best interests ahead of the individual, and emphasise interdependence of group members, individual behaviour being shaped by group norms, and individuals behaving in a communal way (Triandis, 1995).

In Hofstede's (1984) research, New Zealand was classified as highly individualistic, along with other Western countries such as the United States of America, Canada, the United Kingdom and Australia (from which many of the psychometric assessments used in Aotearoa New Zealand originate). However, it is not likely that there was an adequate representation of Māori in Hofstede's sample at the time of his research. Within the Māori culture, individuals self-identify to a tribal affiliation and place a high value on kinship ties. They have a strong sense of reciprocal responsibility for and interdependence with members of their extended whānau (family) and wider community – especially within a marae (central area of a village and its buildings) setting (Mead, 2003; Patterson, 1992; Walker, 1989). Given the differences between individualistic Western cultures (including European New Zealanders) and the collectivist Māori culture, it is debatable as to whether norm referencing some psychometric assessments ensures those assessments are valid for Māori. Even if the norm group does include Māori respondents, the question remains as to whether the value assumptions upon which the assessment is

predicated in the first place, is a true and fair reflection of the values and experiences of Māori, including Māori in the workplace.

1.5.6 The Context of History in Aotearoa New Zealand

Within the Aotearoa New Zealand context, examining Hofstede's (1984) cultural differences alone to determine whether a psychometric assessment is valid for Māori is somewhat simplistic. In fact Hofstede and Bond (1984) acknowledge that "... sociological, political and economic functioning of social systems" (p. 417) are also influenced by culture. The sociological, political and economic systems in New Zealand have been shaped by our unique history.

Māori and non-Māori in Aotearoa New Zealand co-exist within the historical context of Māori having been extensively colonised by English and other European cultures and religions. Since the signing of the Treaty of Waitangi in 1840, approximately 3.25 million acres of land have been lost to Māori through illegal deals, breaches of contract and confiscation, to the point that today Māori hold less than five percent of the land (Sullivan, 1995). This deliberate and systematic stripping of land has also stripped Māori of their economic, cultural and spiritual base, which has resulted in detribalisation, and marginalisation from the now dominant Western Pākehā (non-Māori European) culture (Sullivan, 1997). Hopa (1999) noted that such dispossession of an economic resource not only created a detribalised, marginalised, disempowered and increasingly dependent people, but also left Māori struggling to correct their unequal position within Aotearoa New Zealand. Māori protests over the illegal theft of their land resources have been part of the history of Aotearoa New Zealand since the mid-1800s, as successive governments have systematically eroded not just Māori economic resources, but political power too (Kelsey, 1997).

According to Sissons (1995), biculturalism was adopted in 1982, but the government's lack of a clear definition of what that meant allowed them to avoid any genuine attempt to empower Māori to enjoy power sharing in government processes, equality of resources, and therefore equal rights and opportunities. In fact, Fleras (1989) argues that government efforts to embrace biculturalism and provide Māori sovereignty have instead continued to endorse the political status quo, and ensured that Western Pākehā

liberal-democratic values retain the dominance they have enjoyed since colonisation. However, the ethos of a nation for one people, which governments since 1840 have been trying to achieve, has not succeeded (Lashley, 2000). To date, chronic poverty, poor social conditions, and problems with race relations remain a reality for many Māori. In addition, according to Kelsey (1997), many Māori perceive that Aotearoa New Zealand continues to be occupied by a colonial power, and ongoing resistance to that power revolves around the Treaty of Waitangi.

Māori protest over perceived legalised theft of Māori resources or the struggle to have a Māori voice in the political arena did not end in the 1800s or the 1900s. As recently as May of 2004, Māori Member of Parliament, Tariana Turia, resigned from the New Zealand Labour Party in protest over proposed foreshore and seabed legislation (Tariana Turia to resign and force byelection, 2004). The controversy over the foreshore and seabed erupted when the New Zealand Court of Appeal ruled in 2003 that the Ngāti Apa iwi, who had sought a judgement about the foreshore and seabed in the Marlborough Sounds (in the northern part of the South Island) ruled that Māori could seek 'customary title' of the foreshore and seabed in their rohe (territory) in the Māori Land Court (Johansson, 2004). Despite the fact that such 'customary title' had not yet even been tested in the Māori Land Court, and amid politically fuelled fears that such 'customary title' would lead to (among other things) Māori excluding ordinary New Zealanders from free access to beaches, the New Zealand Labour Party's response was to legislate the foreshore and seabed into crown title instead. This political move was seen by many Māori to be yet another legalised theft of Māori resources by the crown, effectively denying Māori any recourse through the Māori Land court (Johansson, 2004). As a result of this event, and a protest march of over 20,000 people on parliament, a new independent Māori political voice, through the establishment of the Māori Party, was born, with Tariana Turia as the co-leader (Maddison, 2006).

In January of 2004, the then new leader of the New Zealand National Party, Don Brash, made his infamous speech to the Orewa Rotary club, in which he talked about race relations in New Zealand and the special place of Māori (which he interpreted as 'Māori special privilege'), advocating instead for 'one law for all' (Brash, 2004). Don Brash also referred to the 'entrenched Treaty grievance industry', and asserted that the Treaty of Waitangi (supposedly a relic of 19th century law) was undermining attempts to build the

nation. This speech was instrumental in gaining the National Party leader a public profile, and increasing the popularity of the National Party in the polls. Sadly, it also marked another chapter of tense race relations in Aotearoa New Zealand and a period when many Māori felt persecuted in the public arena. In an analysis of the Orewa speech, Johansson (2004) set the context for the National Party's political strategy to 'play the race card' and the subsequent scapegoating of Māori for the purpose of reviving the party's fortunes in the polls. Then, in his 2006 book titled *The Hollow Men: A Study in the Politics of Deception*, Nicky Hagar revealed documents from leaked sources within the New Zealand National Party, that claimed (among other things) that Don Brash's Orewa speech was a deliberate and cynical exploitation of tense race relations in Aotearoa New Zealand in an attempt to win the 2005 election.

Although Don Brash's Orewa speech was not the first time divisive politics have been used in New Zealand for the purpose of gaining votes, the speech did tap into an underlying resentment towards Māori and the Treaty of Waitangi issues, highlighting racial tensions in Aotearoa New Zealand. Those racial tensions extend into the workplace, creating a unique context for ways that Māori experience occupational stress. Western developed assessments of occupational stress have not taken this context into consideration, and norm referencing is not sufficient to capture that unique experience.

1.6 *Rationale for Developing Mahi Oranga*

Given the cultural difference and historical context for Māori and non-Māori alike in Aotearoa New Zealand, it is difficult to accept that Western developed psychometric instruments, whether norm referenced or not, can accurately capture the experience of occupational stress for Māori. In addition, Western psychometric measures focus on occupational stress and how to reduce it, but often lack a positive focus on ways to build healthy workplaces. Although it is increasingly recognised that Western worldviews differ from Māori and other indigenous worldviews in the context of general and mental health and wellbeing, that understanding in the context of occupational health and wellbeing has not yet been widely recognised. No evidence could be found in the literature review that any specific measure (psychometric or otherwise) of occupational stress or wellbeing for

indigenous groups yet exists. Mahi Oranga therefore breaks new ground towards achieving a culturally responsive, psychometric measure of occupational health and wellbeing.

Focussing research attention on Māori in the health and disability workforce in Aotearoa New Zealand came about because of the stories the researcher heard from friends and whānau within that workforce about their experiences of ‘toxic workplaces’ and other issues related to occupational stress. Further research revealed that Māori are under-represented in the health and disability workforce, but health disparities for Māori in the wider population persist (Ministry of Health, 2006c). The question was, how can our tangata whaiora (Māori patients or clients) be receiving the best possible health services if our Māori health workforce are working in toxic workplaces and experiencing high levels of occupational stress? It is hoped that this thesis research will go some way towards addressing some of the causes of occupational stress for our Māori health workforce, so that health disparities in the wider Māori population can be successfully addressed. It is also hoped that this thesis research will provide Māori health workers a much needed voice to have their experiences heard.

1.7 Thesis Overview

Chapter 2 discusses some of the literature on occupational stress, including models, theories, and sources of occupational stress. Evidence is also presented that occupational stress varies among occupational groups and the chapter concludes with a focus on stress in the health sector. Chapter 3 provides the Aotearoa New Zealand context in relation to occupational stress and healthy workplaces, including relevant health and safety in employment legislation, resources to help organisations address occupational stress, and the role of the Treaty of Waitangi in the public sector. Then the limited existing research about Māori and occupational stress is examined, followed by a discussion of government policy in relation to Māori in the health and disability sector workforce. Chapter 3 concludes by shifting focus from occupational stress to occupational wellbeing, and presents an expanded transactional model of health and wellbeing that locates ethnic or cultural worldviews as an individual moderator and cultural wellbeing as an individual outcome in the occupational wellbeing process. Chapter 4 presents an alternative to the dominant Western worldview of

health, and examines a variety of indigenous models of health and wellbeing. In addition to the Western biomedical model and the World Health Organization definition of health, Chapter 4 presents worldviews and models from Native American Indian and First Nation Tribes of North America, from the Kānaka Maoli people of Hawai'i, the Aboriginal peoples of Australia, and a variety from Pacific Islands peoples. Chapter 5 then brings the focus back to Aotearoa New Zealand, and examines a range of Māori models of health and wellbeing, including Te Whare Tapa Whā, Te Wheke, Ngā Pou Mana, Te Pae Māhutonga, and Te Pōwhiri Poutama. Chapter 5 concludes by providing a rationale for choosing the particular Māori model of health and wellbeing used to develop Mahi Oranga. Chapter 6 details the consultation phase of developing Mahi Oranga, and presents the various themes that emerged from those discussions with Māori participants working in the health and disability sector. Chapter 7 details the process of developing the Mahi Oranga questionnaire, including sources that informed the development phase. Chapter 8 details the data collection phase of Mahi Oranga and presents the quantitative results of that data collection including exploratory factor analysis, correlations and t-tests. Chapter 9 details the qualitative results of the data collection phase and discusses the findings according to occupational stress experiences that are common to all staff, those that are unique to Māori, and culturally responsive coping strategies. Chapter 10 discusses the various interventions that organisations tend to use to address occupational stress, and advocates a move beyond just stress reduction interventions to interventions that create healthy workplaces. It also highlights further research implications as a result of the findings of this thesis. The chapter (and thesis) closes with a call for the need to increase awareness, knowledge, and skills regarding issues around Māori occupational stress amongst a variety of stakeholder groups. Those stakeholder groups include managers and organisations, mainstream industrial/organisational and human resources professionals, and lecturers of industrial/organisational and human resource programs in the tertiary education sector.

Chapter 2 – Occupational Stress

Since the late 1970s the topic of occupational stress has, and continues to, generate a large volume of research literature. The purpose of this chapter, rather than comprehensively review all of the occupational stress literature, is to present selected aspects of the literature to provide an overview of what is relevant to the purpose of this thesis research. Accordingly, this chapter will first present a selection of occupational stress models, before moving on to sources of occupational stress. Next it will provide evidence of variations in levels of stress between occupational groups. Finally it will discuss occupational stress and the health sector professions, then conclude with a chapter summary that argues for the need for organisations to address sources of occupational stress alongside the current popular interventions of employee focussed programs such as EAP and workplace wellness programs.

2.1 Models of Occupational Stress

Research on the general topic of stress has been traced back to 1914, with a more specific focus on models of occupational stress beginning in the early 1960s, progressing to sustained research on a range of occupational stress topics since the late 1970s (Jex, 1998). In this section of the chapter, a selection of occupational stress models will be briefly outlined to gain an overview of research in this area, followed by a brief critique of each model. The selection of models presented here is not exhaustive, but is representative of the more widely accepted models in the occupational stress and wellbeing literature.

2.1.1 Job Characteristics Model

The job characteristics model was developed by Richard Hackman and Greg Oldham (1976) as a model of work motivation and job design rather than a model of occupational stress. Although it is the most widely used model of job design (Parker & Wall, 1998), it is routinely discussed in the occupational stress and wellbeing literature (de Jonge & Schaufeli, 1998; Hurrell & Murphy, 1996; Landsbergis, 1988; Sullivan & Bhagat, 1992), so has also been included here. According to the job characteristics model (see Figure 2.1 below), five core job dimensions result in three critical psychological states.

These three critical psychological states result in positive personal and work outcomes. The core job dimensions, critical psychological states, and personal and work outcomes are said to be moderated by the individual difference of growth need strength. The motivating potential of a job can be calculated using the following formula:

$$\text{Motivating Potential Score (MPS)} = \left[\frac{\text{Skill Variety} + \text{Skill Identity} + \text{Task Significance}}{3} \right] \times \text{Autonomy} \times \text{Feedback}$$

Hackman and Oldham (1976) assert that employees who have a high need for personal growth and development and will respond more positively to jobs high in motivating potential, thereby experiencing less stress.

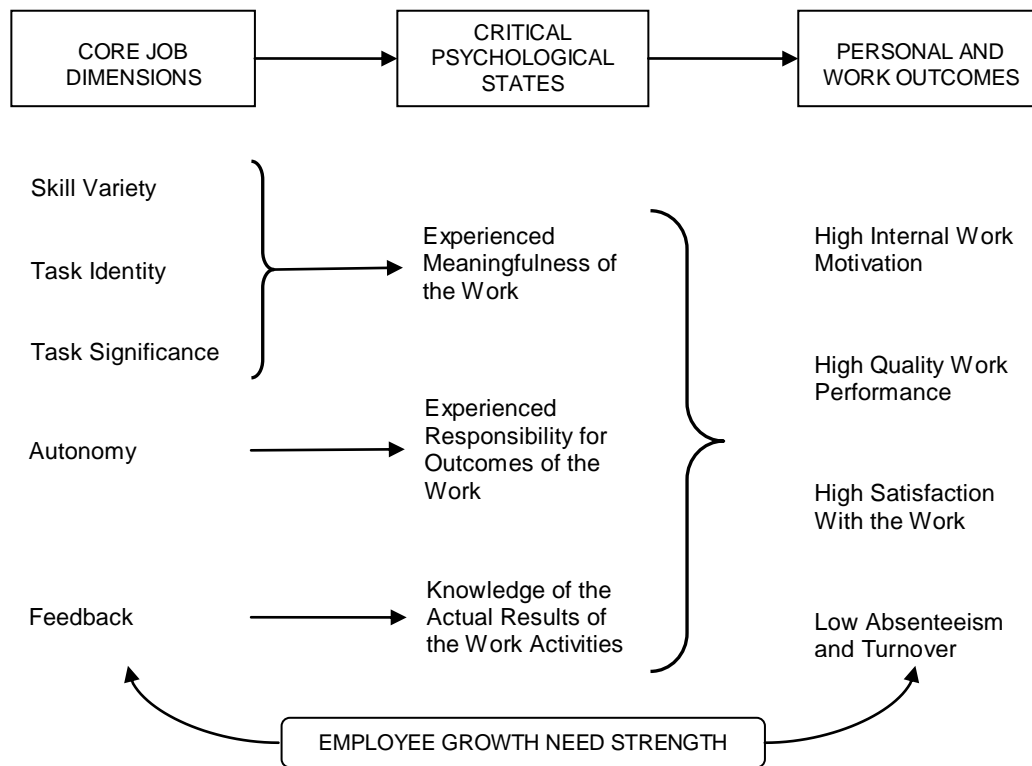


Figure 2.1 Job Characteristics Model of work motivation (Hackman & Oldham, 1976).

While this model has practical application in the field of job design, it still has five limitations, which will only briefly be identified here. For a more comprehensive discussion of these limitations, see Parker and Wall (1998). The first problem lies with the

distinctiveness of the five job characteristics, and the second problem lies with the role of the critical psychological states. The third problem lies with the moderating effect of growth need strength, and the fourth problem lies with the efficacy of the motivating potential score. The fifth and final problem lies with the relationship between the outcome variables. In addition, from the perspective of occupational stress it does not take into account other individual factors such as personality differences, cultural differences, or differences in coping strategies. Nor does it take into account situational factors within the organisation such as leadership style, climate, or social support. Caution is therefore advised when considering this model in the context of occupational stress.

2.1.2 Job Demands-Control-Support Model

The original job demands-control model (see Figure 2.2 below) was developed by Robert Karasek (1979), and posited that the relationship between job demands and stress was moderated by job control (job decision-latitude). According to Wall, Jackson, Mullarkey, and Parker (1996) the core hypothesis of this model is that high job demands only result in psychological strain when decision latitude is low. The model was later expanded by Jeffrey Johnson (1989) to include social support, and became the Job Demands-Control-Support Model (Daniels, 1999). Johnson (1989) found that there was an interaction between job demands, job control, support, and wellbeing, such that social support moderates the relationship between job demands and wellbeing by influencing a person's coping strategies.

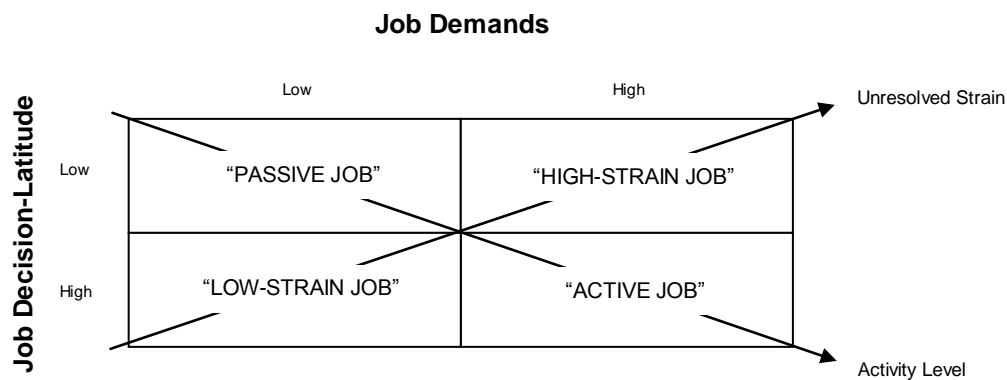


Figure 2.2 Job-Demands-Control Model of occupational stress Karasek (1979).

While this model focuses on the job factors that contribute to occupational stress (strain), it assumes that all job demands result in some degree of strain, and that the problem of high job demands can be resolved by increasing a person's job control. It also assumes that all forms of social support result in lower levels of occupational stress. However, not all demands are evaluated by a person as a threat to their wellbeing, and some individuals would feel more, rather than less, stress by having more job control. In addition, different forms of social support will influence a person's coping strategies differently, and may also result in more, rather than less, stress. Finally, as well as coping strategies not being an explicit component of this model, it too does not comprehensively take into account individual or situational factors that contribute to occupational stress (Kristensen, 1995).

2.1.3 Person-Environment Fit Model

The Person-Environment (P-E) Fit model was first pioneered by Robert Kahn (Kahn, Wolfe, Quinn, Snoek & Rosenthal, 1964), and was referred to at the time as Person-Role Fit. The P-E Fit model identifies two types of 'fit' between a person and the environment, with the discrepancy being labeled as a 'misfit'. The first type focuses on the job and whether those factors meet the needs and preferences of the person. The second type focuses on the person and whether they have the skills and abilities to meet the requirements of the job (van Harrison, 1985). Fit or 'misfit' depends on the relationship between the skills and abilities of the employee (person) and the supply of resources available in the work environment (environment) to meet work goals (French, Caplan & van Harrison, 1982). The horizontal axis (see Figure 2.3 below) shows the scale of person-environment fit. The zero on the scale shows the 'perfect' fit, whereby the supply of resources in the environment matches the motives, skills and abilities of the employee. The negative scores on the scale occur if the supply of resources in the environment is lower than the motives, skills and abilities of the employee, and indicates a 'misfit' (strain) for the person. The positive scores on the scale occur when the motives, skills and abilities of the employee are lower than the requirements of the job, and indicates a 'misfit' (strain) for the organisation.

Other variants of the P-E Fit model include the Person-Organisation (P-O) Fit model, and the Person-Job (P-J) Fit model. All of these 'fit' models more commonly included in the selection rather than stress literature.

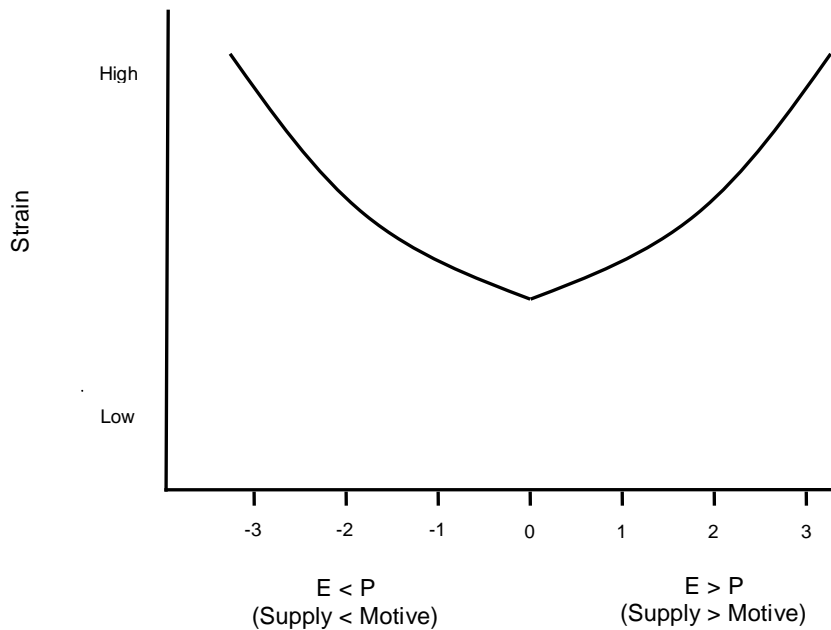


Figure 2.3 Relationships between P-E Fit and Strains (French, Caplan & van Harrison, 1982).

Although the P-E Fit Model is discussed within the occupational stress literature, as previously mentioned, it is more commonly discussed in the selection literature to explain the importance of selecting the right person for the organisational environment. That said, there is some utility for the model to help understand aspects of occupational stress. This model does at least consider individual factors (person) and situational factors (environment) in the relationship between job demands and occupational stress (strain). However, according to Cooper, Dewe, and O'Driscoll (2001) although it has been one of the most widely discussed models in the literature, there is very little empirical evidence to support it with regard to stress. This is largely due to a lack of clarity around the nature of 'misfit', as well as problems measuring the constructs involved.

2.1.4 Work Adjustment Theory

Another theory of person-environment fit, variously known as work adjustment theory (WAT) or the theory of work adjustment (TWA), was first developed by Llyod Lofquist, Gene England and René Dawis in 1964. It has been refined several times since 1964, but the basic assumption of WAT is that individuals will try to achieve and maintain correspondence, or 'fit' with their work environment (Dawis & Lofquist, 1984). Correspondence occurs when there is a fit between the skills an individual brings to the work environment, and the rewards the individual receives from the work environment. The process of trying to achieve and maintain correspondence is said to be continuous and dynamic, and it is that process that Dawis and Lofquist (1984) refer to as work adjustment. If stability of correspondence is achieved between an individual and their work environment, the outcome is tenure in the job. Satisfaction is the extent to which the requirements of an individual are fulfilled by the work environment, and satisfactoriness is the extent to which the requirements of the organisation are fulfilled by an individual. Figure 2.4 below demonstrates how work adjustment can be predicted. Although WAT does not specifically focus on occupational stress, it follows that a lack of correspondence or 'fit' will result in stress or strain, in which case an individual will try to achieve correspondence either by attempting to change the work environment (referred to as an active adjustment style) or themselves (referred to as a reactive adjustment style) (Dawis & Lofquist, 1984). If satisfaction is not achieved, WAT predicts the individual will quit. The organisation also has several courses of action depending on the level of satisfactoriness, including promoting, transferring, firing or retaining the individual.

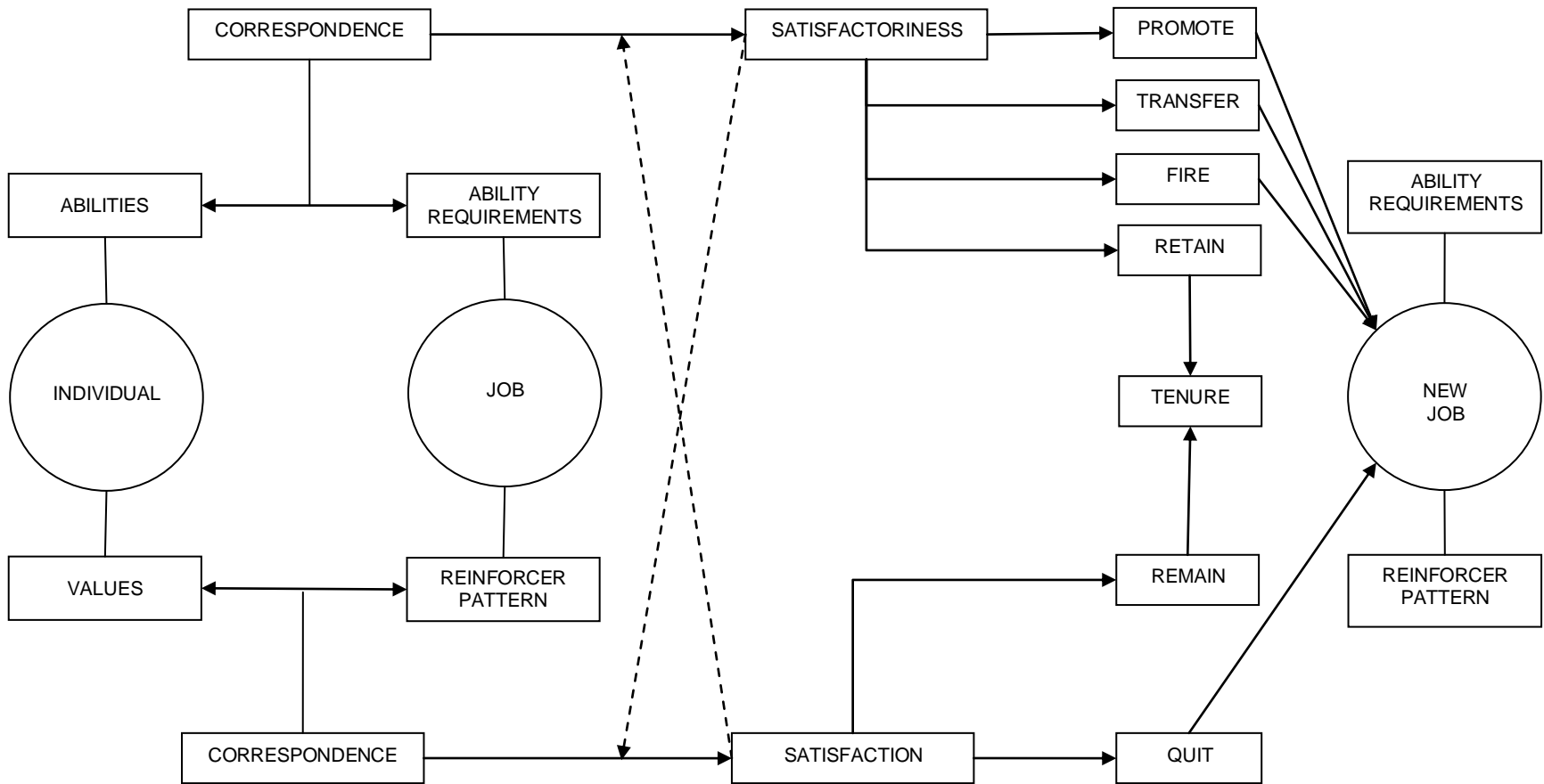


Figure 2.4 Prediction of work adjustment (Dawis & Lofquist, 1984).

Like other models of P-E fit, WAT has its origins in selection rather than occupational stress literature. It therefore has limited utility for understanding stress, but WAT does illustrate where a lack of 'fit' or correspondence (resulting in stress) can occur between an individual and their work environment. One of the criticisms of WAT is that the research focus on 'fit' has tended to rely on normative perspectives of work environments, rather than what actually happens in the 'real' world of work (Tinsley, 2000). In addition, WAT research has tended to focus on macro-environments (for example, all primary school settings), which does not account for variances at the micro-environment level (such as a specific primary school setting).

2.1.5 Transactional Model of Stress

The transactional model of stress was originally developed by Richard Lazarus and Susan Folkman (1984), and expanded the focus on job demands as the cause of stress. Three theories play a key role in understanding the transactional model: transaction, process, and emotions as a system. According to Lazarus and Folkman (1987), transaction refers to the relationship between the person and the environment. So for example 'threat' as a concept is meaningless unless something is understood about the environment within which the threat is apparent, as well as understanding something about the person who is experiencing that threat. Process refers to coping, and requires examining the thoughts or actions a person is actually experiencing, which may be different from their usual thoughts and actions. In addition, coping must take into account the context within which the demand is being experienced, and that may change over time or within different contexts. Emotion is viewed from a systems perspective which takes into consideration environmental antecedents, mediating processes, short-run outcomes and long-run adaptational outcomes. Environmental antecedents might include variables such as demands, available resources, and how ambiguous the situation is. Mediating processes include the way a person appraises the environmental antecedent and then copes with it. Short-run outcomes include the immediate emotions or actions of a person in response to the environmental antecedent. Long-run adaptational outcomes include psychological wellbeing or physical wellbeing. What distinguishes the transactional model of stress from the other models is the inclusion of appraisal and coping as mediating variables to explain

the stress process, as well as the focus on the transactional relationship between people and their external environment. According to Cooper et al. (2001) this transactional process has dramatic consequences for measuring ‘stress’ for two reasons. First, consideration must be given to defining the structural components of the appraisal process, and second, whether current measurement practices are sufficient to capture the transactional process.

Lazarus and Folkman’s (1984) transactional model of stress was further adapted by McGowan (2004) to explicitly recognise for the first time that individual outcomes (short-run and long-run) rather than being only negative resulting in distress, can also be positive resulting in eustress (see Figure 2.5 below). Please note that the terms ‘distress’ and ‘eustress’ will only be used in reference to this specific model, but elsewhere in this thesis more common term of ‘stress’ and ‘wellbeing’ will be used. Explicit recognition of positive eustress outcomes means that focus can be shifted from models of occupational stress to models of occupational wellbeing, and also ways to create healthy workplaces that maximise the positive eustress outcomes for individuals and organisations.

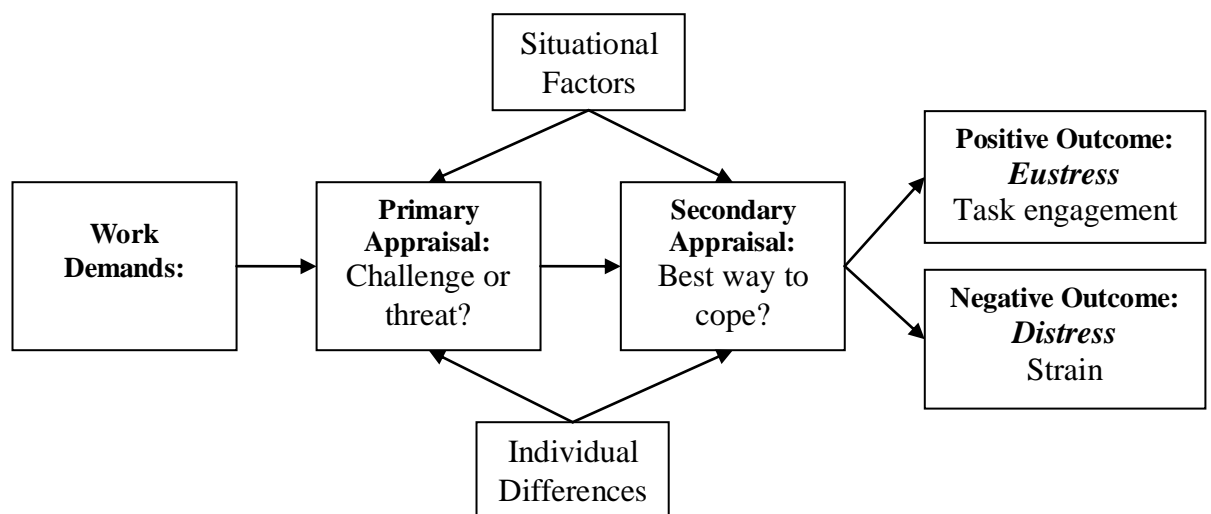


Figure 2.5 An Appraisal-Coping Model of occupational stress (McGowan, 2004).

The core model developed by Lazarus and Folkman (1984) and expanded on by McGowan (2004) provides the most comprehensive understanding of the process of occupational stress. It acknowledges that occupational stress is a dynamic process, with

multiple dimensions and influencing factors. Not only does it consider the influence of situational factors such as the nature of the job, or the culture of the industry or organisation, it also considers individual differences. In addition, the identified outcomes of distress or eustress provide an opportunity for researchers to identify not just those variables that reduce stress, but also those variables that create eustress.

In terms of individual differences that moderate distress/eustress outcomes, (McGowan, 2004) mentions variables such as resilience, hardiness, vulnerability, neuroticism, Type A personality, optimism, and internal locus of control. While research into those variables adds to our greater understanding of the occupational distress/eustress process, to date research on the role that a person's culture plays has been limited, and the literature review has so far revealed no research into the ways that indigenous culture impacts that process.

2.2 Sources of Occupational Stress

Sources of occupational stress also received research attention in the late 1970s, however few major contributions have been made in this area since then. Instead, the original five sources identified by Cooper and Marshall (1976) in their model of stress at work (see Figure 2.6 below) have been further refined. The original five sources included those intrinsic to the job, role in the organisation, career development, relationships at work, and organisational structure and climate. At that time, Cooper and Marshall (1976) acknowledged that factors outside the organisation could cause stress to an individual, and they labeled these extra-organisational sources of stress. However, in the late 1990s Cartwright and Cooper (1997) refined the original model and redefined the original sources of stress at work, to the broader heading of sources of stress. They then included the original 'extra-organisational sources of stress' – now renamed 'non-work factors' under that heading as a sixth source of stress in their dynamics of work stress model (see Figure 2.7 below). In addition, they more clearly separated individual and organisational symptoms of stress. Since 1997, researchers have ultimately only given different names to the original sources. For example, de Dreu and van Vianen (2001) refer to interpersonal conflict, which could be mapped back to the original 'relationships at work' source, and

Cooper et al. (2001) redefined the 1997 source of 'non-work factors' and called it 'the home-work interface'. For a more detailed discussion of each of the six sources of occupational stress, refer to Cooper et al. (2001).

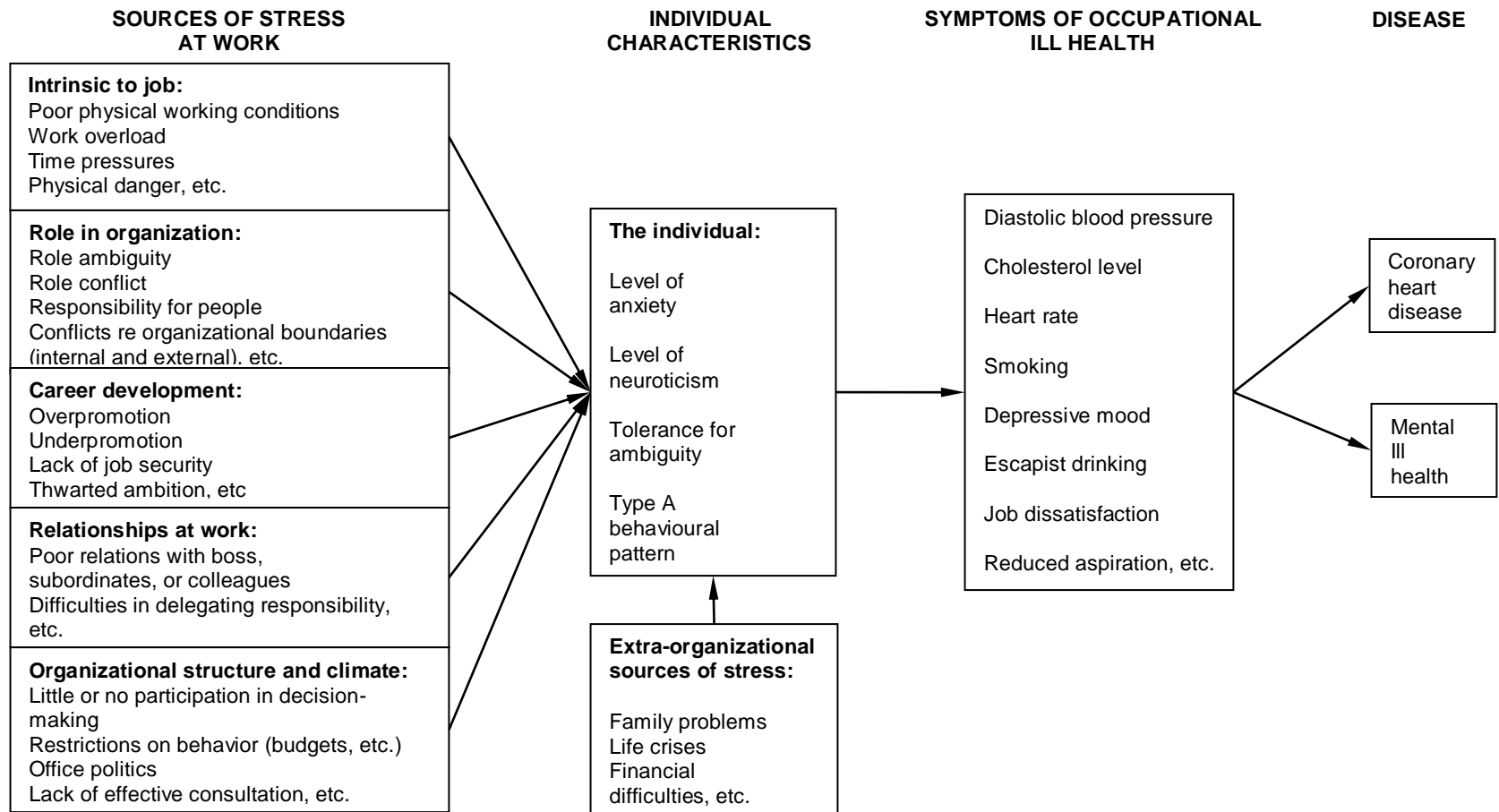


Figure 2.6 A model of stress at work (Cooper & Marshall, 1976).

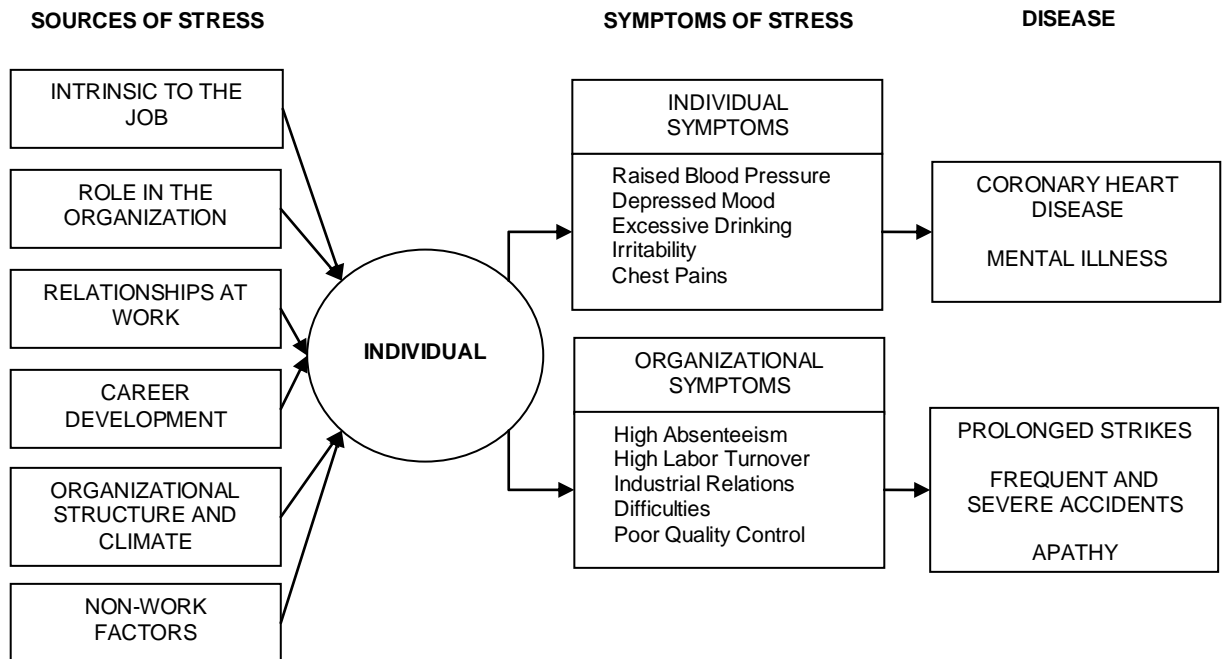


Figure 2.7 Dynamics of work stress model (Cartwright & Cooper, 1997).

What seems clear from Cooper and Marshall's (1976) and Cartwright and Cooper's (1997) model is that more sources of occupational stress will result in more individual and organisational symptoms of stress, and ultimately more individual and organisation disease. It therefore follows that reducing sources of occupational stress will result in fewer individual and organisational symptoms of stress and less individual and organisational disease. However, most organisational interventions target employees through health education, health promotion or stress management and EAP programs (Cooper & Cartwright, 1994) rather than the organisational sources of stress (Noblet & LaMontagne, 2006).

2.3 Variations in Occupational Stress Among Occupational Groups

Worldwide, a variety of occupational groups has received research attention in the occupational stress literature. For the most part, research abounds on individual occupational groups within a single country, including Australia and Aotearoa New Zealand. For example, police in Australia (Hart, Wearing & Headley, 1993), the hospitality industry in Aotearoa New Zealand (Lo & Lamm, 2005), farmers in Aotearoa New Zealand

(Firth, Williams, Herbison & McGee, 2007), and policy officials in Aotearoa New Zealand (Baehler & Bryson, 2009) to name a few. However, some research has compared the same occupational group across different countries. For example, Cooper and Hensman (1985) compared how occupational stress was experienced by executives in 10 different countries. McCormick and Cooper (1988) extended that comparison and added executives in Aotearoa New Zealand to the literature.

Yet more research has focused on comparisons between different occupational groups within the same country. For example, the International Labour Organization (ILO, 1996) examined five occupational groups (air traffic control, nursing, offshore oil and gas production, bus driving, and shop floor work) in the United Kingdom. In addition Johnson et al. (2005) compared occupational stress across 26 occupations in the United Kingdom. Of particular interest from their research is their ranking of occupations on the variables of psychological wellbeing, physical health, and job satisfaction. Roberson Cooper (2002, as cited in Johnson et al., 2005) developed a survey called ASSET that measures sources of occupational stress, and Johnson et al. (2005) used the benchmark scores from ASSET to compare their findings against. In Table 2.1 below, occupations in italics report scores higher than those benchmarked in ASSET and indicate worse than average psychological wellbeing and physical health, and lower than average job satisfaction. When it comes to psychological wellbeing and physical health, a rank of 1 indicates the worst level and a rank of 26 indicates the best level. When it comes to job satisfaction, a rank of 1 indicates the lowest level and a rank of 26 indicates the highest level.

Table 2.1

Occupations ranked on psychological wellbeing, physical health, and job satisfaction (Johnson et al., 2005).

Rank	Psychological Wellbeing	Physical Health	Job Satisfaction
1	<i>Social services providing care</i>	<i>Ambulance</i>	<i>Prison officer</i>
2	<i>Teachers</i>	<i>Teachers</i>	<i>Ambulance</i>
3	<i>Fire brigade</i>	<i>Social services providing care</i>	<i>Police</i>
4	<i>Ambulance</i>	<i>Customer services – call centre</i>	<i>Customer services – call centre</i>
5	<i>Vets</i>	<i>Bar staff</i>	<i>Social services providing care</i>
6	<i>Lecturers</i>	<i>Prison officer</i>	<i>Teachers</i>
7	<i>Clerical and admin</i>	<i>Mgmt (private sector)</i>	Nursing
8	<i>Mgmt (private sector)</i>	<i>Clerical and admin</i>	Medical/dental
9	<i>Prison officer</i>	<i>Police</i>	Allied health professionals
10	<i>Research – academic</i>	<i>Teaching assistant</i>	<i>Bar staff</i>
11	<i>Police</i>	<i>Head teachers</i>	<i>Mgmt (private sector)</i>
12	<i>Customer services – call centre</i>	<i>Secretarial/business support</i>	<i>Fire brigade</i>
13	<i>Director (public sector)</i>	<i>Research – academic</i>	<i>Vets</i>
14	Allied health professionals	<i>Lecturers</i>	<i>Clerical and admin</i>
15	<i>Bar staff</i>	<i>Senior police</i>	<i>Mgmt (public sector)</i>
16	Nursing	Nursing	<i>Lecturers</i>
17	Medical/dental	<i>Mgmt (public sector)</i>	<i>Head teachers</i>
18	<i>Senior police</i>	Allied health professionals	<i>Teaching assistant</i>
19	<i>Secretarial/business support</i>	Medical/dental	<i>Secretarial/business support</i>
20	<i>Head teachers</i>	<i>Accountant</i>	<i>Director (public sector)</i>
21	<i>Mgmt (public sector)</i>	<i>Fire brigade</i>	<i>Research – academic</i>
22	<i>Accountant</i>	<i>Vets</i>	<i>Senior police</i>
23	<i>Teaching assistant</i>	<i>Director (public sector)</i>	<i>School lunchtime supervisors</i>
24	<i>Analyst</i>	<i>Analyst</i>	<i>Accountant</i>
25	<i>School lunchtime supervisors</i>	<i>School lunchtime supervisors</i>	<i>Analyst</i>
26	<i>Director/MD (private sector)</i>	<i>Director/MD (private sector)</i>	<i>Director/MD (private sector)</i>

The key take-home points are that reported levels of stress vary between occupational groups, and that some occupational groups experience higher than average levels of stress. The reasons for the variation will differ depending on what sources of occupational stress are relevant for that occupation. In addition, according to the transactional-appraisal-coping model of stress the variations will also depend on how individuals appraise the demands, and the coping strategies that they can draw on to moderate their experience of stressors.

2.4 Occupational Stress and the Health Sector

In terms of Cartwright and Cooper's (1997) six sources of stress (intrinsic to the job, role in the organisation, relationships at work, career development, organisational structure and climate, and non-work factors), the health sector is no different from other occupational groups. However, because of the nature of the health sector, some of those six

sources are more predominant than others. For example, Landsbergis (1988) found that occupational stress was higher for hospital and nursing home employees when work overload (intrinsic to the job) and low decision latitude (role in the organisation) were combined. Piper (2006) asserts that human conflict (relationships at work) is one of the most pervasive challenges in health sector organisations. Indeed in the nursing literature, human conflict (particularly conflict between colleagues) is referred to as horizontal violence (McKenna, Smith, Poole & Coverdale, 2003), highlighting the prevalence of the problem. Browning, Ryan, Thomas, Greenberg, and Rolniak (2007) examined three nursing specialties (nurse practitioners, nurse managers, and emergency nurses) and found that burnout was more predominant in nursing specialties that had the least control over the workplace and patient outcomes.

As well as variations in sources of stress between health sector specialties or disciplines, the level and experience of stress also varies. For example, according to Moore and Cooper (1996) although mental health professionals are subjected to similar sources of stress as other health sector professionals, the nature of dealing with troubled people means that mental health professionals also face different occupational stress issues. Gellis (2002) compared occupational stress between social workers and nurses, and found both similarities and differences in the levels and experience of stress between the two disciplines. Lloyd, McKenna, and King (2005) compared occupational stress between occupational therapists and social workers, and found that social workers reported slightly more occupational stress than occupational therapists.

The key point is that just as levels and experience of stress vary according to occupational group, there is also variation between health sector specialties or disciplines because the sources of stress and situational factors vary between them. However, from an occupational stress perspective, the problem for all health sector specialties is that patient care suffers when stress is high (Kahn, 1993; Simon 2004). Since patient care outcomes are one measure of organisational performance, it is the central argument of this thesis that health and disability sector organisations in Aotearoa New Zealand should be proactive about taking all practicable steps not just to isolate or minimise occupational stress, but to build and maintain healthy workplaces. While healthy workplaces in the sector would

obviously benefit staff by reducing levels of stress it will also have positive flow on effects for the patients that use the health services.

2.5 Chapter Conclusion

The models presented in this chapter each contribute to our understanding of the phenomenon of occupational stress in different ways. However, the transactional-appraisal-coping model really starts to shed light on how complex and multidimensional the process of occupational stress really is. Additionally, McGowan (2004) refinement of the model explicitly acknowledges that work demands have positive (eustress) outcomes and not just have negative (distress) outcomes for individuals and organisations. The transactional model also recognises that situational factors as well as individual differences can impact the experience of occupational distress or eustress. However, focus in the literature is still on stress, and the negative connotation that goes with it, rather than shifting the lens of analysis to wellbeing and healthy work. In addition, to date little (if any) research attention has been directed to the ways in which indigenous cultures experience occupational stress or wellbeing, and how that might differ from other cultures. Given that all of the models of occupational stress have been developed from a Western, individualist perspective, it is time that their relevance and appropriateness for indigenous collectivist cultures is examined.

The challenge for organisations, then, is not simply to reduce levels of occupational stress, but to create healthy workplaces that maximise the positive outcomes for employees and therefore the organisation. One way to create healthy workplaces is to examine work demands within the organisation to identify ways in which those demands can be modified to reduce stress or build healthy workplaces. Some of the sources of work demands (stress) identified in this chapter are not always within the organisation's control, such as the isolation of rural work, or the emotional toll that may result from working in palliative care. However, many work demands, including culturally relevant and appropriate responses to those demands, are within the control of the organisation and would be relatively easy and cost effective to fix compared to the cost of doing nothing.

This chapter also demonstrated that occupational stress varies across occupations, with some occupations such as teachers, ambulance officers and police being rated as more stressful than others. And, in the health sector, occupational stress also varies between health specialties or disciplines. Additionally, some sources of occupational stress within the health sector, such as interpersonal conflict, appear more prevalent than for other industries. According to the transactional model of stress, in addition to organisations addressing some of the sources of work demands, those in high-stress industries could also improve the individual and organisational stress outcomes by helping employees develop more effective coping strategies suited to that industry. The imperative for the health sector to address these issues is about more than just providing ‘nice’ employee and organisational outcomes. Since patient care suffers when health sector staff are stressed, patients too will benefit from health sector organisations’ efforts to address occupational stress issues.

The next chapter examines the Aotearoa New Zealand context of occupational stress, including legislation and other issues such as the Treaty of Waitangi in the public sector and government policy in the health and disability sector. It will also include discussion of the limited research conducted on Māori occupational stress.

Chapter 3 – The Aotearoa New Zealand Context

Māori in Aotearoa New Zealand have a similar history of colonisation and the negative consequences of colonisation as other indigenous people for whom a wide range of economic and social disparities also exist. However, the Aotearoa New Zealand context is somewhat unique in that the Treaty of Waitangi, despite its historic problems, is a feature of our political landscape. While not a legally binding document in itself, the government gives recognition to the principles of the Treaty, and is pursuing initiatives to reduce the social disparities that still persist for Māori.

One of the challenges of reducing those disparities is the tension between Pākehā, meaning in this particular context the non-Māori dominant Western culture, and their associated individualistic values, beliefs and behaviours and the collectivistic values, beliefs and behaviours of Māori. Another tension is that the Treaty of Waitangi is regarded by most Māori as the founding document of Aotearoa New Zealand which is still relevant today, whereas for many Pākehā it is simply a historical document which no longer reflects the multicultural demographics or aspirations of mainstream New Zealand. While those issues and associated challenges remain foremost in the researcher's mind every day, the focus of this thesis research is firmly on achieving positive outcomes for Māori employees despite those challenges. In line with positive psychology's focus on appreciating human potential, capacity and motives (Sheldon & King, 2001) this thesis will acknowledge what institutions and organisations are doing well while at the same time identifying areas that still need improvement.

This chapter first outlines the legislative obligations of employers and employees in relation to occupational stress, then provides an overview of the free resources available to help employers address occupational stress. Next, it briefly outlines the history of the Treaty of Waitangi and the place of the Treaty principles in the public service sector. Then the findings of previous research related to Māori and occupational stress are presented, followed by contextual information and research related to the Māori workforce in the health and disability (MWHD) sector. Finally, the chapter concludes with acknowledgement that the government of Aotearoa New Zealand, through the Ministry of Health (MoH) and related services, has gone a long way from a policy standpoint to address

the health disparities of Māori by addressing a range of MWHD sector issues related to recruitment, retention and training. However, it would seem that implementation of those policies in the health and disability sector has not yet fully achieved the aspirations of MoH principles, goals and objectives.

3.1 The Legislative Context

Occupational safety and health legislation in Aotearoa New Zealand has always legally obligated employers to protect employees from work related harm and to protect them from unnecessary injury, illness and death in the workplace (Scott-Howman & Walls, 2003). However, the legislation was reviewed in 2002, resulting in the Health and Safety in Employment Amendment (HSEA) Act. Of those changes, the one that attracted the most attention of employers was that work-related stress was confirmed as a potential cause of harm. Specifically section 2 of the Health and Safety in Employment Amendment Act (2002) defines harm as including “...physical or mental harm caused by work-related stress”. In combination with the requirement for employers to take all practicable steps to ensure employees are safe at work (detailed in section 6), including a duty to involve employees in processes relating to health and safety at work (detailed in section 19), it is clear that employers are now expected to be proactive about the prevention of harm in all areas of workplace health and safety, including work-related stress. Therefore, more than just being the moral and socially responsible thing to do, employers have a legal obligation to protect employees from harm caused by work-related stress (Scott-Howman & Walls, 2003).

In contrast to earlier legislation that resulted in punishment of employers, according to Scott-Howman and Walls (2003) the focus of the HSEA Act is to promote the prevention of harm in the workplace. Indeed, section 5 explicitly states that the object of the HSEA Act is to “promote the prevention of harm to all persons at work...”, indicating a shift in thinking and emphasis from compliance and punishment to supporting organisations to achieve good management practice. That said, this strengths-based approach does not mean employers will have the freedom to ignore health and safety issues

around work-related stress, and those that do may still be fined in addition to being required to fix their poor management practices if harm is found to have occurred.

3.2 Resources to help Organisations Address Occupational Stress

In Aotearoa New Zealand, the Department of Labour administers and enforces the HSEA Act in most places of work, and offers a range of free resources to organisations. In 1998 the Department of Labour published a resource to help occupational health professionals, human resource practitioners and others to understand some of the issues related to occupational stress and employer obligations under the then Health and Safety in Employment Act 1992 (Occupational Health and Safety Service, 1998). With a focus on workplace safety and health, this document discussed the interrelationship between work, stress and fatigue, and suggested employers manage stress and fatigue along with other employee safety issues. By 2003, and in response to the HSEA Act, OHSS published new resources that shifted the emphasis away from stressful work towards healthy work (Occupational Health and Safety Service, 2003a). Indeed, Occupational Health and Safety Service (2003b) also made the link between workplace health and safety being good for business, and promoted ‘healthy work’ as being more fulfilling for employees and more productive for organisations. In addition, one of the strong themes that came out of a Workplace Stress Conference held in Sydney in 2007 was that psychological wellbeing in the workplace has links to the wellbeing of organisations (Graham, Jensen & Darby, 2007). The view of the Department of Labour is that building healthy places of work is a way organisations can avoid occupational stress, and is good for business. In 2003, the State Services Commission published their document titled ‘Creating a positive work environment: Respect and Safety in the Public Service Workplace’ (State Services Commission, 2003). Primarily focussed on harassment (workplace, racial and sexual) and bullying in the sector, it offers a focussed range of strategies for organisations in the public sector to understand the issues and address the problem. Just like the resources available from OHSS, this resource emphasises positive, healthy work environments.

3.3 The Treaty of Waitangi in the Public Sector

The Treaty of Waitangi is a formal agreement between Māori and the Crown that was intended to guarantee protection of Māori interests when British settlers started to come in substantial numbers to Aotearoa New Zealand. Ever since it was signed in 1840, controversy has surrounded it because of subsequent breaches of that guaranteed protection, and the subsequent economic and social disparities that arose for Māori, which still persist to this day. Māori have consistently relied on the Treaty of Waitangi to have their unique position as the indigenous people of Aotearoa New Zealand recognised and to address disparities between Māori and non-Māori (Ellison-Loschmann & Pearce, 2006). Although the Treaty itself is not recognised as a legally binding document, the Treaty of Waitangi Act (1975) established the concept of Treaty principles, but did not define them (Barrett & Connolly-Stone, (1998). The three Treaty articles were subsequently distilled into the three broad principles of partnership, protection, and participation, which then needed to be viewed in light of how they would apply in a given context, such as resource management, education or health. It is those Treaty principles that are recognised and embedded in a range of current statutes.

Reforms in the public sector during 1986 were designed to promote accountability and efficiency, and the State-Owned Enterprises Act 1986 gave statutory force to the principles of the Treaty (Barrett & Connolly-Stone, (1998). As a result, all government departments were required to define the Treaty principles as they relate to each set of public services, and determine ways to reduce disparities for Māori through commitment to those Treaty principles. Jacobs (2000) contends that although New Zealand has been noted for its public sector innovations, problems have still occurred attempting to integrate Māori concerns with State bureaucracy. Despite these problems, the public sector and government departments have developed and refined strategies and policies committed to the Treaty principles, and reducing disparities for Māori. Examples of those inroads will be provided in this chapter's section on Māori and the health and disability sector.

3.4 Research about Māori and Occupational Stress

Although Victoria Simon's (2004) pilot research identified high levels of occupational stress for Māori nurses related to work overload and especially cultural safety, insufficient detail of those findings have yet been published, so cannot be analysed for further insight. Cultural safety is defined as "the effective nursing practice of a person or family from another culture, and is determined by that person or family" (Nursing Council of New Zealand, 2005, p. 4), and has been formally recognised in Aotearoa New Zealand since 1992. The focus of cultural safety is the experience of the client or patient, and whether the service provided is respectful of and allows dignity to that client or patient. From a Māori health workers focus, cultural safety also includes the experience of interactions with their non-Māori colleagues.

The only other piece of published and detailed research that directly investigated Māori and occupational stress was conducted by Sisley and Waiti in 1997. They examined occupational workload and stress for Māori staff belonging to the Association of Staff in Tertiary Education. According to Sisley and Waiti (1997) although a substantial body of research had been conducted during the 1990s within the teaching profession, only a small portion of it really addressed the dilemmas faced by Māori teachers. In addition, the 'Tomorrows Schools' education reforms of 1989 had been identified in much of that research as the cause of heavy workloads for teaching staff. However, that research had not examined the different experiences of workload and stress for Māori staff, and according to Mitchell and Mitchell (1993) issues such as the conflict between Māori cultural values and those Pākehā beliefs and values of the mainstream education system, the inability of Māori teachers to retain their integrity as Māori and teach at the same time, dual accountabilities to whānau, hapu, iwi as well as to management structures in the schools, and a lack of support and resources predated the reforms.

In order to better understand the significance of Sisley and Waiti's (1997) findings, some context of that time and Māori aspirations in the education sector is required. First, as with disparities for Māori in sectors such as health and corrections, taura Māori (Māori students) achieved lower quality and levels of attainment than their non-Māori counterparts, and Māori were under-represented in the education workforce. Second, under the Education Act 1989, the education sector required institution charters (then and now) to

reflect the unique position of Māori culture, and as part of the New Zealand government's commitment to the principles of the Treaty of Waitangi, and the National Education Guidelines (then and now) required the education sector to operate consistently with them (Ministry of Education, 2010). The government legislation and resulting policy guidelines were intended to address the education disparities for Māori.

A distinctive feature of the education sector (then and now) is that marae are very often part of institutional infrastructure and located on institutional property. Institution-based marae were (and still are) regarded as a culturally responsive pedagogy in the education sector. Responsibility for the operation of those marae fell to Māori staff. Finally, the complexities of occupational stress for Māori are related to the dynamics of Māori identification and their aims and aspirations in the workplace.

Sisley and Waiti (1997) noted that some of the aims and aspirations of the Māori staff in their research included:

- ◆ To provide an appropriate and highly beneficial support service for students which will allow them to succeed at school/education, and have excellent educational outcomes
- ◆ For taura Māori (Māori students) to gain skills, knowledge and understanding to enable them to feel empowered to be part of iwi owned and operated institutions after school/education
- ◆ For taura Māori (Māori students) to have pride and confidence to be able to compete equally with Pākehā in the general workforce
- ◆ To develop, manage, control and deliver Māori education institutions operating under a Māori philosophy that better meet the needs of taura Māori and help them achieve their full potential
- ◆ A fair and equitable education system that does not result in Māori feeling like 'Second Rate citizens', but instead empowers them to be whole and encompass all aspects of tikanga (protocols), te reo (language), wairua (spirituality) and mana Māori (wellbeing and pride in being Māori).

These aims and aspirations of Māori education staff are consistent with rangatiratanga (Māori self-determination) but also reflect their collectivist (and perhaps altruistic) motivations. In order to achieve these aims and aspirations, Māori education staff necessarily work differently from their Pākehā colleagues, to provide culturally relevant and appropriate education services for taura Māori. For one participant, this different way of working was neither valued nor understood by his Pākehā principle, who determined job performance of Māori teachers only on the criteria outlined in the job description without taking into account the extra workload required for Māori teachers to achieve those criteria.

Sisley and Waiti (1997) categorised their research findings on occupational stress among Māori staff into three themes: institutional racism, work environment, and time and tasks. Institutional racism occurred because tertiary educational institutions reflected the cultural values and beliefs of the dominant Pākehā Western culture. The struggle for Māori staff was in reconciling their Māori values and beliefs with those of their institution. Sadly, Sisley and Waiti (1997) regarded extra stress and conflict for Māori staff as “inevitable” as a result of attempts to reconcile these cultural differences.

In terms of the institutional racism category, Sisley and Waiti’s (1997) participants reported that Pākehā made all the major decisions. Despite the Treaty principle of partnership, Māori staff were often left out of decision-making processes, including those related to how to achieve best educational outcomes for taura Māori. Those decisions were made based on Pākehā Western assumptions of how best to achieve those outcomes, without consultation with Māori to establish whether in fact those ways of working with taura Māori would be effective. Another example of institutional racism reported by participants included a lack of cultural safety for Māori staff, especially those who were prepared to challenge Pākehā management. One participant reported that Pākehā management would recruit Māori staff who would not challenge the existing order of inequitable or racist structures, leaving those Māori staff who were prepared to resist or contest those structures burnt out, or leaving the institution or sector altogether. Another reported example of institutional racism was of Māori staff work performance being judged only on employment contractual issues, which did not reflect Māori methods of achieving work outcomes. For example Māori staff who networked with other Māori, both inside and

outside the workplace were regarded with suspicion, or their networking activities were not regarded as ‘proper’ work and therefore undervalued. One final example of institutional racism was the expectation that Māori staff would take responsibility for work-related Māori cultural processes on the marae such as pōwhiri (formal Māori welcome). Not only was there no expectation of Pākehā staff to take on any responsibilities in this area in the spirit of the partnership principle of the Treaty of Waitangi, but no recognition of the cultural skills and expertise was given to those Māori staff who did.

In terms of stress arising from the work environment, it was encouraging that Sisley and Waiti (1997) found that despite heavy (and sometimes unreasonable) workloads, some Māori staff were optimistic about work because they felt they were making a positive contribution to advancing Māori adult education, because they felt nurtured and sustained by working with Māori colleagues and students, and because their whānau (family) gave them the strength to continue. On the down side, almost half of the participants reported experiencing work-related injuries and illnesses such as back and neck injuries and cardiovascular illness during the previous three years. These work-related injuries did not just impact their physical health, but also their emotional and spiritual health and interpersonal relationships. Many of these staff indicated that if it had not been for their whānau (family) and Māori colleagues, their work performance would have suffered. Participants commented on the fact that there was no organisational awareness of how excessive workloads impacted their wairua (spirit) or their whānau (family) commitments. Cultural safety was another theme that participants reported as impacting their workload, along with the requirement for professional development (by studying to increase skills and qualifications), and because of the time demands of working and studying, relationships with whānau, friends and colleagues suffered.

In terms of the time and tasks category, participants not only reported an increase in their workload during the previous three years, but that their job descriptions did not adequately reflect the nature of the work they did. Sisley and Waiti (1997) found that examples of the nature of that work for Māori staff that did not apply to their Pākehā colleagues included:

- ◆ Dual obligations and accountability to iwi (tribe) and employer,
- ◆ Manaakitanga (care) of students and fellow colleagues
- ◆ Providing advice on tikanga Māori (Māori customs and protocols) and te reo Māori (the Māori language) for Pākehā staff
- ◆ Managing the marae and associated kawa (marae protocol), and
- ◆ Cultural awareness training with Pākehā colleagues.

These expectations were considered by Pākehā management and Māori staff alike as fundamental to the role of Māori staff, however, most often they were not recognised or acknowledged in any tangible way such as remuneration.

Unfortunately, despite government legislation and education policy committing to the principles of the Treaty of Waitangi and recognising the unique place of Māori culture, Sisley and Waiti's (1997) findings would suggest systemic structural barriers prevented true partnership and participation for Māori in the mainstream education sector. Whether that remains the case 14 years later could not be determined because if follow-up research has been done, it is not easily accessible. However, the key point of interest for the purposes of this thesis is that Sisley and Waiti's (1997) research revealed, possibly for the first time, that Māori do in fact experience occupational stress in different ways than non-Māori.

3.5 Government Policy in the Health and Disability Sector

As mentioned in Chapter 1, the reason for the focus of this research is the under-representation of Māori in the health and disability workforce given that Māori health disparities exist. Anecdotes from friends and whānau about their experiences of being Māori and working in the health and disability sector raised this researcher's concerns about retention issues for our Māori health workers, and especially those issues relating to occupational stress. The additional concern was that the quality of service provision from Māori health workers can be affected by occupational stress. In order to provide some context around Māori and the health and disability sector, this section of the chapter will outline the relevant government strategy and policy documents, including associated

principles, visions, goals or objectives related to Māori health, and particularly the Māori Workforce in the health and disability sector (MWHDS).

In *Tatau Kahukura*, the Māori Health Chart Book 2010, the Ministry of Health (MoH) reaffirmed its commitment to delivering fairness and equity in the sector, particularly to Māori (Ministry of Health, 2010b). The MoH acknowledges that the health and disability sector has not always worked well for Māori, and this remains one of the sector's biggest challenges. Although Māori health and disability providers are a distinctive feature of the New Zealand health sector, the MoH places responsibility on all parts of the health and disability system for improving Māori health outcomes, and has developed a range of strategy and policy documents that health providers are expected to implement within their organisations. Figure 3.1 below illustrates the connections between these strategies, action plans, and development plans for Māori.

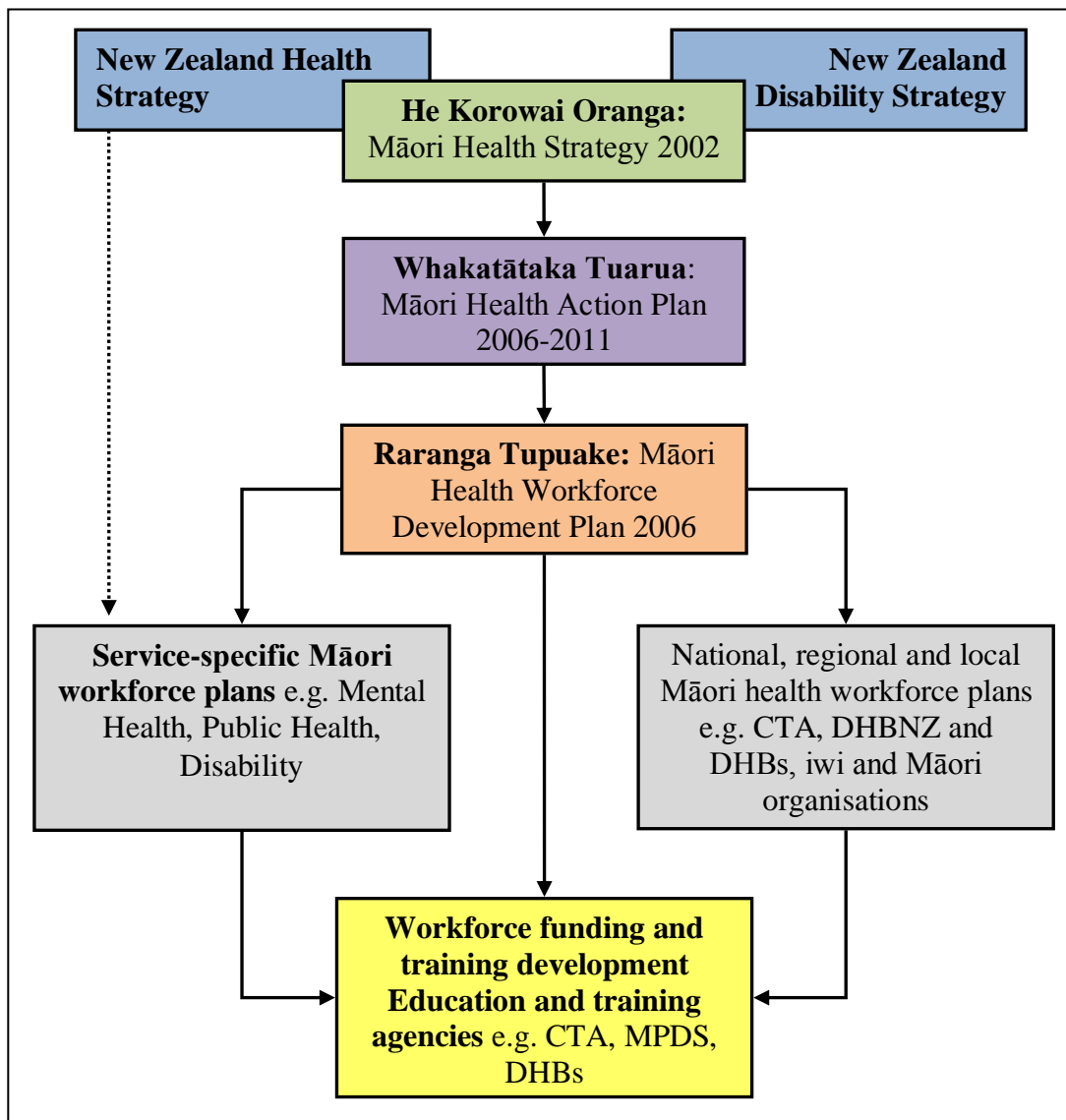


Figure 3.1 Structure of New Zealand Health policy related to Māori health and MWHDS development.

The remainder of this section will outline those details from the New Zealand Health Strategy, *He Korowai Oranga: Māori Health Strategy 2002*, *Whakatātaka Tuarua: Māori Health Action Plan 2006-2011*, and *Raranga Tupuake: Māori Health Workforce Development Plan 2006* that provide understanding of the context within which Māori health and disability sector employees work, as well as offering insight into what will contribute to creating healthy workplaces.

3.5.1 The New Zealand Health Strategy (NZHS)

In Aotearoa New Zealand, the New Zealand Health Strategy (NZHS) provides the framework within which District Health Boards and other organisations across the health and disability sector operate, and highlights the priorities the Government considers to be most important (Ministry of Health, 2000). The New Zealand Disability Strategy sits alongside the NZHS, with *He Korowai Oranga* sitting between these two. Together these policy documents provide principles, goals and objectives relevant to the health of Māori and others in New Zealand.

Principles contained in the NZHS of particular relevance to Māori include: “acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi”, and “an improvement in health status of those currently disadvantaged” (Ministry of Health, 2000, p. 7). Another principle has a positive focus on “good health and wellbeing for all New Zealanders throughout their lives” (Ministry of Health, 2000, p. 7). With respect to the Treaty of Waitangi and the health and disability sector, the three principles of partnership (in service delivery), protection (and improvement of Māori health status), and participation (at all levels) is acknowledged in the NZHS as forming the basis of the relationship between Māori and the Crown. The NZHS also acknowledges that on average, Māori “have the poorest health status of any group in New Zealand” (Ministry of Health, 2000, p. 18) and therefore prioritising Māori health gains and development is critical for the Government. In terms of the framework of goals and objectives of the NZHS, those of particular relevance to Māori and MWHDS development are listed in Table 3.1 below:

Table 3.1

NZHS goals and objectives relevant to Māori (Ministry of Health, 2000).

Goal	Objective
Reducing inequalities in health status	<ul style="list-style-type: none"> ◆ Ensure accessible and appropriate services for Māori.
Māori development in health	<ul style="list-style-type: none"> ◆ Build the capacity for Māori participation in the health sector at all levels ◆ Enable Māori communities to identify and provide for their own health needs ◆ Recognise the importance of relationships between Māori and the Crown in health services, both mainstream and those provided by Māori. ◆ Collect high-quality health information to better inform Māori policy and research and focus on health outcomes. ◆ Foster and support Māori health workforce development.

3.5.2 *He Korowai Oranga: Māori Health Strategy 2002*

He Korowai Oranga is the 2002 Māori Health Strategy which provides a framework for the health and disability sector, along with other sectors, to take responsibility for supporting the health status of Māori (Ministry of Health, 2002b). *He Korowai Oranga* also articulates the Government’s commitment to the Treaty of Waitangi principles by defining partnership as “working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services”, participation as “involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services”, and protection as “working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices” (Ministry of Health, 2002b, p. 2).

The overall aim of *He Korowai Oranga* is whānau ora (healthy families), which take two directions: Māori aspirations and contributions, and Crown aspirations and contributions, demonstrating the partnership and collaborative approach to Māori health (Ministry of Health, 2002b). From those two directions flow three key threads, which are:

rangatiratanga (which in this context means Māori having control over the direction and shape of their own institutions, communities and development as a people); building on the gains that have already been made in Māori health; and reducing inequalities in health and disability outcomes for Māori. From those three key threads flow four pathways for action which are: Te Ara Tuatahi – Pathway One which relates to the development of whānau, hapū, iwi and other Māori communities; Te Ara Tuarua – Pathway Two which relates to Māori participation in the health and disability sector; Te Ara Tuatoru – Pathway Three which relates to effective health and disability services; and Te Ara Tuawhā – Pathway Four which relates to working across sectors. The connections between these aims, directions, threads and pathways is illustrated in Figure 3.2 below.

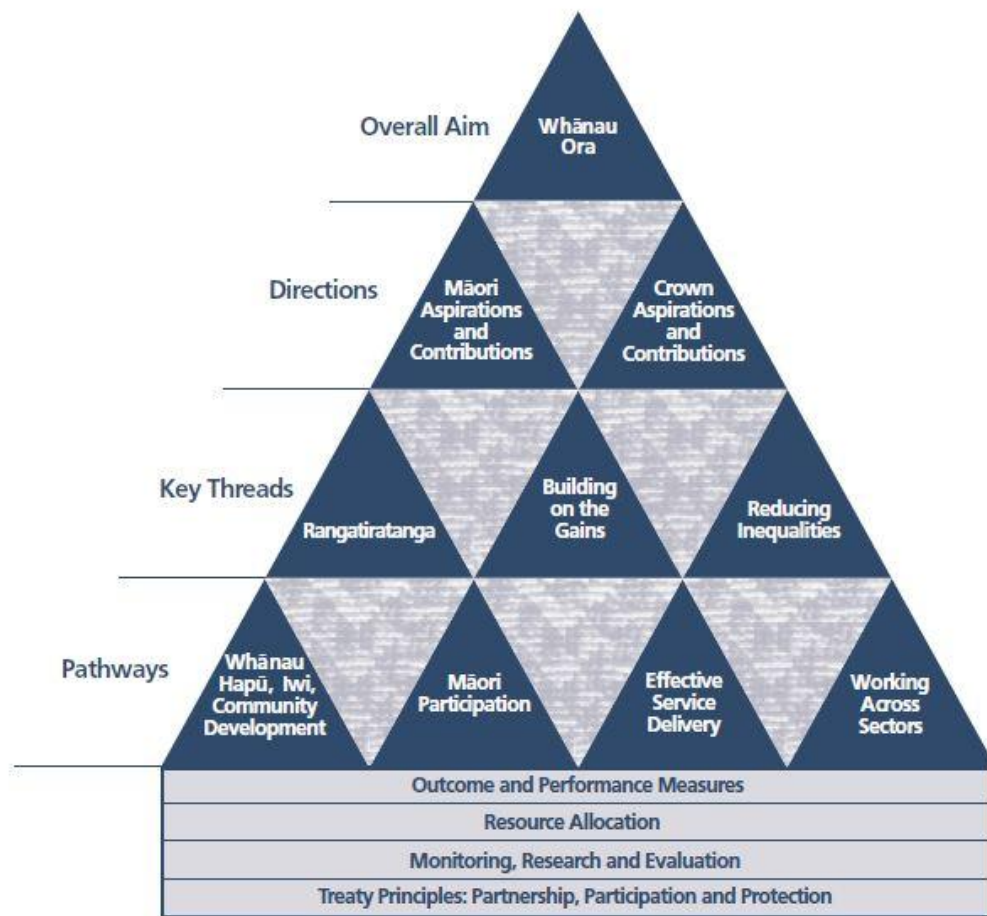


Figure 3.2 He Korowai Oranga: Māori Health Strategy 2002 (Ministry of Health, 2002b, p. 4).

Details of how *He Korowai Oranga* is currently being implemented is provided in Whakatātaka Tuarua: Māori Health Action Plan 2006 – 2011, which will be discussed next.

3.5.3 *Whakatātaka Tuarua: Māori Health Action Plan 2006-2011*

Whakatātaka Tuarua is the Māori Health Action Plan for the 2006 to 2011 period, and builds upon the first *Whakatātaka* that came into effect between 2002 and 2005. Although a number of gains had been achieved during the 2002 – 2005 period, the health and disability sector called for a more focussed approach that prioritised specific areas for attention, and *Whakatātaka Tuarua* was a response to that challenge. It details the specific actions required, which agencies are responsible for them, the milestone/progress measures to be used and the timeframes within which all four pathways and objectives of *He Korowai Oranga* are to be achieved (Ministry of Health, 2006c).

Of the four pathways, the one most relevant to MWHDS development is Te Ara Tuarua – Pathway Two, Māori participation in the health and disability sector. Within Te Ara Tuarua, there are three objectives as follows:

- ◆ **Increasing Māori participation in decision-making**

Iwi and Māori communities and government health agencies working together in effective relationships to achieve Māori health objectives

- ◆ **Increasing Māori provider capacity and capability**

To increase the capacity and capability of Māori providers to deliver effective health and disability services for Māori

- ◆ **Developing the Māori health and disability workforce**

To increase the number and improve the skills of the Māori health and disability workforce at all levels

Of these three objectives, developing the Māori health and disability workforce is the most relevant to reducing levels of occupational stress and creating healthy workplaces. *Whakatātaka Tuarua* details one of the specific actions plans to achieve objective three, which is to implement *Raranga Tupuake*, the Māori Health Workforce Development Plan 2006. The agencies responsible for implementing *Raranga Tupuake* include the MoH,

District Health Boards (DHBs), Primary Health Organisations (PHOs), the Ministry of Education (MoE), the Tertiary Education Commission (TEC), and the education sector. The timeframes to have the various milestones/progress measures achieved range from 2006 to 2010 (Ministry of Health, 2006c).

3.5.4 *Raranga Tupuake: Māori Health Workforce Development Plan 2006*

Raranga Tupuake, the Māori Health Workforce Development Plan 2006 is the strategic framework for the development of the MWHDS. The vision for *Raranga Tupuake* is to build a competent, capable, skilled and experienced Māori health and disability workforce over the next 10 to 15 years, and details the key organisations and actions required to implement its goals, by working collaboratively across the sector and ensuring activities are aligned to the principles of the Treaty of Waitangi for the purpose of improving Māori health. The three goals detailed within *Raranga Tupuake* are (Ministry of Health, 2006b, p 1):

- ◆ **Goal 1: Te Raranga Tuatahi:** Increase the number of Māori in the health and disability workforce.
- ◆ **Goal 2: Te Raranga Tuarua:** Expand the skill base of the Māori health and disability workforce.
- ◆ **Goal 3: Te Raranga Tuatoru:** Enable equitable access for Māori to training opportunities.

One final document focused on workforce development in the health and disability sector that needs mentioning is *Health Workforce Development: An Overview 2006*, and will be discussed next.

Health Workforce Development: An Overview 2006

Driving forces such as ongoing health disparities for Māori, and population predictions indicating that the proportion of Māori expected to access healthcare services will increase significantly by 2021 mean that addressing MWHDS development issues are

critical to achieving the goals and objectives of the various strategies, action plans, and development plans. In 2006 the Health Workforce Advisory Committee identified a number of shortfalls in both the regulated and unregulated health and disability workforce which were addressed in the report *Health Workforce Development: An Overview*. In particular, difficulties were identified in recruiting and retaining “Māori and Pacific health practitioners and support workers, iwi and community support workforce” (Ministry of Health, 2006a, p. 14). In terms of activities the MoH is engaged in to address workforce development in the sector, Table 3.2 below outlines those of particular relevance to Māori.

Table 3.2

MoH workforce development activities relevant to Māori (Ministry of Health, 2006a, p. viii and ix).

<p>◆ Organisational development Goal: Health services develop the organisational culture and systems which will attract and grow their workforce and meet service needs</p> <p>Actions:</p> <ul style="list-style-type: none"> • Improve leadership capacity and practice (particularly by under-represented workforce groups) • Increase the range of health workforce groups involved in governance • Develop innovative models of care and support (e.g. continuum of care approach, primary health teams) • Improve healthy workplace environments and practices (e.g. magnet hospitals) • Align workforce with service needs (i.e. identify and plan to address service gaps)
<p>◆ Recruitment and Retention Goal: Health services have a nationally and regionally co-ordinated approach to recruiting and retaining staff, which results in increased capacity and capability of the health workforce</p> <p>Actions:</p> <ul style="list-style-type: none"> • Develop strategies to train and recruit under-represented groups within the health workforce (Māori, Pacific, Asian workforces)
<p>◆ Training and Development Goal: All stages of health workforce training are aligned to service needs and promote retention</p> <p>Actions:</p> <ul style="list-style-type: none"> • Establish a set of cultural competencies within training programs to improve service delivery to cultural groups and recruitment of staff from them

It is clear from these various policy documents, that the Government, through the MoH is committed to improving health disparities for Māori, and the under-representation of Māori in the health and disability workforce. The MoH has monitoring processes in place to evaluate the effectiveness of these strategies and action plans. However, until research was conducted related to recruitment and retention of Māori in the health and disability sector, it has been difficult to establish how effective the strategies and action plans have been for them, and that research will be discussed next.

3.6 Māori in the Health and Disability Sector Workforce

In a 2007 report commissioned by the MoH called *Rauringa Raupa*, Ratima et al. (2007) researched recruitment and retention issues for Māori in the health and disability sector with participants from a range of stakeholder groups including community informants, career advisors, tertiary providers, health service providers, professional bodies, and other stakeholder agencies by way of interviews with Māori who had left the health and disability workforce, focus groups, and a survey of tertiary students. For the purposes of this thesis, discussion here will focus only the retention issues, because they are most closely related to healthy work environments.

Ratima et al. (2007) identified nine factors considered to be retention barriers for Māori in the workforce, and asked participants to rate their importance as either 'Not an issue', 'A little', 'Quite a lot', and 'Major importance'. Table 3.3 below presents the nine factors, and the percentage of participants that rated their importance as either 'Quite a lot' or 'Major importance'.

Table 3.3

Barriers to retention of Māori in the health and disability sector (Ratima et al., 2007, p. 125).

Issues	
◆ In mainstream roles, expected to be expert in and deal with Māori matters	65%
◆ Māori cultural competencies are not valued	64%
◆ Dual responsibilities to employer and Māori communities	58%
◆ Lack of or low levels of Māori cultural competence of colleagues	58%
◆ Limited or no access to Māori cultural competency training	51%
◆ Limited or no access to Māori cultural support/supervision	48%
◆ Racism and/or discrimination in the workplace	39%
◆ Isolation from other Māori colleagues	33%
◆ Difficult to be Māori in the workplace	29%

The cultural competence concept listed here is distinguished from cultural safety in that the focus is on the capacity (knowledge, skill and ability) of a health worker to improve the health status of a client from a different ethnic or cultural background from the health worker (Durie, 2001). As a concept, cultural competence began to be recognised in the wider Aotearoa New Zealand health and disability sector from 2000, and acknowledges that unless a health worker is aware of their cultural attitudes, they may not provide the best quality or most effective service.

As well as being retention barriers for Māori in the health and disability sector workforce, the above nine factors also indicate possible culturally-based sources of occupational stress. The participant ratings demonstrate that not all factors are as important to retention for Māori as others, but they are at least a starting place for investigating ways to reduce occupational stress. However, since building healthy workplaces for Māori in the health and disability sector is the ultimate goal, stress reduction alone is not the only answer.

Ratima et al. (2007) also identified a range of factors clustered around 'Contribution to Māori', 'Cultural factors', 'Professional development', 'Work conditions' and 'Workforce composition' that were considered to be retention facilitators for Māori in the workforce. Participants were asked to rate their level of encouragement to staying in the workforce as either 'No encouragement', 'A little encouragement', 'Quite a lot of encouragement', and 'A major encouragement'. Table 3.4 below presents the clusters of retention facilitation factors, and the percentage of participants that rated their importance as either 'Quite a lot of encouragement' or 'A major encouragement'.

Table 3.4

Retention facilitators for Māori in the health and disability sector (Ratima et al., 2007, p. 122).

Retention factors	
Contribution to Māori	
◆ Making a difference to Māori health	92%
◆ Being able to work with Māori people	89%
◆ Making a difference for my iwi/hapū	84%
◆ Being a role model for Māori	80%
Cultural factors	
◆ Ability to network with other Māori in the profession	83%
◆ Māori practice models and approaches valued	81%
◆ Opportunities to work in Māori settings	80%
◆ Opportunities to work in Māori contexts using Māori practice models	78%
◆ Supportive and culturally safe manager/supervisor	75%
◆ Recognition and valuing of Māori cultural competencies	75%
◆ Culturally safe work environment	73%
◆ Access to cultural resources	71%
◆ Access to Māori cultural supervision	69%
Professional development	
◆ Paid professional development opportunities	55%
◆ Paid Māori cultural competency development opportunities	45%
◆ Scholarships and grants	37%
Work conditions	
◆ Provision for whānau/Māori community commitments	77%
◆ Mana/prestige of my profession	61%
◆ Clear career pathways	60%
◆ Pay rates	55%
Workforce composition	
◆ Strengthening Māori presence in the health sector	92%
◆ Having Māori colleagues	78%
◆ Having Māori role models	72%

These retention facilitators provide insight into the motivations and aspirations of Māori working in the health and disability sector, potential sources of positive individual workplace outcomes, and potential coping strategies. These retention facilitators also provide rich information about possible ways to build healthy workplaces for Māori, noting that while many of the facilitators are specific to Māori, some of them, such as professional development and work conditions are relevant to non-Māori as well.

What should be celebrated is that the MoH has gone a long way to acknowledging and addressing the challenges of Māori participation in the health and disability sector

through the development of culturally responsive, relevant and appropriate strategies, action plans and development plans. However, as these barriers to retention, along with the retention facilitators identified earlier demonstrate, effective implementation of these policies has not yet been achieved. As well as impacting retention, it can safely be assumed that these issues contribute to lowered levels of occupational health outcomes. It is also interesting to note that the retention issues identified in the *Rauringa Raupa* report closely parallel the experiences of Māori staff in the tertiary education sector, indicating that these experiences may be common to Māori staff in the broader arena of the public sector in Aotearoa New Zealand.

3.7 Expanded Transactional Model of Occupational Wellbeing

Based on the information discussed in this chapter, an expanded appraisal-coping-model of occupational wellbeing was developed to provide a framework for this thesis research (see Figure 3.3 below). It is a model of wellbeing (rather than stress) to reflect the shift towards a positive focus in the legislation, the current philosophy of the Department of Health and the growing positive psychology movement. It also reflects a desire to shift from a deficit model in which Māori are often negatively portrayed, to a strengths-based model to acknowledge the positive dimension of Māori cultural values and beliefs.

Examples of work demands have been included in the model to reflect the sources of occupational stress identified by Cartwright and Cooper (1997) discussed in Chapter 2. Examples of individual and situational factors that moderate the appraisal stages have been provided for context, but more importantly to acknowledge Māori-based cultural values and coping strategies as moderators in the individual appraisal process. Examples of individual as well as organisational outcomes have also been provided for context, acknowledging that at both levels, outcomes could be positive or negative. In particular the individual outcome of cultural wellbeing has been included, which encompasses cultural safety as well as a range of other values, beliefs and practices important to the wellbeing of Māori people generally, and especially to Māori in the health and disability workforce. Examples of organisational outcomes have been included as a reminder that healthy workplaces should expect positive results on these dimensions.

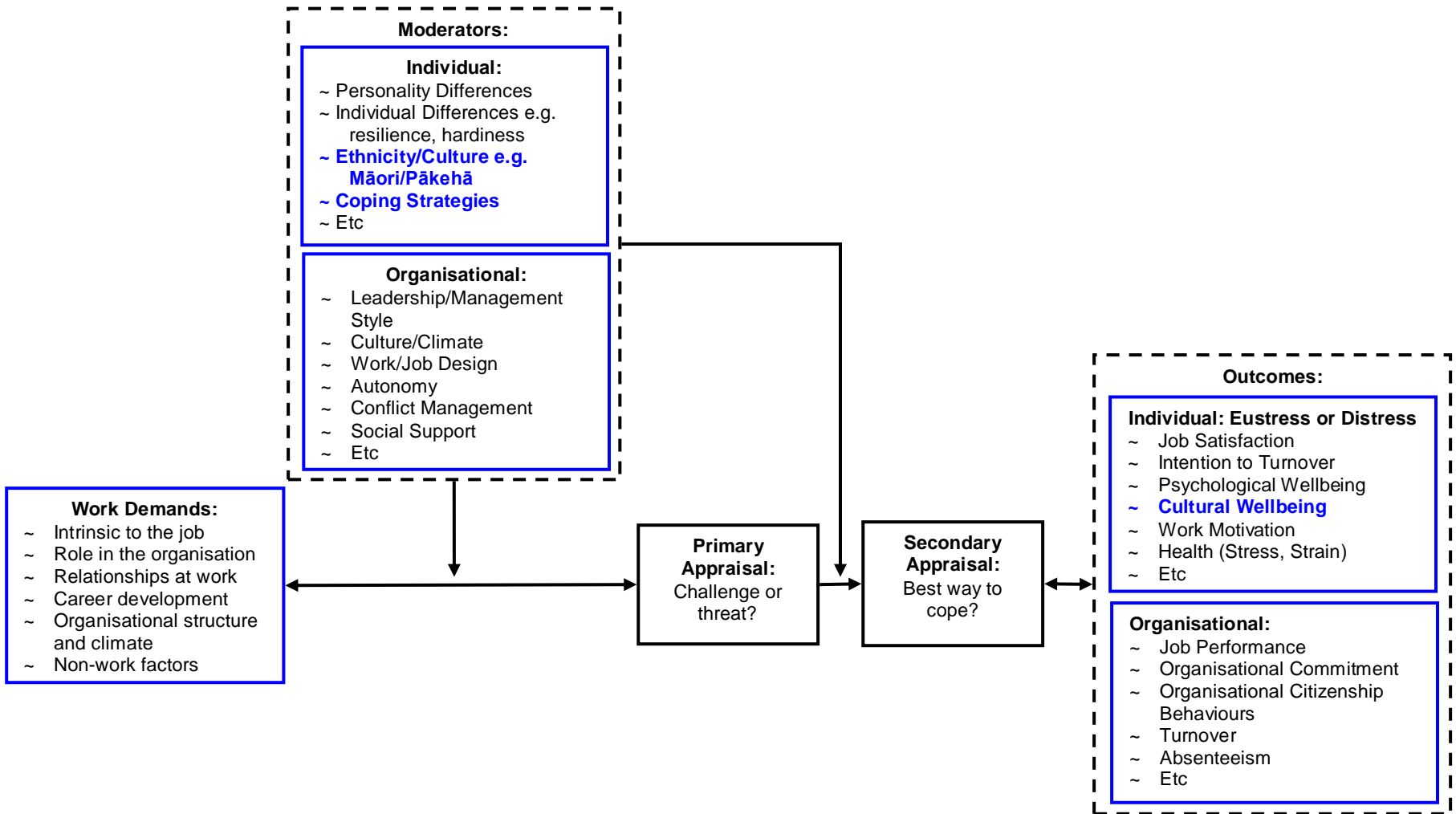


Figure 3.3 An expanded transactional model of occupational wellbeing.

3.8 Chapter Conclusion

Against a backdrop of health and safety legislation along with a commitment to the principles of the Treaty of Waitangi in the public sector, the MoH has made substantial policy gains in addressing disparities in Māori health as well as MWHDS development issues. However, research shows that challenges still exist in fully achieving the aspirations of MoH principles, goals and objectives as they relate to Māori. In terms of the way that Māori experience occupational stress, research demonstrates that it is a very difference experience compared to their Pākehā counterparts, partly because of the differences between the collectivist worldview of Māori and the individualist worldview of Pākehā, and partly because of the historical and ongoing context of the Treaty of Waitangi and its associated challenges. Similarities of the occupational stress experience were found between Māori working in the tertiary education sector, and Māori working in the health and disability sector (in this case demonstrated as barriers to retention), indicating that these differences are cultural rather than industry related. An expanded transactional model of wellbeing now provides a framework within which these cultural differences can be used to understand the process of occupational wellbeing, with one of the many positive (eustress) individual outcomes being cultural wellbeing.

The next chapter will examine indigenous models of health and wellbeing, and how they differ from dominant Western worldviews.

Chapter 4 – Indigenous Models of Health and Wellbeing

Indigenous people in and around the Pacific rim share similar histories of colonisation and subsequent loss of self-determination, land and language. Despite a resurgence and revitalisation of their cultures, health disparities continue to exist for many indigenous peoples when compared with the dominant colonising culture. In some instances, most notably the Native American Indian and the Kānaka Maoli (Native Hawai'ian) people, indigenous issues are subsumed not just by the dominant colonising culture, but also other minority non-indigenous cultures. Since the World Health Organisation's (WHO) definition of health in 1948 and the subsequent focus on indigenous health promotion in 1986 as a result of the Ottawa Charter, indigenous health determinants, worldviews and models have attracted significant research attention from indigenous and non-indigenous people.

This chapter will provide an overview of a range of indigenous (but non-Māori) models of health and wellbeing to enlighten readers about two points. The first point is the ways in which indigenous worldviews differ from dominant Western worldviews. The second point is to understand that applying Western worldviews of health and wellbeing to indigenous people will not achieve optimal health outcomes because those worldviews differ. Although these worldviews are most widely applied in the general and mental health and wellbeing context, since those worldviews stay with us regardless of whether we are at home or work, they are just as relevant in the occupational health and wellbeing context. This chapter is by no means comprehensive, partly because of the difficulty of finding published information on indigenous perspectives and models on health and wellbeing. In addition, there is insufficient space here to fully discuss and therefore appropriately honour the subtleties and nuances of these indigenous worldviews. However, the information presented in this chapter does highlight the key theme that indigenous models reflect a more holistic view of health and wellbeing than the Western biomedical model.

This chapter will first outline two Western perspectives on health and wellbeing, including the biomedical model, and the World Health Organisation (WHO) definition of health. Next, a range of indigenous worldviews are presented, including Native American

Indian and First Nation Tribes from North America, Kānaka Maoli (Native Hawai’ian), Australian Aboriginal, and Pacific Islands. The chapter will close with a summary of the common themes amongst indigenous worldviews, highlighting the inadequacy of Western models to capture what is important to indigenous peoples. These inadequacies highlight that indigenous health disparities cannot be solved by applying Western worldviews to indigenous health problems. Similarly, neither can occupational stress or wellbeing for indigenous people be adequately solved by using Western developed psychometric measures.

4.1 Western Perspectives on Health and Wellbeing

4.1.1 The Biomedical Model

The predominant approach to ‘health’ in Western countries for the past century has been the biomedical model (White, 2005). With its microbiological focus, diseases which were previously fatal were able to be cured, surgery became safer, and the human lifetime was extended. However, over time health professionals began to recognise the model’s limited focus on health. As much as the biomedical model advanced health from where it was, there are a number of limitations that stem from its core assumptions. Those assumptions are that “all illness has a single underlying cause, that disease (pathology) is always the single cause, and removal or attenuation of the disease will result in return to health” (Wade & Halligan, 2004, p. 1398). However, the biomedical model does not take into consideration social and other determinants of health and wellbeing. In addition, although the biomedical model works well in curing disease, it does nothing proactive to create health.

4.1.2 The World Health Organization (WHO) Definition of Health

According to Saylor (2004) the broader concept of wellbeing came about when the World Health Organization redefined health in 1948 as “a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity” (World Health Organization, 1948, p. 1). Compared with the biomedical model and its limited

focus on physical health and causality, the WHO definition is broader and encompasses mental and social aspects of health. Despite this broader definition of health, according to Larson (1999) the more limited definition of health as freedom from disease remains the prevailing Western health perspective.

Saylor (2004) and Larson (1999) noted that this WHO definition came up against criticism for a number of reasons, including the difficulty of measuring the mental and social components, that the concepts of mental and social wellbeing are culturally bound and are therefore different across cultures; and that complete wellbeing is utopian and not realistically possible. Perhaps these criticisms are why in the medical arena the biomedical model prevails. However, according to Larson (1999) the WHO definition remains the most popular worldwide. And, as the next sections of this chapter will illustrate, when compared with indigenous worldviews of health and wellbeing, the WHO definition is a more accurate (though still incomplete) reflection of indigenous perspectives than the biomedical model.

4.2 The Medicine Wheel – Native American Indian and First Nation Tribes of North America

The Medicine Wheel, from the Native American Indian and First Nation Tribes in North America, is a well recognised conceptual model that represents their core cultural values. Of ancient origin, it is not strictly speaking a model of health, but rather a framework for growth and direction in life (Roberts, Harper, Bull, & Heideman-Provost, 1998). However, it is widely used in the health context. For example, Cargo, Peterson, Lévesque and Macaulay (2007) found in their work with the Kanien'kehá:ka (Mohawk) people in Kahnawake (15 miles south of Montreal in Canada), that health was regarded as more than just the absence of physical ailments and that wellbeing was the desired goal. Indeed, “being alive well” was the goal of the northern Manitoba Cree First Nations community in Canada (Isaak & Marchessault, 2008, p. 115).

Since the philosophy of the Medicine Wheel is used by many Native American Indian and First Nations Tribes, there are many different teachings about it. However, common to all these teachings is that the Medicine Wheel represents interconnectedness in

that all aspects of one's life influence the others. The Medicine Wheel is typically subdivided into four sacred sections that represent the circle of life. A widely varied range of components could be included in the four sacred sections, depending on the users' focus. Examples of components that could be included in Medicine Wheels are the four components of our being (spiritual, emotional, physical, and mental) (Cargo et al., 2007; Isaak & Marchessault, 2008; Muehlenkamp, Marrone, Gray & Brown, 2009), the four directions (north, east, south, and west) (Muehlenkamp et al., 2009), the four sacred colours (white, yellow, red and black) (Muehlenkamp et al., 2009), the four seasons (spring, summer, fall, and winter) (Dumbrill & Green, 2008), the four stages of life (infant, youth, adult, and elder) (Dumbrill & Green, 2008), the four sacred animals (white buffalo, eagle, red tail hawk, and bear) (Dapice, 2006), the four medicines (sweetgrass, tobacco, cedar and sage) (Dapice, 2006), or four values important to a specific tribe (for example respect, generosity, wisdom, and courage for the Lakota tribe) (Muehlenkamp et al., 2009). The main emphasis of the Medicine Wheel is on achieving a balance between each of the four sacred sections. Some Medicine Wheels even include a central circle that depicts this emphasis on balance (see Figure 4.1 below).

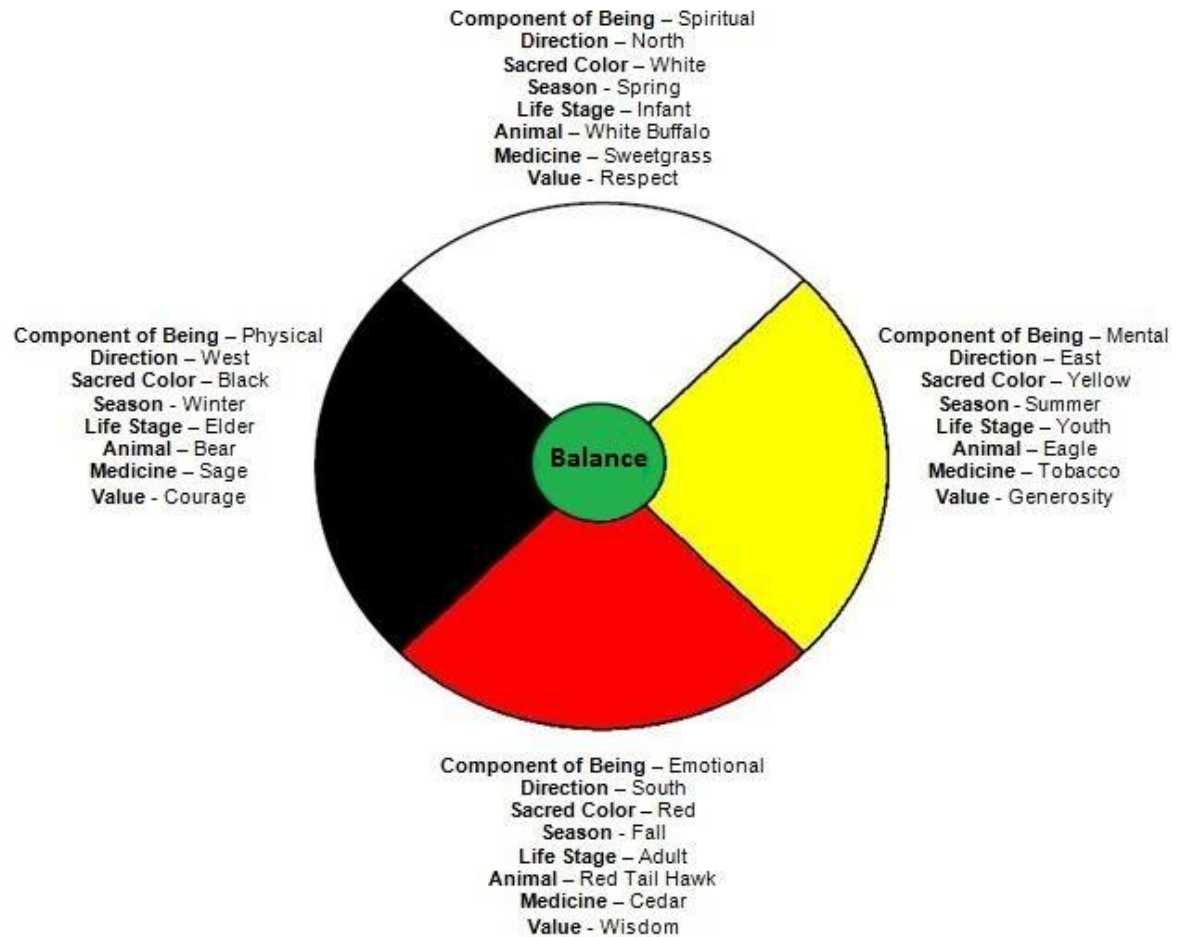


Figure 4.1 Medicine Wheel depicting the four sacred sections.

According to the literature, the Medicine Wheel has been used in a range of contemporary North American contexts. For example Cargo et al. (2007) used the Medicine Wheel to determine the relationship of perceived holistic health and self-reported physical activity and television watching with Kanien'kehá:ka (Mohawk) youth. Dumbrill and Green (2008) used the Medicine Wheel in Canada to re-conceptualise academic and societal space to develop a pedagogical framework that enables indigenous knowledge to be included in the Social Work Academy in ways that ensure it is not colonised in the process. Isaak and Marchessault (2008) used the Medicine Wheel to explore perspectives on the meaning of health in a northern Manitoba Cree First Nations community in Canada. Bloom (2008) uses the Medicine Wheel with Native American Indian clients in domestic violence and anger management therapy. Muehlenkamp et al. (2009) used the Medicine

Wheel as a guiding framework to develop a college suicide prevention model for Native American Indian students, and Kattlemann, Conti and Ren (2009) used the Medicine Wheel in a nutrition intervention for a diabetic education study with the Cheyenne River Sioux Tribe in South Dakota.

One adaptation of the general Medicine Wheel model combines both contemporary biomedical and Canadian Aboriginal First Nations models of health. According to Waldram, Herring and Young (2006) this adaptation was developed to explain health determinants in a way that reflects holistic aboriginal world views of health. Figure 4.2 below is a model that was adopted by the Sioux Lookout First Nations Health Authority in Ontario, Canada in the mid-1990s, presented in both Cree-Ojibwa syllabics and English. In the centre wheel is the individual, family, and community. The next wheel includes promotive, curative, supportive, rehabilitative, and preventive dimensions of health. The outside wheel includes environmental, context, political, cultural, and spiritual determinants of health.

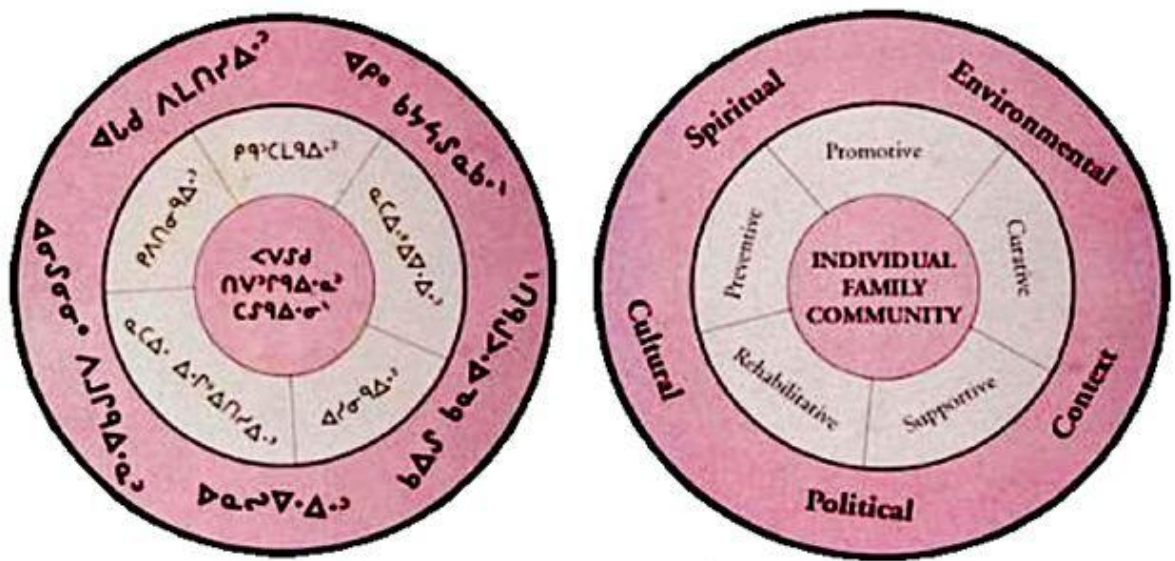


Figure 4.2 Holistic model of health adopted by the Sioux Lookout First Nations Health Authority (Waldram et al., 2006).

Jiwa, Kelly and St Pierre-Hansen (2008) found this same model (see Figure 4.3 below for Jiwa et al's. diagram) being used in community based alcohol and substance

abuse treatment programs for Nisnawbe Aski Nation people in Northern Ontario. It is recognised as a culturally appropriate model because it reflects and respects traditional aboriginal ways of knowing, being and healing.



Figure 4.3 Primary health care model adopted by Nisnawbe Aski Nation and the Sioux Lookout First Nations Health Authority (Jiwa et al., 2008).

4.3 *Kānaka Maoli/Native Hawai’ian Models*

Similar to the Medicine Wheel, the models presented in this section are not strictly speaking models of health, but are more accurately described as a worldview that illustrates traditional Kānaka Maoli values. Themes common to other indigenous cultures such as ‘ohana (family), ‘āina (land) and ho’omana (the spiritual realm) are not only important, but form the basis of cultural healing solutions for Kānaka Maoli (Duponte, Martin, Mokuau & Paglinawan, 2010). Within the Kānaka Maoli culture, unity, harmony and balance are highly valued and practiced (Blaisdell & Mokuau, 1991), and are reflected in diagrams representing Hawai’ian worldviews. Unlike other models in this chapter, the diagrams depicting Kānaka Maoli worldviews do not appear to be named, so have been numbered instead.

4.3.1 *Kānaka Maoli – Diagram One*

The two Hawai’ian worldview diagrams presented by Duponte et al. (2010) are conceptually the same, but viewed from either the macro/collective perspective, or the micro/individual perspective. Both are represented by an equilateral triangle resulting in balance and harmony in the centre. Problems occur when a lengthening or shortening of the sides brings the centre out of balance and harmony. On a macro/collective level (see Figure 4.4 below) the triangle includes *Akua/’Aumakua* (God/ancestral gods) and spirituality at the top, and *nā kānaka* (mankind, interrelationships, and intrarelationshi) and *’āina, lani, and moana* (the environment) at the foundation. Within the triangle is *lōkahi/pono* (unity/harmony).

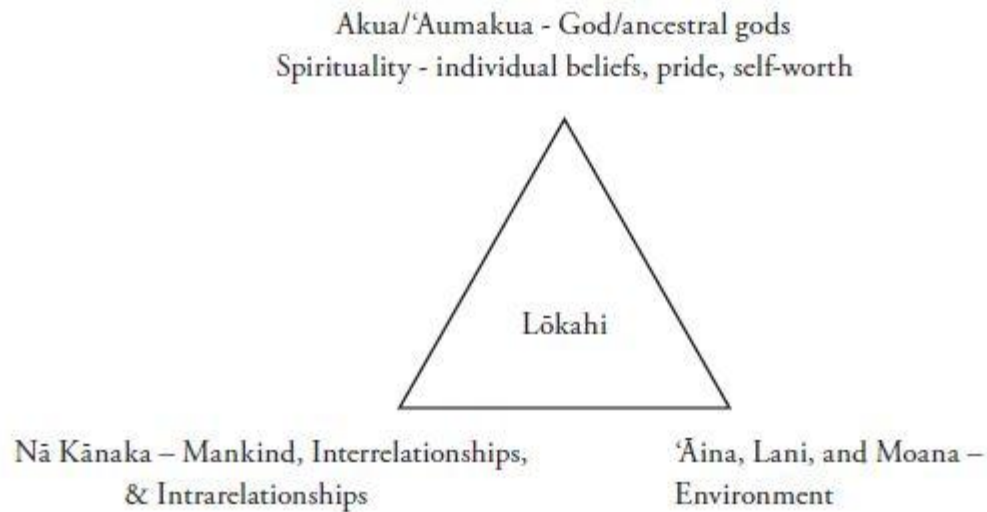


Figure 4.4 Macro/collective level Hawai’ian worldview (Duponte et al., 2010).

On a micro/individual level (see Figure 4.5 below) the triangle includes *uhane* (spirit) at the top, and *kino* (body) and *mana’o* (thoughts and feelings) at the foundation. Within the triangle is *pono* (balance).

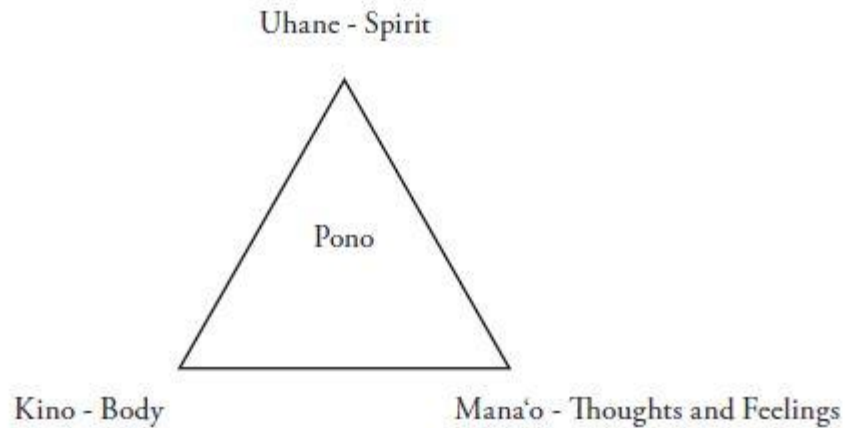


Figure 4.5 Micro/individual level Hawai'ian worldview (Duponte et al., 2010).

4.3.2 *Kānaka Maoli – Diagram Two*

The diagram presented by McCubbin and Marsella (2009) in Figure 4.6 below demonstrates the interconnectedness between prosocial human relations and prospiritual relations that is so important to Kānaka Maoli, and is founded on the interaction between body, mind and spirit. A series of concentric circles, with the person at the centre depicts the interdependent and interactive forces between them and 'ohana (family or kin group), makani/'aina/wai (nature), and the 'akua/'aumakua (gods and spirits). The desired state is *lōkahi* (harmony), with the unifying force holding these elements together being *mana* (life energy).

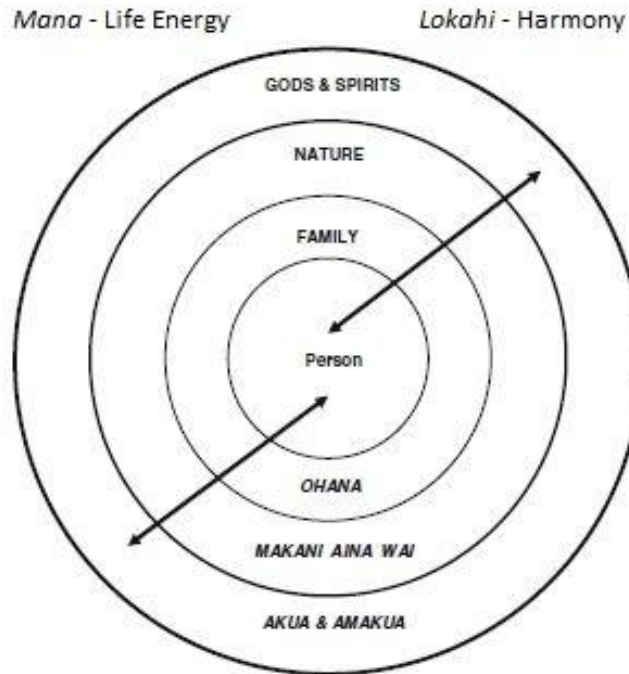


Figure 4.6 Traditional Native Hawai'ian Conception of Psyche (McCubbin & Marsella, 2009).

The importance of understanding Native Hawai'ian worldviews when working with Kānaka Maoli in the health context is acknowledged as vital to improving health disparities (Davis, 2010). However, published information about these worldviews depicted in diagram form was not easy to find. The difficulty in finding published information may reflect, among other things, that this information is not yet widely known outside of Kānaka Maoli circles. However, these world views are in use, albeit that use may be limited at this point. The diagrams presented by Duponte et al. (2010) use the worldviews in diagram 4.3.1 in a social work training program with students at the University of Hawai'i at Mānoa. The diagram presented by McCubbin and Marsella (2009) comes from the psychology arena, with a specific goal of enlightening the psychology profession so that knowledge can be used to enhance the health and wellbeing of Native Hawai'ians.

4.4 Australian Aboriginal Concepts of Health and Wellbeing

In the health statistics literature about Australian Aboriginal people, the indigenous people of Torres Strait are often also included in published material, although they are recognised as separate from Australian Aboriginals. Australian Aboriginal people's experiences engaging with health services have not often been culturally aware, safe or secure. In fact, according to Coffin, Drysdale, Hermeston, Sherwood and Edwards (2008) racism can at times be blatant, and although Aboriginal people are employed in the health system, their views may not always be heard. In addition, over the generations Aboriginal people have become suspicious of researchers who come and take indigenous knowledge, and never give anything back. All of these factors help explain the relative lack of information about Aboriginal models of health and wellbeing. Indeed, Aboriginal models of health and wellbeing as we understand them may not yet exist in the academic or health provider arena. Nonetheless, some understandings are beginning to develop about the ways in which Australian Aboriginals and Torres Strait Islanders view health and wellbeing. However, Maher (1999) as well as Boddington and Räisänen (2009) make the important point that Aboriginal concepts of health may not accurately translate into English terminology, so caution should be used.

Reid (1982) explains that for Aboriginal people, health is “not a simple matter of good fortune, a prudent lifestyle or good diet. It is the outcome of a complex interplay between the individual, his territory of conception and his spiritual integrity: his body, his land and his spirit” (p. xv-xvi). Interconnectedness between the Aboriginal people, spirituality, and the land is clearly central to their worldview of health and wellbeing, and Lutschini (2005) explains that if any of these interrelations are disrupted, ill health results. Lutschini (2005) also found that in addition to physical, mental, emotional, social, and spiritual dimensions, Aboriginal people include cultural, environmental, economic, political, and community capacity as important components of health and wellbeing.

Kaur (2007) identified the critical importance of ecology to Aboriginal perspectives of health and wellbeing. The environment provides food, medicine and shelter, along with clean air, water and land resources. For the Aboriginal people, a healthy ecology and environment provides security for present and future generations, and is the

foundation of social values, cultural values, and it is therefore crucial to have freedom to access land and water resources.

Boddington and Räisänen (2009) found that while there are similarities between Aboriginal worldviews of health and the WHO definition, Aboriginal views are broader than just physical, mental and social aspects, and includes cultural and community aspects. In addition, Aboriginal people view health as a whole of life experience, and self determination is recognised as an important component. In their 1996 report promoting the health of indigenous Australians, the National Health and Medical Research Council (1996) provided this definition of indigenous health:

Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life (p. 4).

Although the report has since been rescinded, the definition still illustrates the multiple interconnecting dynamics of Aboriginal worldviews in relation to health and wellbeing.

Maher (1999) acknowledges the inadequacies of Western perspectives of health when applied to Aboriginal people. According to Maher (1999) Aboriginal people look for “meaningful explanations of illness and to respond to the personal, family and community issues surrounding illness” (p. 234). Based on the variety of factors which contribute to Aboriginal perspectives of illness and health, those meaningful explanations include far more than just the microbiological causality of the biomedical model.

4.5 Pacific Islands Models

According to Crawley, Pulotu-Endemann and Stanley-Findlay (1995), people of Pacific Islands ethnicity experience ill health differently from *Palagi* (people of European ethnicity and other non-Pacific Islands people), and are inclined to have a more holistic view of health and wellbeing. The common theme in this literature is that Pacific Islands models of health came about in response to the lack of culturally appropriate models for Pacific Islands people seeking health care services in New Zealand. The drive for

culturally appropriate models has come from the mental health sector, and followed the emergence of Māori models of health and wellbeing (discussed in Chapter 5). They are all holistic, and reflect cultural values of interconnectedness with people, the environment, and spiritual beliefs.

4.5.1 Fonofale

Fonofale is a Samoan model of health that was conceptualised by Fuimaono Karl Pulotu-Endemann in 1984, then developed and refined specifically for use in the Aotearoa New Zealand health and disability sector context (Pulotu-Endemann, 2009). During the development and refining period, Pulotu-Endemann drew ideas about *Fonofale* from discussion with Samoans, Cook Islanders, Tongans, Niueans, Tokelauans, and Fijians to ensure it was representative of a range of Pacific Islands people's views of health and wellbeing. Pulotu-Endemann considered it necessary to develop *Fonofale* largely because other models of health and wellbeing were an inadequate reflection of Pacific Islands people's values and perspectives.

The model is symbolised by a *fale* (house) with a foundation, four main support *pou* (posts) and a roof (see Figure 4.7 below). The foundation represents the family (both nuclear and extended), which is the fundamental source of strength for Pacific Islands people. The four main support *pou* (posts) include: physical; spiritual; mental; and other dimensions of health and wellbeing. The physical dimension relates to biological wellbeing of the body, which is considered 'well' when there is an absence of illness or pain. The spiritual dimension relates to belief systems which can include Christianity, and/or traditional Pacific Islands spirituality. The mental dimension relates to health and wellbeing of the mind including emotions and thoughts. The final 'other' dimension includes a range of variables including but not limited to sexuality, gender, age, and socio-economic status. The roof represents Pacific Islands people's culture, which is a shelter for life. The *fale* is encircled by the environment, time and context to represent holism and continuity. The environment refers to the physical environment in either the rural or urban setting. Time refers to either the historical or current time that impacts on Pacific people. Context refers to the where, what or how that has meaning to a person or group.



Figure 4.7 Fonofale Model (Pulotu-Endemann, 2009).

4.5.2 Fonua

By contrast to the other Pacific Islands models in this section, *Fonua* is a model of health promotion rather than a model of health belief, and reflects a Tongan perspective. Health promotion is defined in the Ottawa Charter in 1986 as “the process of enabling people to increase control over, and to improve, their health” (World Health Organization, 1986). As a Pacific Islands health promotion concept, *Fonua* is the cyclic, dynamic, interdependent relationship between humanity and its ecology for the ultimate purpose of health and wellbeing in sustainable ways (Tu’itahi, 2009).

According to Tu’itahi (2009) the overall aim of *Fonua* is to achieve harmony and wellbeing of life (see Figure 4.8 below). It includes five dimensions, which are *sino* (physical), *‘atamai* (mental), *laumalie* (spiritual), *kainga* (collective community), and *‘ataakai* (environment). All five dimensions must be cared for equally for individual health and wellbeing. It requires action at five levels, which are *tautaha* (individual), *kainga*

(family), *kolo* (village), *fonua* (nation), and *mamani* (global society). The health of society must be addressed at all levels to achieve health and wellbeing. The harmony and wellbeing of society will take place in four phases, which are *kumi fonua* (exploratory phase), *langa fonua* (formative phase), *tauhi fonua* (maintain and sustain the community phase), and *tufunga fonua* (reform and reconstruct society phase). Finally, *Fonua* encompasses four values, which are *fe'ofa'ofani* (love), *fetokoni'aki* (reciprocity), *fefaka'apa'apa'aki* (respect), and *fakapotopoto* (prudent, judicious, wise leadership and management).

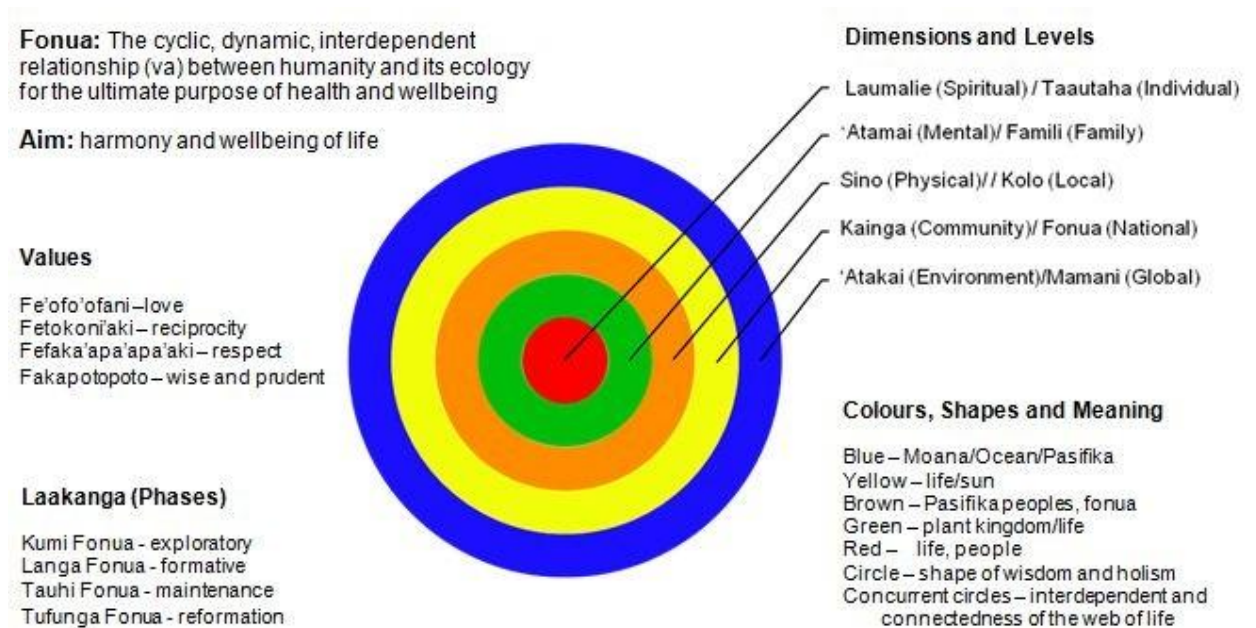


Figure 4.8 Fonua Model (Tu'itahi, 2009).

4.5.3 The Pandanus Mat Model

The Pandanus Mat model of health was one of a number of Pacific Islands models discussed by Sitaleki Finau at the 'Applying Pacific Health Models to health promotion work' workshop held in Auckland in 2007. For this model, the pandanus mat symbolises the holistic interrelatedness of each dimension of health, and includes spiritual, mental, social and physical dimensions, with the central goal being wholeness of the person with their dignity intact (see Figure 4.9 below). Unfortunately, no written information was found about the origins of the Pandanus Mat model and why it was developed, however

Agnew et al. (2004) explain that just like a good pandanus mat, the good health and wellbeing of a Pacific Islands person depends on how well the different dimensions of their life have been woven together. The Pandanus Mat model has been reported to be in use within the mental health sector in New Zealand with Pacific Islands communities (Agnew et al., 2004), and more general health and disability sector settings in at least one Pacific Islands primary health care organisation in Auckland (Ministry of Health, 2010a).

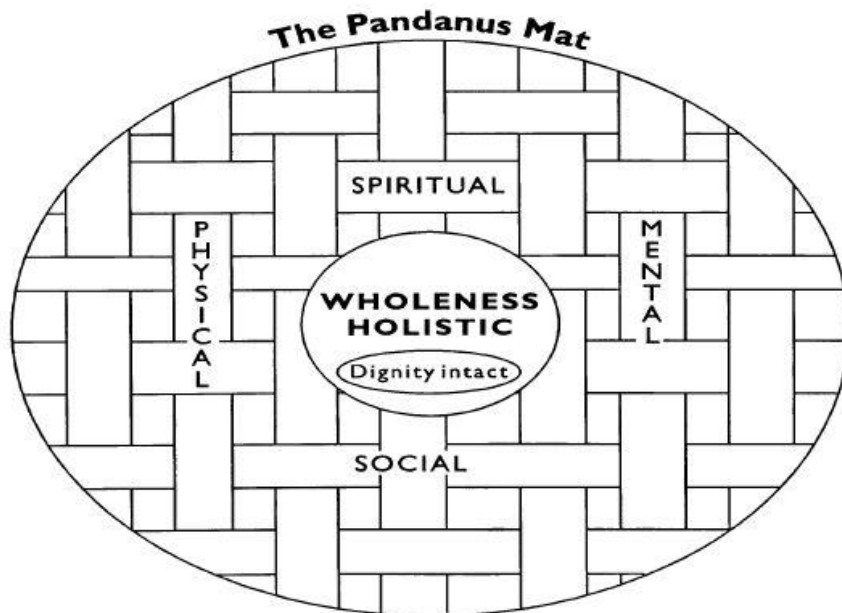


Figure 4.9 The Pandanus Mat Model (Finau, 2007).

4.5.4 *Te Vaka Atafaga Model*

Te Vaka Atafaga as a model of health was developed by Kupa Kupa, then endorsed by the Tokelau community in New Zealand in 1992, and is a metaphor for Tokelau values and concepts considered fundamental to mental health and wellbeing (Kupa, 2009). Although other Māori and Pacific Islands models of health had been developed and were in use in the Pacific mental health sector in New Zealand at the time, Kupa realised that while those models were culturally relevant in some ways, they did not capture aspects of health that were unique to Tokelau people and their families. *Te Vaka Atafaga* uses the symbol of a traditional Tokelau outrigger canoe with a sail, which reinforces cultural identity, and supports Tokelau people during times of distress when engaging with health

services. *Te Vaka Atafaga* is reported by Agnew et al. (2004) and Kupa (2009) as being used in the Pacific mental health sector in New Zealand.

According to Kupa (2009), the wooden structure of the *paopao* (canoe) represents *te tino o te tagata* (the physical body) and the *tautai* (expert navigator) represents the *mafaufau* (mind). The intertwined threads of the *lau-kafa* (sennit or rope) represents the *kaiga/pui-kaiga* (family) and the *la* (sail) represents *tapuakiga/talitonuga* (spirituality/belief systems). Everything that surrounds the *paopao* (canoe) represents the *puipuiga o te tino o te tagata* (environment), and includes the *tau* (weather), *fenua* (land) *moana* (sea), *namo* (lagoon), *lagi* (sky), *fetu* (stars), *mahina* (moon), *mata matagi* (wind), and *ea lelei* (air). Finally, the *ama* (outrigger) represents the *fakalapopotoga/tautua* (social/support systems) (see Figure 4.10 below).

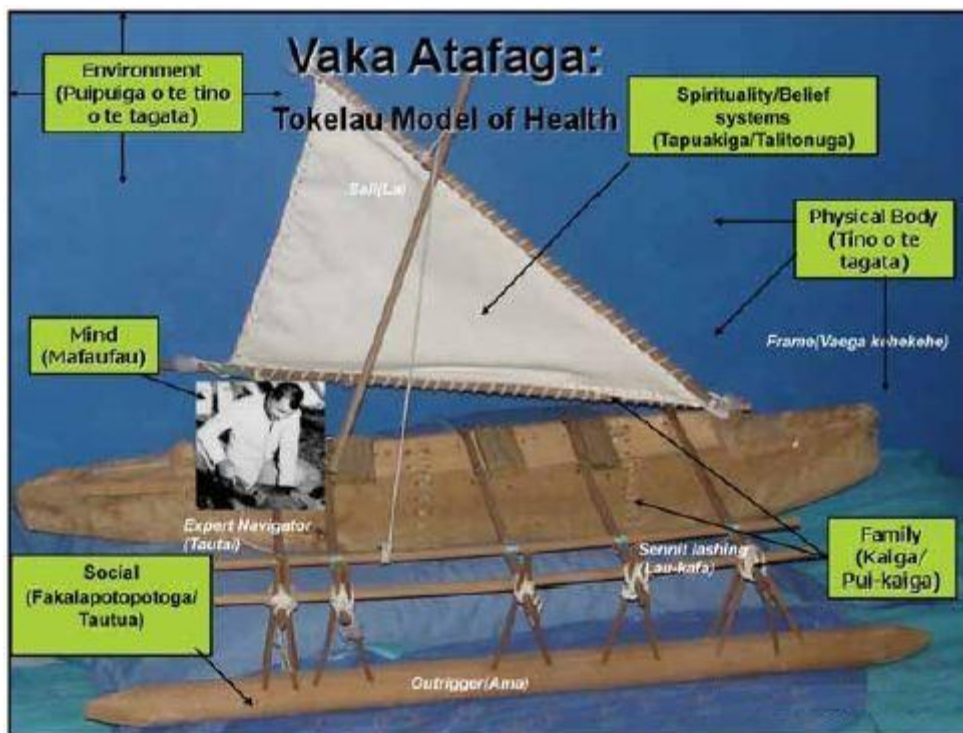


Figure 4.10 Te Vaka Atafaga – A Tokelau Model of Health (Kupa, 2009).

4.6 Chapter Conclusion

The most common theme among these indigenous worldviews or models is that they are holistic and interconnected, which is a vital component of health missing from the

biomedical model. Also important (and common) amongst the indigenous worldviews is a spiritual component (which may be derived from traditional spiritual beliefs, or religious beliefs), and connections to the land (which may encompass the environment, the sea, and the air). Cultural beliefs, along with the importance of family and social connectedness are also common themes of these indigenous worldviews.

Although there are many similarities amongst these indigenous models, some have unique elements too. For example, the political element in the model used by the Sioux Lookout First Nations Health Authority, the economic and political elements for Australian Aboriginals, and the recognition in *Fonofale* of sexuality and socio-economic status when it comes to health. Even these unique aspects of some indigenous models reiterates the folly of adopting a 'one size fits all' approach to health beliefs, in the way that Western models have historically expected to address the health disparities of indigenous peoples.

Clearly these more holistic indigenous perspectives of health and wellbeing are in contrast to the comparatively limited focus of physical, mental and social wellbeing in the WHO definition of health, and particularly the even more limited focus on physical biological health within the biomedical model. These differences are one reason why indigenous health disparities cannot be solved by simply applying Western worldviews to the problem. These cultural perspectives of health and wellbeing also carry over to the occupational context, but these differences have not yet been recognised in the occupational stress literature.

The next chapter discusses a range of Māori models of health and wellbeing, which are more similar to the indigenous models presented here than they are to Western perspectives of health and wellbeing.

Chapter 5 – Māori Models of Health and Wellbeing

As with other indigenous peoples, Māori have their own worldview of what constitutes health and wellbeing. A range of Māori models of health and wellbeing were developed during the 1980s because of increasing debate within Māoridom about concepts of health other than the narrow focus on biological dysfunction that is the emphasis of the predominant Western biomedical model of health used in Aotearoa New Zealand Durie (1998). However, rather than replacing the biomedical approach altogether, these Māori models were intended to provide a more balanced, holistic perspective of health in order to address the large and persistent health disparities for Māori. It is in that interface between the Western (and now globalised) world that Durie (2004) argues that indigenous and Māori health workers have a special role to play. Because of their indigenous background and their professional training in health, indigenous and Māori health workers have access to two bodies of knowledge unavailable to their non-indigenous colleagues. Those bodies of knowledge can be used to strengthen indigenous and Māori worldviews while at the same time contributing to good health.

According to Ratima, Edwards, Crengle, Smylie and Anderson (2006), common features of Māori health models include that they are holistic in nature, that multiple determinants of health are recognised, that a continuity between the past and present is recognised, and that the connection to the land and environment is acknowledged. Māori health models also focus on cultural integrity and recognise the importance of a secure Māori identity when it comes to health. The criticism that Ratima et al. (2006) make about Māori health models is that they do not make allowances for the diverse realities of Māori. For example, as part of the colonisation process and inter-cultural marriages through the generations, many Māori have become disconnected from their Māori heritage and resources, and in some cases do not know or have access to their whakapapa (genealogy or cultural identity). In these instances, Māori health models imply that these individuals cannot achieve good health. As long as Māori health workers recognise this potential concern when they are working with Māori people, then they can ensure that good health in such situations is measured by multiple standards.

This chapter will present five Māori models of health and wellbeing in chronological order of their development: Te Whare Tapa Whā; Te Wheke; Ngā Pou Mana; Te Pae Māhutonga; and Te Pōwhiri Poutama. A short background of each model will be provided, then the model's components will be identified and briefly explained. Next, each model's strengths will be discussed, followed by examples of how each model is being used in the health and disability sector in Aotearoa New Zealand. Finally it will conclude with a comparison of Māori and other indigenous models of health, ending with a discussion of the considerations taken into account when choosing which Māori model of health to use in the development of Mahi Oranga.

5.1 Te Whare Tapa Whā – The Four Cornerstones

Te Whare Tapa Whā (known variously as the four cornerstones or the four walls) emerged out of a training session in 1982 for a Māori Women's Welfare League research project called Rapuora (Durie, 1998). A number of people contributed to the model, including kaumātua Tupana te Hira, who emphasised wairuatanga (spirituality) as an important component of health; psychiatrist Henry Bennett, who discussed mental health; and Dr Jim Hodge, who discussed physical health. Mason Durie drew these themes together and discussed what was widely considered to be the four essential components of health. Although Te Whare Tapa Whā has generally been considered a traditional model of Māori health, in fact it is a contemporary model through which traditional concepts are articulated (Kingi, 2005).

The four essential components of health are symbolised by the four walls (or cornerstones) of a house (see Figure 5.1 below), and include: taha wairua (the spiritual side); taha hinengaro (the thoughts and feelings side); taha tinana (the physical side); and taha whānau (the extended family side). All four dimensions are necessary for strength and balance, however, Māori generally feel that taha wairua is the most essential requirement for health (Durie, 1998).



Figure 5.1 Te Whare Tapa Whā – The Four Cornerstones

Wenn (2006) argues that applying Te Whare Tapa Whā in the contemporary world depends on understanding the definitions of its components (an intellectual approach), rather than an understanding based on experience of its components (an experiential approach). That definitional understanding may be why it is readily accepted by non-Māori. Therefore, Durie's (1998) matrix identifying the focus of each component along with their key aspects and themes has been presented in Table 5.1 below.

Table 5.1

Te Whare Tapa Whā focus, key aspects, and themes (Durie, 1998, p. 69).

	Taha Wairua	Taha Hinengaro	Taha Tinana	Taha Whānau
Focus	Spiritual	Mental/Emotional	Physical	Extended Family
Key Aspects	The capacity for faith and wider communication	The capacity to communicate, to think, and to feel	The capacity for physical growth and development	The capacity to belong, to care, and to share
Themes	Health is related to unseen and unspoken energies	Mind and body are inseparable	Good physical health is necessary for optimal development	Individuals are part of wider social systems

Te Whare Tapa Whā's strength is its focus on the individual, while at the same time taking into consideration the individual's wider whānau connections and how the social component contributes to health and wellbeing. It has broad applicability across a range of health, and other contexts. As a model, it is simple to understand and easy to apply to the range of contexts it is used in.

Te Whare Tapa Whā has gained acceptance with the MoH, and has even been included in the New Zealand Health Strategy to draw a parallel between the new holistic approach to health in the sector and the holistic worldview of Māori models of health and wellbeing (Ministry of Health, 2000). It has been included in a number of MoH publications, such as 'Building on Strengths' (Ministry of Health, 2002a), is widely known and understood amongst Māori and non-Māori working in the health and disability sector, and is reasonably well known in other sectors too. Rochford (2004) discussed Te Whare Tapa Whā's application as a response to diabetes, in the mental health arena, and as a potential model for a comprehensive, marae-based community development program. Glover (2005) used Te Whare Tapa Whā as a framework to analyse Māori smoking cessation behaviour. Herewini (2008) uses it in her work in the Māori mental health arena, and says that Te Whare Tapa Whā is often used for doctor and nursing training education programs.

In addition to being used in Māori mental health, Te Whare Tapa Whā has also been adapted and applied as a clinical assessment tool in mental health. Pitama et al. (2007) discuss the development of their Meihana model as a clinical assessment framework, which used Te Whare Tapa Whā as its foundation. During the development of the Meihana model, Suzanne Pitama discovered the need to add two dimensions to the original four of Te Whare Tapa Whā: taiao (physical environment) and iwi katoa (societal context). Kingi and Durie (2000) used Te Whare Tapa Whā as the framework for *Hua Oranga*, which is a Māori measure of mental health outcomes. *Hua Oranga* is a culturally responsive tool for the Māori mental health sector, compared with the DSM-IV (Diagnostic and Statistical Manual of Mental Health Disorders), which takes a Western worldview approach to diagnosing mental health disorders.

5.2 *Te Wheke – The Octopus*

Another Māori health model, Te Wheke, was first discussed by Rose Pere at the Hui Whakaoranga in 1984. That hui (meeting or conference) was about education but Rose Pere has since developed this model for the health context. According to Wenn (2006), the values of Te Wheke are founded on Māori cosmogony which includes an esoteric aspect that was known only to an inner circle of tohunga (experts or priests), and an exoteric aspect that was more generally known. This spiritual foundation of Te Wheke emphasises the multiple dimensions and interconnectedness of its components.

Te Wheke focuses on the health of the whānau (family), which is symbolised by an octopus (Pere, 1984). Each part of the octopus, from the head to the tentacles, represents an aspect of whānau health (see Figure 5.2 below). The head and body represent the individual and whānau unit, each tentacle represents a particular dimension of individual/whānau health, the intertwining of the tentacles represents the close link between each dimension of individual/whānau health, the suckers on each tentacle represent the many components of each tentacle's dimension, and the eyes represent the total wellbeing of the individual and whānau. The eight tentacles represent: wairuatanga (spirituality); mana ake (uniqueness); mauri (life principle or ethos); hā a Koro mā a Kui mā (the 'breath of life' from forebears); hinengaro (the mind); whatumanawa (the emotional aspect);

whanaungatanga (the extended family and group dynamics); and taha tinana (the physical side).

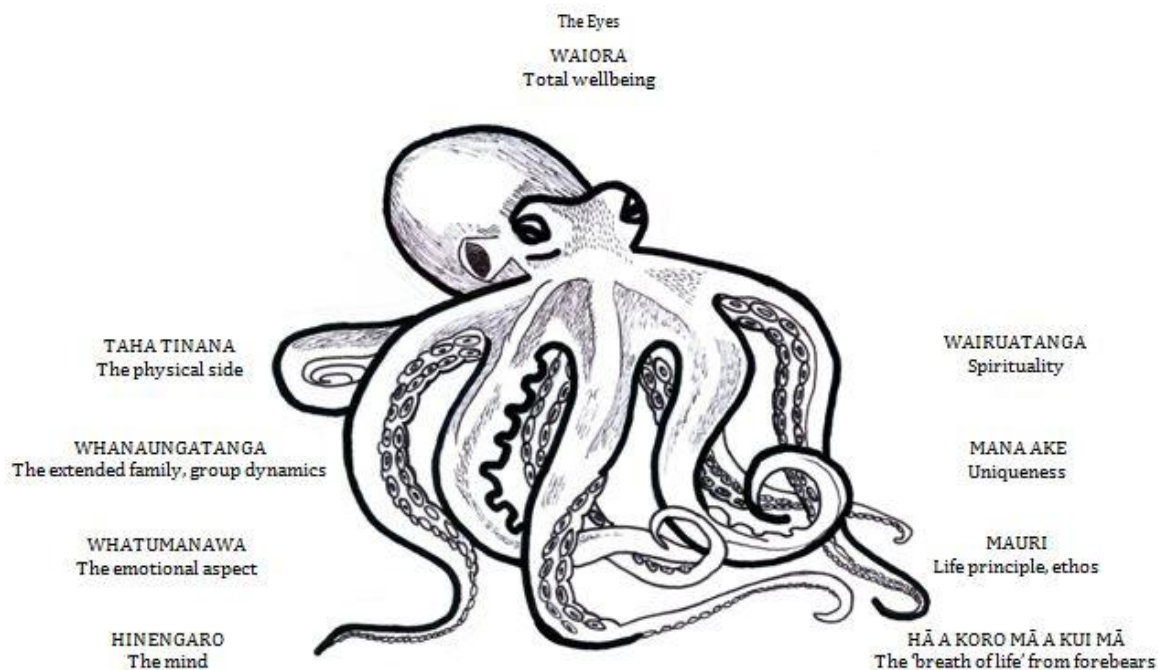


Figure 5.2 Te Wheke – The Octopus (Pere, 1984).

Te Wheke’s strength is its focus on both the individual and their wider whānau (family), which could also have application at the hapū (sub-tribe) and iwi (tribe) level. Indeed, because of its applicability to groups, it seems well suited, but not limited to, the social services arena. It is a rich model but more complex to understand than Te Whare Tapa Whā. According to Wenn (2006), because the values of Te Wheke are founded on Māori cosmogony, trying to retain that original understanding is what makes it more complex.

Like Te Whare Tapa Whā, Te Wheke has gained acceptance with the MoH, and has been included in some of their publications, such as ‘Building on Strengths’ (Ministry of Health, 2002a). However, it does not seem to be widely known amongst non- Māori, possibly because of its complexity compared with the relative simplicity of Te Whare Tapa Whā. Herewini (2008) uses it in her work in the Māori mental health arena, but contends that because of its complexity, it is overlooked by some of her colleagues. According to

Love (2004), it has been used in a range of training and education programs such as general health (especially nursing), mental health, education and social services. In research that Simon (2006) conducted to identify characteristics of nursing, Te Wheke was one of three Māori models of health known about by her participants, and used by them in their nursing practice. Wenn (2006) noted that Te Wheke was being promoted in the rohe (territory) of Ngāti Kahungunu (a tribe from the lower East Coast area of the North Island of Aotearoa New Zealand, that includes Wairoa, Heretaunga [the Hawkes Bay], and the Wairarapa) as a tool that could be used for “health service development, Kōhanga Reo [Māori preschool], and in organisations providing social services to Māori” (p. 114). Wenn (2006) further noted that an attempt had been made to use Te Wheke as a development tool for a primary health organisation’s Māori health plan.

5.3 Ngā Pou Mana – The Four Supports

In 1988 Manuka Henare prepared a report for the Royal Commission on Social Policy that examined foundations for social policies and social wellbeing (Durie, 1998). Ngā Pou Mana as a model outlines four values and beliefs that are pre-requisites for health and wellbeing, and which bring together social, cultural, and economic dimensions (Henare, 1998). In the context of developing social policy, the focus of Ngā Pou Mana is to contribute to the development and enhancement of mana Māori (Māori wellbeing and integrity which emphasises the wholeness of social relationships). Symbolised by four supports, this model of health focuses on the external environment (see Figure 5.3 below), and includes: whanaungatanga (family); taonga tuku iho (cultural heritage); te ao tūroa (the physical environment); and tūrangawaewae (land base).

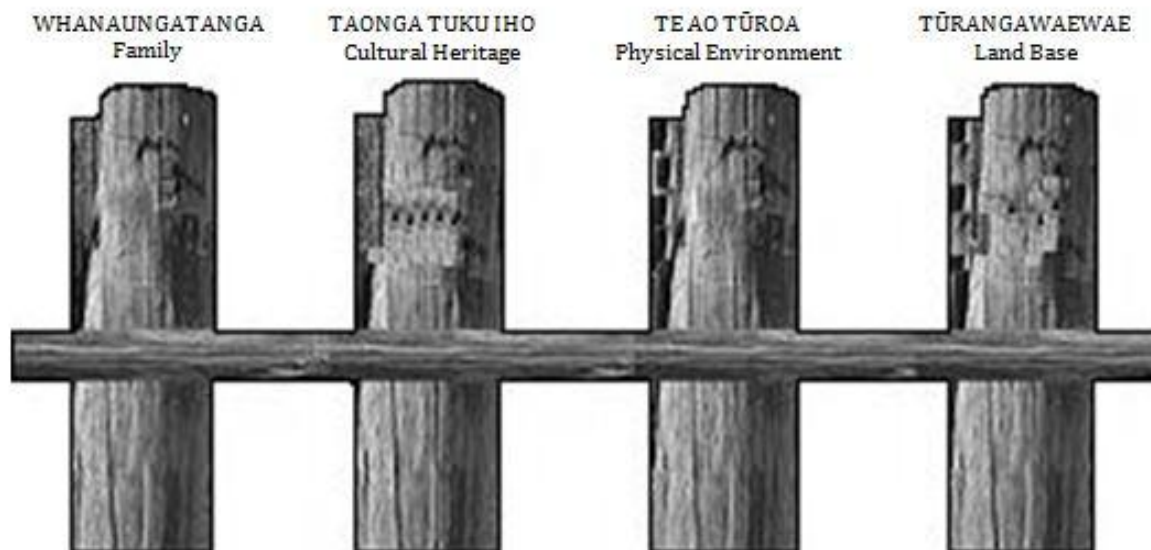


Figure 5.3 Ngā Pou Mana – The Four Supports (Henare, 1998).

Ngā Pou Mana’s strength is in raising awareness of issues related to mana Māori, especially in the context of social policy development. However, Wenn (2006) suggests it also has relevance in the area of environmental development, because it includes external environmental factors. It seems then, that Ngā Pou Mana has the flexibility to be adapted for use outside social policy development, into other areas of health development and health promotion.

Despite the strengths of Ngā Pou Mana, according to Wenn (2006) its use in health service development has been minimal. It is not as widely known, even amongst Māori, as Te Whare Tapa Whā, Te Wheke, or Te Pae Māhutonga, so does not enjoy their universality. Neither has it currently attracted as much research attention in the published literature as Te Whare Tapa Whā, Te Wheke, or Te Pae Māhutonga.

5.4 Te Pae Māhutonga - The Southern Cross

Te Pae Māhutonga was developed by Mason Durie in 1999 (Durie, 1999) in response to the 1986 Ottawa Charter, in which the World Health Organization shifted towards health promotion as a means to achieving physical, mental and social wellbeing (World Health Organization, 1986). Te Pae Māhutonga may have only recent history as a

modern health promotion model, but has its origins in the early 1900s when Maui Pomare (the first Māori medical practitioner) was appointed to the Department of Public Health in 1901 (Durie, 1999). During his time in the Department of Public Health, Pomare adopted a five point health promotion plan that included: health leadership; addressing socio-economic adversity; acknowledging the cultural realities of Māori; gaining political commitment to health; and the development of skilled health workers.

Te Pae Māhutonga is symbolised by the Southern Cross constellation of stars (see Figure 5.4 below). The four central stars, which represent the four key tasks of health promotion are: mauriora (access to te ao Māori); waiora (environmental protection); toiora (healthy lifestyles); and te oranga (participation in society). The two pointer stars, and prerequisites of effective health promotion, are: nga manukura (leadership); and te mana whakahaere (autonomy).



Figure 5.4 Te Pae Māhutonga – The Southern Cross (Durie, 1999).

Te Pae Māhutonga focuses on Māori health promotion in the wider community, and looks beyond the provision of health services to include healthy environments and healthy lifestyles. Te Pae Māhutonga’s strength as a model of health is in the development of strategies to improve the external environmental factors, rather than just the individual

level factors that contribute to community health. It is also flexible enough to be tailored for local environmental conditions, such as whether the community is rural or urban, coastal or inland, and the variations in each of Te Pae Māhutonga's components as a result of local conditions.

Like Te Whare Tapa Whā and Te Wheke, Te Pae Māhutonga is accepted by the MoH and included in a number of their publications, such as 'Building on Strengths' (Ministry of Health, 2002a). Because it has been acknowledged by the MoH, Te Pae Māhutonga is widely recognised in the health sector as a model of health promotion by Māori and non-Māori alike, and frequently used by those Māori health providers responsible for promoting community health. Smylie, Anderson, Ratima, Crengle and Anderson, (2006) noted that Te Pae Māhutonga was used by a rural Māori health provider as a monitoring framework. They tailored the model for their local needs but were unfortunately unable to obtain funding support to implement the strategies they had developed. Henwood (2007) alluded to Te Pae Māhutonga being used by five Māori health providers in Te Taitokerau (the Northland area) to promote toiora (healthy lifestyles), which included physical exercise and nutrition initiatives.

5.5 Te Pōwhiri Poutama – The Steps of Welcome

Te Pōwhiri Poutama is a model of health developed and taught by Te Ngaru Learning Systems (2002, cited in Herewini, 2008), which aligns with a traditional, formal Māori pōwhiri (welcome) process. Te Pōwhiri Poutama can be symbolised by a traditional Māori design often used in raranga (weaving) that represents the steps or stairway to heaven. According to Herewini (2008), within the mental health context, it is not necessary to conduct each step in sequence as long as each step takes place at some time during a meeting with a tangata whaiora (Māori patient or client) and their whānau (family). The steps of Te Pōwhiri Poutama (see Figure 5.5 below) include: karakia (prayer); mihimihi (exchange of greetings); whakapuaki (letting wellness flow); whakaratarata (expression of openness and trust); whakaoranga (respect of life); and whakaotinga (completion or new beginnings).

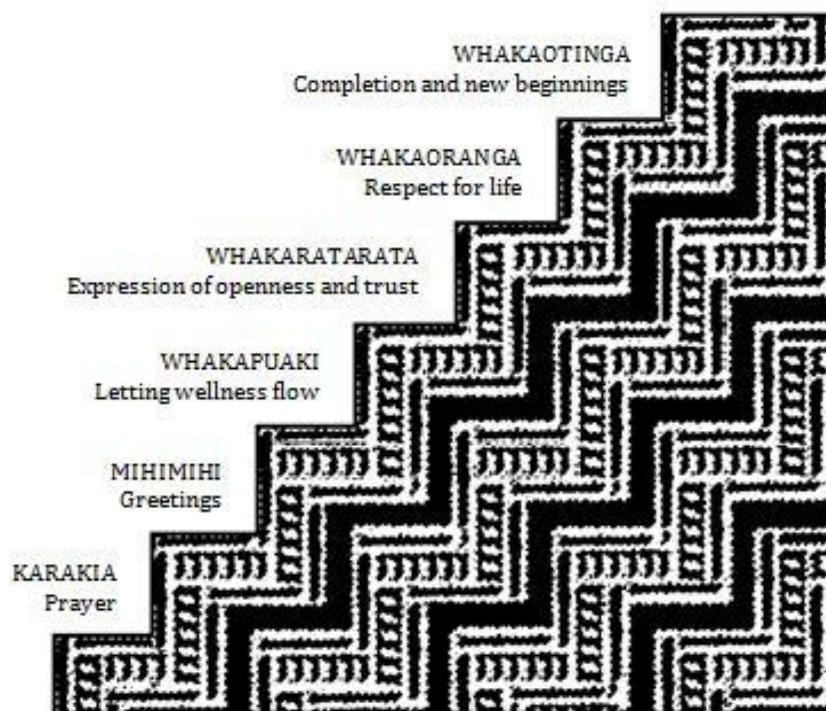


Figure 5.5 Te Pōwhiri Poutama – The Steps of Welcome

Te Pōwhiri Poutama differs from the other four Māori models which have been explicitly developed for use in health or education. Te Pōwhiri Poutama takes the concept of the traditional formal Māori welcome (the pōwhiri), and uses that process to help restore health and wellbeing to tangata whaiora (Māori patients or clients). Herewini (2008) has reported using Te Pōwhiri Poutama in a Māori mental health setting. The pōwhiri is a highly spiritual occasion during which the spiritual realms are opened when the karanga (call) goes out to the tūpuna (ancestors) asking for their protection and guidance throughout the proceedings. Because of its spiritual focus, Te Pōwhiri Poutama as a healing model seems well suited for use in the mental health context for tangata whaiora and their whānau.

This model does not appear to be widely known, or used in the health context. Herewini's (2008) work is the only published reference found for this model. It is possible that other Māori health workers are familiar with and use it, but based on the lack of published literature, it certainly has not enjoyed the same level of recognition and research attention as the other models in this chapter.

5.6 Chapter Conclusion

These Māori models of health have similarities with many of the other indigenous models discussed in Chapter 4. They take a holistic approach to health, recognise the collective approach of indigenous peoples, affirm cultural identity, and acknowledge the unbreakable connection to the land. There are also some differences between these Māori models of health and some of the indigenous models that reflect the very different political climate for our indigenous cousins in North America and Australia.

Each Māori model of health has a particular focus, which means care must be taken to apply them in the appropriate context. For example, Te Pae Māhutonga is not best suited to measure individual health outcomes, and Te Whare Tapa Whā is not best suited to measure environmental health outcomes. In deciding which Māori model of health to use to develop Mahi Oranga, consideration was given to the model's ability to measure individual and group occupational health outcomes, as well as work demands and coping strategies. In addition, since the focus for developing Mahi Oranga is Māori working in the health and disability sector who are often managed by non-Māori managers, it was important to consider how responsive the non-Māori leaders in the health sector would be in terms of familiarity with the model, as well as its ease of use. For these reasons, and because it has already successfully been developed into an individual and group outcome measure with *Hua Oranga*, Te Whare Tapa Whā was selected as the basis and philosophy for developing Mahi Oranga. However, Te Whare Tapa Whā requires one small adaptation to fit the occupational context, and that is to include 'work and professional colleagues' in the whānau quadrant along with relatives and other extended family.

The next chapter will discuss the consultation phase of Mahi Oranga's development.

Chapter 6 – Mahi Oranga: Consultation Phase

Health and disability sector policymakers in Aotearoa New Zealand have developed detailed strategies, action plans, and development plans in response to the government's commitment to the principles of the Treaty of Waitangi, and to ensure culturally responsive, relevant and appropriate health services to Māori in order to address their persistent health disparities. We know from earlier chapters that indigenous and Māori worldviews of health and wellbeing differ from Western worldviews of health. Since those cultural values and worldviews regarding health and wellbeing are still carried into the workplace, it is possible that worldviews of occupational stress and healthy work will also differ between Māori and Western cultures. However, to date limited research has been conducted about the ways in which Māori experience occupational stress, and therefore whether the Western developed psychometric measures of occupational stress are relevant or appropriate for Māori.

Western psychometric measures of occupational stress with their associated Western worldviews are often assumed to accurately measure Māori experiences of occupational stress by virtue of the process of establishing norm reference data for Māori employees. Although the practice of gathering norm reference data for particular groups does provide benchmark data against which scores can be compared, it does not address the different underlying worldviews and values of Māori, or the historical context of colonisation and political struggle of Māori, so may not adequately reflect their workplace experiences. In addition, Western psychometric measures also focus on occupational stress and how to reduce it, but often lack a positive focus on ways to build healthy workplaces.

This thesis research aimed to develop a Māori-specific psychometric measure of occupational wellbeing. The first phase was to consult with Māori health and disability sector employees, the second phase was to develop Mahi Oranga and gain feedback from participants and their suggestions for improvement, and the third phase was to pilot and gather data on Mahi Oranga. The integrity and success of the overall project depended on gaining the buy-in and acceptance of the people who would end up contributing information. It was therefore critical that the starting point of research with participants was to consult with Māori health and disability sector employees.

The primary aim of the consultation phase was to establish whether there would be support or a need at ‘flax roots’ level within the health and disability sector for a Māori-specific measure of occupational stress and healthy work. Secondary aims of this first phase were to ensure the resulting measure (Mahi Oranga) would have cultural and practical validity with Māori health and disability sector employees, be designed to meet the needs of those employees, and have support for the development and piloting phases.

Targeted groups included Māori urban health and disability sector employees working in a mainstream health service, Māori urban health and disability sector employees working in a kaupapa Māori health service, Māori rural health and disability sector employees working in a mainstream health service, and Māori rural health and disability sector employees working in a kaupapa Māori health service. The reason for interviewing employees from these groups was to determine whether the occupational stress and healthy work issues were different enough to warrant development of separate questionnaires for each group, or similar enough to warrant developing one questionnaire, with separate norm reference data for each group.

The purpose of this consultation phase was to interview Māori health and disability sector employees about the following four key questions (see Appendix A for the interview question template):

- (1) How might this research help you in the workplace? (practical implications)
- (2) What would the self-report measure look like to you?
- (3) How would you use the measure in the workplace?, and
- (4) Are you prepared to be involved in the next phase of research?

6.1 Method

6.1.1 Participants

Thirteen Māori health and disability sector employees (three male and ten female) were interviewed. Data regarding the age of participants was not collected. Eight were Māori urban health and disability sector employees working in a mainstream health service. Three were Māori urban health and disability sector employees working in a kaupapa Māori health service. Two were Māori rural health and disability sector employees

working in a kaupapa Māori health service. Although attempts were made to contact Māori rural health and disability sector employees working in a mainstream health service, connections were not successfully made with participants from this sector.

The thirteen participants self-identified (according to the job title displayed on their business card) as belonging to either the nursing, mental health, community health, or Māori Health Promotion disciplines. Nursing was represented by three participants (nurse leader, staff nurse in a hospital emergency department, and a community-based rehabilitation team coordinator). Mental Health was represented by six participants (three intern psychologists, an occupational therapist, a keyworker, and a consumer advisor). Community Health was represented by two participants (service and whānau development manager, and a parenting co-ordinator). Māori Health Promotion was represented by two participants (mana whakahaere/CEO, and a strategic coordinator promoting health in schools).

6.1.2 Procedure

Participants were recruited through the researcher's personal, whānau and friends networks. Initial contact was made by telephone and/or email, and a meeting arranged for a time and place that suited the participant and researcher. All of those who were initially contacted agreed to take part, however two were unable to meet at an agreed time due to illness.

Participants were interviewed individually. Interviews began with the researcher introducing herself, the study, and explaining that the research was being undertaken to contribute towards a Master of Arts thesis in Industrial/Organisational Psychology. The expected outcome of this research was then explained, that is, the development of an occupational stress and well-being measure based on Te Whare Tapa Whā, followed by pilot-testing to establish reliability, validity, and norm reference data. Then the primary objective of the consultation phase was explained, that is, to establish whether participants would support or need a Māori-specific occupational stress and wellbeing measure.

A brief background to the topic of occupational stress was provided, and included an overview of the need to consider organisational factors, personality (individual difference) factors, and coping strategies. The potential for the measure to contribute

information to management to deal with the causes of occupational stress was discussed, including possibilities of raising awareness of the financial, organisational, and human costs of maintaining the status quo. Up to this point, the researcher had done most of the talking while ensuring that background information was brief and relevant, and provided context for the interview questions.

Participants were then asked each of the four consultation questions. Each issue raised by each question was explored in detail, using unstructured probing questions. Interviews were not audiotaped so extensive notes were made during the course of the interview. Responses were then typed up within 24 hours. Transcripts were not provided to participants at the time, but a feedback report was provided once all interviews were completed.

6.1.3 Data Analysis

The data analysis was conducted using the six phases of Braun and Clarke's (2006) method of thematic analysis, which includes: familiarisation with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report. The remainder of this section will be structured around these six phases.

Familiarisation with the Data

Once all interviews were completed and the handwritten notes had been typed up by the researcher they were edited into bullet point format and material was collated to reflect the four interview questions. Bullet point notes were then reviewed until the researcher was sure those notes were a true reflection of the participants views, and then re-read to ensure familiarisation with the responses.

Generating Initial Codes

Only one rater generated the initial codes for the entire data set, which involved printing out the combined bullet pointed notes (which at this stage were now anonymous), and determining whether to analyse the data at the semantic explicit level or at the latent interpretive level. Based on the responses in the data set, the semantic level of analysis

were determined to be the most appropriate. Lists were then made of ideas generated from each question. For the final question, “Are you prepared to be involved in the next phase of research?” all participants responded in the affirmative, so detailed analysis of these responses was not required.

Searching for Themes

The researcher was mindful of Braun and Clarke’s (2006) caution against allowing the questions to become the themes, but in this case, the first three questions were seen as framing three domains around which themes were explored. For example, the first question domain, “How might this research help you in the workplace?” revealed different themes from the second question domain, “What would the self-report measure look like to you?”, but some similar themes to the third question domain, “How would you use the measure in the workplace?” An initial list of themes within each question domain was generated.

Reviewing Themes

During the review of themes, two raters analysed the initial coding data, and discussed each data item until all data was classified into themes. Scorer reliability was not computed as there were no cases in which the raters disagreed on an item’s classification. The process of reviewing themes involved re-reading all the combined bullet pointed notes again, this time ignoring which questions domain responses were from. Individual ideas from the data set were then sorted into related themes. In all, 30 lower order themes were identified at this stage.

Two raters then reviewed the 30 lower order themes to identify any overarching themes. For independence, this part of the analysis was conducted by one of the original reviewers and an additional reviewer who had not been involved in the initial theme identification. Again, scorer reliability was not computed as there were no cases in which the raters disagreed. Four overarching themes and 11 sub-themes were identified and allocated working titles.

Defining and Naming Themes

Having allocated working titles to the four overarching themes and 11 sub-themes, all of the data was reviewed one final time to ensure the single ideas from each response really did fit one of the sub-themes and overarching themes.

Producing the Report

The results of the thematic analysis was created showing each of the themes and subthemes, and used to structure the feedback report for participants, and the Results section below.

6.2 Results

The four overarching themes were: the motivations or aspirations of Māori health and disability sector employees, the literature on models of occupational stress, creating healthy workplaces, and the development of Mahi Oranga. Responses below are indicated with the code [SR], but are not attributed to a specific participant, so the number sequence is the order the responses appear in this section.

6.2.1 Theme 1: Motivations or Aspirations of Māori Health and Disability Sector Employees

The first overarching theme was around the motivations or aspirations for Māori working in the health and disability sector. Participants referred to improving health outcomes for tangata whaiora [SR01] [SR02], and their whānau background in the health and disability sector [SR03].

[SR01] *“Decrease health disparities for Māori.”*

[SR02] *“And ultimately to improve provision of services to tangata whaiora.”*

[SR03] *“Whānau history (within the health sector) contributes to my sense of responsibility and role modeling – not only for my whānau (now that my parents have passed away and I am now the whānau matriarch), but for hapū, iwi, and other Māori.”*

6.2.2 Theme 2: Literature on Models of Occupational Stress

The second overarching theme was about literature on models of occupational stress, with sub-themes being: workplace demands, individual factors, organisational (health sector) factors, and negative outcomes. In terms of the sub-theme workplace demands, there were five related streams: demands intrinsic to the job, the need for professional development, roles in the (health sector) organisation, relationships at work, and organisational processes and expectations. Regarding demands intrinsic to the job, participants talked about those specifically related to the rural sector [SR04].

[SR04] *“Highlight some of the issues related to rural delivery of health services e.g. physical isolation and lots of travel.”*

Regarding the need for professional development, participants talked about management skills [SR05], the lack of non-Māori colleagues cultural competence [SR06], and general lack of skills [SR07].

[SR05] *“Māori managers don’t have skills to deal with occupational stress – non-Māori mental health service is far less toxic/has fewer problems or problems are not as frequent as in Māori mental health.”*

[SR06] *“Non- Māori colleagues lack of cultural competence.”*

[SR07] *“Some staff, including managers lack of knowledge, skill, ability in some areas (e.g. HR issues like the lack of job descriptions for some staff).”*

Regarding roles in the (health and disability sector) organisation, participants talked about the nature of the health and disability sector [SR08], difficult decisions [SR09], leadership issues [SR10], and being the only Māori to have a particular role in a region [SR11].

[SR08] *“ED nursing means their workplace relationships are often short-lived and transient.”*

[SR09] *“Sometimes, when job stress levels [in management positions] are constantly high, a trade off may need to be made between the money that comes with the management position, and salvaging personal sanity.”*

[SR10] *“Some leaders do not want to be accountable with funding.”*

[SR11] *“I am the ONLY Māori in this type of role – all others at the same level in other organisations are non-Māori. Therefore, their expectation is that I will deal with ‘Māori’ things rather than colleagues taking responsibility and ownership for that themselves i.e. Treaty partners.”*

Regarding relationships at work, participants talked about issues with colleagues [SR12] [SR13], and patients’ whānau members [SR14].

[SR12] *“Colleagues can be a source of huge conflict stress – in nursing this is referred to as horizontal violence.”*

[SR13] *“Ignorance of non-Māori colleagues also an issue – anything ‘Māori’ becomes of responsibility of Māori staff to do, even though responsibility rests with the organisation.”*

[SR14] *“Last night I was verbally and physically assaulted by a patient’s whānau, because they felt they weren’t getting enough attention. My primary focus at that time was on meeting the needs of the patient, NOT the whānau – but unfortunately aggression from patients and/or their whānau is not unusual for ED nursing.”*

Regarding organisational processes and expectations, participants talked about job descriptions and what is expected of staff [SR15] [SR16] [SR17], and the requirements of reporting systems [SR18] [SR19].

[SR15] *“Sometimes, job description requirements are so unrealistic that position holders can’t achieve what they’re trained for i.e. people are being set up for failure.”*

[SR16] *“Constant report deadlines, meetings to attend, risk management responsibilities.”*

[SR17] *“Nursing position job descriptions require tertiary qualifications as a minimum, and the expectation of a postgraduate qualification (especially in management positions) is high. For Māori this is sometimes unrealistic.”*

[SR18] *“Highlight the lack of formalised reporting systems to advise stress/wellbeing issues i.e. currently heavy reliance on personal disclosure about stress issues to governance board.”*

[SR19] *“Highlight the outputs versus outcomes measurement of ‘successful’ results i.e. no acknowledgement that issues such as parents now smoking outside the house, and parents now using car seats in vehicles, and boil ups now being drained of fat are improvements as a direct result of educational work done by [Māori service] staff. Focus is only on outputs...not outcomes.”*

In terms of the sub-theme individual factors, participants talked about Māori cultural issues, particularly expectations of whānau [SR20], and tribalism [SR21]. Participants also mentioned coping strategies, their need to be able to inform management of their issues [SR22], and the need to have their experiences of occupational stress validated [SR23].

[SR20] *“Because of my whānau background in health, I have had to fight for recognition in my whānau as a leader in my own right. They have such high expectations of me.”*

[SR21] *“One issue for this role is tribalism.”*

[SR22] *“Would be good to tell management ‘my story’ and gain some level of healing.”*

[SR23] *“On a personal level it would be good to have some validation or acknowledgement that occupational stress is happening.”*

In terms of the sub-theme organisational factors, participants talked about the culture and climate in the health and disability sector. In particular, participants shared experiences of institutional racism [SR24] [SR25] [SR26], a lack of recognition [SR27], a lack of workplace social support [SR28], and a lack of appropriate cultural or professional supervision [SR29]. Participants also mentioned how government allocated resources impacted their work [SR30] [SR31].

[SR24] *“It’s a struggle to be recognised as a valid and relevant rōpū. Institutionalised racism is alive and well, and creates barriers to development and progression of Māori.”*

[SR25] *“Tikanga and Treaty training not prioritised as highly as (for example) fire safety training.”*

- [SR26] *“I am constantly worried about potential or actual accusations of financial impropriety just because I am Māori. My non-Māori colleagues are not scrutinised as closely as I am.”*
- [SR27] *“It takes more for Māori to be here [in management positions in the health and disability sector] and often we have to fight to create a sense of worth in our roles.”*
- [SR28] *“Lack of peer support to discuss some of these issues as managers and how to deal with them.”*
- [SR29] *“Need to have clinical and cultural supervision in the same (not separate) person/people as is currently the case.”*
- [SR30] *“Multiple funding sources and therefore multiple accountability (reporting).”*
- [SR31] *“Staffing constraints and therefore huge workload.”*

In terms of the sub-theme negative outcomes, participants talked about their own instances of distress [SR32], and how stress for staff led to negative outcomes for the organisation including Māori staff retention and turnover issues [SR33] [SR34], and reduced productivity [SR35].

- [SR32] *“Burnout is a huge issue.”*
- [SR33] *“Major issue – retention of Māori nurses – we need more Nurse Educators in Public Health and in wards – to provide quality service through quality staff.”*
- [SR34] *“High staff turnover.”*
- [SR35] *“Lots of personal grievances, many cases of ‘stress leave’, organisation well known with HR for breaches of OSH.”*

6.2.3 Theme 3: Creating Healthy Workplaces

The third overarching theme was creating healthy workplaces, with sub-themes being: the opportunities for educating stakeholders (including policymakers, management, non-Māori colleagues, and Māori staff), change in the health and disability sector, and organisational change as a result of Mahi Oranga findings. In terms of the sub-theme

opportunities for educating stakeholders, there were two related streams: raising levels of awareness and why this research is important to Māori staff. Regarding raising levels of awareness, participants talked about raising awareness that Māori experience occupational stress differently than non- Māori [SR36] [SR37] [SR38] [SR39], and about raising awareness of occupational stress issues that affect all health and disability sector staff [SR40]. Participants also commented on why increasing awareness of differences between Māori and non-Māori is important [SR41] [SR42].

[SR36] *“Potential to help non-Māori colleagues to see things ‘outside of the box’.”*

[SR37] *“Highlight the differences in ‘ways of being’ between Māori and non-Māori colleagues, especially in relation to reporting of client cases e.g. Māori colleague reporting is contextual and qualitative which maintains the mana of clients, whereas non-Māori colleague reporting is ‘objective’ and quantitative and does not maintain the mana of clients (i.e. deficit model of reporting).”*

[SR38] *“Māori see things differently than non-Māori colleagues – and we prioritise things differently too.”*

[SR39] *“Increase awareness/knowledge of non-Māori colleagues regarding Treaty and cultural safety issues.”*

[SR40] *“There is a real need for this research. Need to raise organisational awareness of their responsibility around occupational stress, what contributes to that, and how it can be effectively addressed.”*

[SR41] *“Increasing awareness of occupational stress issues for Māori will help prevent exploitation of Māori staff.”*

[SR42] *“Work for Māori psychologists is different than for non-Māori, therefore a Māori specific tool will be good.”*

Regarding why this research is important to Māori staff, participants talked about the need for Māori leadership in the health and disability sector [SR43] [SR44], that Mahi Oranga will be a culturally responsive questionnaire [SR45], that the research will help some Māori reconnect with what is important [SR46], and that it will increase their self-awareness of occupational stress issues for themselves and others [SR47] [SR48] [SR49].

- [SR43] *“To develop Māori leadership in health – i.e. Māori health professionals need to ‘walk their talk’ and role model healthy living i.e. not abuse chemicals (smoking, drinking, drugs) eat healthy food, and exercise on a regular basis.”*
- [SR44] *“To provide a model of ‘best practice’ for Māori.”*
- [SR45] *“This research is important to meet the needs of Māori.”*
- [SR46] *“This research is important – to help Māori ‘find’ ourselves, and re-connect to who we really are.”*
- [SR47] *“Would be good to identify (and discuss and compare) stress issues affecting workgroup teams.”*
- [SR48] *“Good to be able to track/graph stress over time (individual), so reflective practice can identify underlying issues when stress is present (can help identify stress ‘flags’ in the future).”*
- [SR49] *“On a personal level, will improve stress awareness for myself, plus improve recognition of stress in colleagues and for colleagues to recognise my stress response.”*

In terms of the sub-theme of change in the health and disability sector, there were two related streams: broad level changes in the sector, and changes at the organisational level. Regarding broad level changes in the sector, participants talked about changes for non-Māori stakeholders understanding of Māori [SR50], about policy level change [SR51] [SR52], that the research has a practical (not just a theoretical) application [SR53], and what they expected the outcomes of change initiatives to be [SR54] [SR55].

- [SR50] *“To help non- Māori stakeholders see things a different way – ‘Don’t judge us – **Understand** us’.”*
- [SR51] *“Contribute to policy development and implementation.”*
- [SR52] *“This research is important. Can contribute to policy development around tikanga Māori and best practice to implement on wards.”*
- [SR53] *“This research is important – has practical application in the workplace and there is a clear connection between the research, and the benefits to Māori healthcare professionals and their clients.”*

[SR54] *“End result would be to have a better (stress free) work environment.”*

[SR55] *“Increase job satisfaction.”*

Regarding changes at the organisational level, participants talked about changes to organisational culture [SR56], organisational accountability [SR57], and the need for workforce development [SR58] [SR59] [SR60]. They also wanted change to happen at all levels of the organisation [SR61], and for there to be ongoing organisational review [SR62] [SR63]. Participants final comments about this sub-theme was about who needs to advise the organisation of the need for change [SR64].

[SR56] *“Springboard for the future to shake up organisational culture.”*

[SR57] *“Inform management of their responsibility to remedy situation.”*

[SR58] *“Retain Māori nurses and develop the Māori health workforce.”*

[SR59] *“Contribute to identification of training needs.”*

[SR60] *“I am often called to de-escalate difficult situations – I have knowledge, skill and ability in this area, but others need to develop that as well.”*

[SR61] *“The results need to be readily utilised at all levels of the organisation.”*

[SR62] *“Changes are implemented in the workplace as a result of the ‘intervention’, with regular reviews – must not be a “one off” intervention.”*

[SR63] *“MUST be a living, working document, aligned with the values of the workplace – NOT a one-off tick the box token gesture.”*

[SR64] *“May require external non-Māori person to feedback to management – i.e. management may not be as receptive if a Māori person gives them the results.”*

In terms of the sub-theme of organisational change as a result of Mahi Oranga findings, participants talked about the ability of Mahi Oranga to help identify **what** needs to change [SR65] [SR66] [SR67], about providing evidence of the need for change [SR68] [SR69], and they made a range of suggestions about some of the initiatives or solutions

they could see were needed in their workplace [SR70] [SR71] [SR72] [SR73] [SR74] [SR75].

- [SR65] *“Highlight the fact that all training must currently be undertaken off-site.”*
- [SR66] *“Highlight to management what the issues are, so strategies can be put in place to address the occupational stress and support Māori staff.”*
- [SR67] *“Cultural audits – currently there are no consistent measures used. I often question what management measures and what they want to find, so it will be good to have something ‘by Māori for Māori’. We need a ‘lens’ to analyse content of Māori involvement in organisations.”*
- [SR68] *“Provide evidence of occupational stress, so that resources can be allocated to put strategies/solutions in place.”*
- [SR69] *“Could be used to support/justify need for things such as peer and supervisor support groups.”*
- [SR70] *“Clinical and cultural supervision is essential.”*
- [SR71] *“Māori cultural supervision is an issue (i.e. the lack of). However, it’s perhaps idealistic to hope that clinical as well as cultural supervision can rest with the same person – they’re two separate specialist areas, and having both in the same person is perhaps tohunga status.”*
- [SR72] *“Important to set up peer support groups – initially within same disciplines, but growing to multi-disciplinary peer support – this is the direction the health sector is moving – interdisciplinary knowledge sharing and collaboration.”*
- [SR73] *“Tangible things – formality around cultural supervision and support. e.g. whakawhanaungatanga, kapa haka, Māori nurses support group.”*
- [SR74] *“Peer support is also badly needed.”*
- [SR75] *“Interventions must be timely.”*

6.2.4 Theme 4: Development of Mahi Oranga

The fourth overarching theme was the development of Mahi Oranga, with sub-themes being: content of Mahi Oranga, usability of Mahi Oranga, administration issues, whether a discipline specific questionnaire was needed and an observation that Te Whare

Tapa Wha is not the only Māori model of health recognised by non-Māori in the health and disability sector. In terms of the sub-theme content of Mahi Oranga, participants wanted both quantitative and qualitative questions to be included [SR76] [SR77], equal representation of Te Whare Tapa Whā quadrants [SR78] [SR79], and for kupu Māori (Māori words) to be included [SR80]. A specific question was also suggested, [SR81].

[SR76] *“Needs to include both quantitative as well as qualitative response options – qualitative most important so my concerns can be voiced.”*

[SR77] *“Quantitative questions to have a Likert rating scale, not ‘Yes/No’ response options.”*

[SR78] *“All quadrants equally important.”*

[SR79] *“Importance of quadrants may depend on job context and age. For me, wairua quadrant is most important.”*

[SR80] *“No expectation that questionnaire be exclusively in te reo, but appropriate and relevant kupu Māori expected.”*

[SR81] *“I would like to see this question to be asked: ‘Has your job ever made you feel depressed, or suicidal, or turn to alcohol?’.”*

In terms of the sub-theme usability of Mahi Oranga, participants talked about the length and time to complete Mahi Oranga [SR82] [SR83], questions being simple and easy to understand [SR84], (one participant based her response on her experience of tangata whaiora [Māori clients or patients] when using *Hua Oranga*) [SR85], and ensuring face validity by making sure the questions are relevant to the quadrant being tapped (again, based on experience with tangata whaiora and *Hua Oranga*) [SR86].

[SR82] *“Able to complete in 20 – 30 minutes.”*

[SR83] *“I am a busy person, so must be quick to complete.”*

[SR84] *“Questions need to be simple and easy to understand.”*

[SR85] *“Hua Oranga is sometimes too difficult for tangata whaiora to understand, and they often need assistance of whānau or us to complete the questions.”*

[SR86] *“Must be relevant. With Hua Oranga, sometimes tangata whaiora can’t see the relevance of the question to the quadrant.”*

In terms of the sub-theme administration issues for Mahi Oranga, participants talked about the need for group and individual feedback reports [SR87], ensuring reports to management were anonymous [SR88], and how to present the results [SR89]. Participants also mentioned concerns about who would analyse their responses [SR90] [SR91].

[SR87] *“Capable of reporting for individuals as well as group report for management.”*

[SR88] *“If individual results reported to management they must be anonymous.”*

[SR89] *“Report to summarise levels of stress in each quadrant (graph is preferred) for individuals.”*

[SR90] *“Qualitative analysis needs to be done by a Māori.”*

[SR91] *“However, definitely need a Māori to interpret results.”*

The final sub-themes related to the development of Mahi Oranga included whether discipline-specific versions needed to be developed, [SR92] [SR93], and the observation that Te Whare Tapa Whā is not the only Māori health model well recognised by non-Māori in the health and disability sector [SR94].

[SR92] *“Need to contextualise responses – may need service-specific questions.”*

[SR93] *“If a single self-report measure could be developed (rather than service or discipline specific), this would reflect the direction of the health sector to move towards interdisciplinary knowledge sharing and collaboration.”*

[SR94] *“Te Pae Māhutonga is another Māori model that is well-known among non- Māori health professionals.”*

6.3 Discussion

The primary aim of this consultation phase was to establish whether there would be support or a need at “flax roots” level within the health and disability sector for a Māori-specific measure of occupational stress and healthy work. Responses indicated strong

support, and a need for such a measure. The secondary aims were to ensure the resulting measure (Mahi Oranga) would have cultural and practical validity with Māori health and disability sector employees, meet the needs of those employees, and gain support for the development and piloting phases of Mahi Oranga. In terms of cultural and practical validity, participants confirmed that this would require longer term work, and that the responses gained during the planned pilot phase along with subsequent validation studies will eventually answer this question. In terms of meeting the needs of Māori health and disability sector employees, participants agreed that feedback from the development phase of this research would provide assurances about that. In terms of gaining support for subsequent phases of Mahi Oranga, all consultation phase participants agreed to take part in the next two phases.

There was insufficient evidence to indicate the need for separate questionnaires for the different targeted groups (Māori urban health and disability sector employees working in a mainstream health service, Māori urban health and disability sector employees working in a kaupapa Māori health service, Māori rural health and disability sector employees working in a mainstream health service, and Māori rural health and disability sector employees working in a kaupapa Māori health service). However, participants expressed the need for the measure to include qualitative questions to provide sufficient opportunity for respondents to give context to their particular issues. Data collected in the pilot phase will help determine whether separate norm reference data will be needed for each targeted group.

Responses indicated that Māori health and disability sector employees experience some aspects of occupational stress in the same way as non-Māori, although the impact on Māori may be more acute because they are under-represented in the health and disability sector workforce, while Māori remain over-represented in the health statistics. The commonalities with other health and disability sector employees included budgetary constraints resulting in staffing constraints and huge workloads, unrealistic job description expectations, lack of management skills and a lack of appropriate professional development. In addition, the nature of the discipline such as ED nursing, isolation and travel in the rural sector, and the negative outcomes of stress for individuals and the organisation were also common for all health and disability sector employees.

However, responses also demonstrated that Māori staff experience occupational stress in different ways. These differences include institutional racism and the resulting lack of cultural safety, and a failure of non-Māori to value Māori cultural competencies. In addition, Māori employees were expected to exclusively deal with ‘Māori’ issues, perhaps in part because of their non-Māori colleagues lack of cultural competence. Finally, the expectations of whānau, hapu and iwi, along with tribalism, were Māori-specific issues that contribute to differing experiences of occupational stress.

Some of the experiences of the Māori health and disability sector employees from this consultation phase mirrored those experienced by Māori tertiary education staff from Sisley and Waiti’s (1997) study. These included the aspirations of Māori staff to provide appropriate services to Māori end users (either students or patients) to improve educational or health outcomes, the issues around institutional racism and the resulting lack of cultural safety, and that Māori cultural competencies are not always recognised and remunerated accordingly. There were also similarities with Ratima et al’s. (2007) findings in terms of low levels of Māori cultural competence of non-Māori colleagues, insufficient access to Māori cultural support and/or supervision, and institutionalised racism. Together, these findings provide strong evidence not only that Māori experience occupational stress differently from their non-Māori colleagues, but of ways in which those experiences differ.

6.4 Chapter Conclusion

Although the sample size was small, the information gained from the consultation phase provided rich information about how Māori experience occupational stress. Participants also made a valuable contribution to the development of Mahi Oranga, and in particular its content and usability, which provides some level of confidence that it will be well received by other Māori health and disability sector employees. Participants were excited about this research and hoped that the findings would ultimately lead to changes in the health and disability sector to improve work outcomes for Māori staff, but also in health outcomes for tangata whaiora.

The next chapter will detail how Mahi Oranga was developed in preparation for the pilot and data collection phase of this research.

Chapter 7 – Mahi Oranga: Developing the Questionnaire Phase

The development phase of Mahi Oranga took part in three stages: draft development, draft revision, then creating the online version. During the draft development stage, four key sources informed the document: findings from the consultation phase of this research (Chapter 6), findings from secondary research on Māori and occupational stress (Chapter 3) including Mitchell and Mitchell (1993), Ratima et al. (2007), Simon (2004), and Sisley and Waiti (1997), the mainstream literature related to sources of occupational stress for the health and disability sector, and Osipow and Spokane's (1992) revised Occupational Stress Inventory (OSI-R). During the draft revision stage, three key sources informed the document: feedback from the consultation phase participants, a further review of mainstream health sector literature, and further Western measures related to occupational stress and coping. An online version of Mahi Oranga was then created on the SurveyMoney.com website, at which point ethics approval was sought and gained prior to data collection. Details of each of these three development stages will be discussed next.

7.1 Draft Development

The process of developing the draft version of Mahi Oranga occurred in four steps. The first was to decide the broad occupational domains to be measured by Mahi Oranga. The second was to decide which dimensions within each of the broad occupational domains needed to be measured. The third was to define each of the four quadrants of Te Whare Tapa Whā for the context of Mahi Oranga and decide which would be relevant for each dimension to be measured. Finally, quantitative and qualitative questions were developed to populate Mahi Oranga. The final structure of Mahi Oranga was expected to consist of three levels: domains (which would make up the main sections of the questionnaire), dimensions (which would ultimately become the scales), and components (the quadrants of Te Whare Tapa Whā that needed to be considered during development of quantitative questions). These three levels are illustrated in Figure 7.1 below.

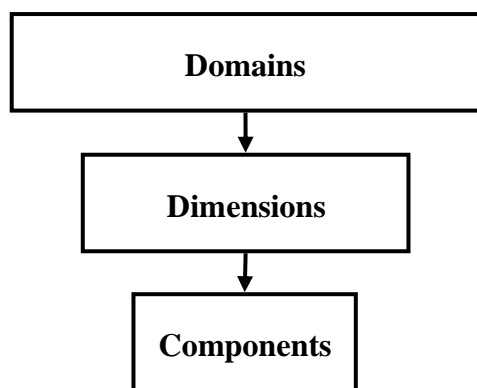


Figure 7.1 The three levels of Mahi Oranga.

7.1.1 Development Decision Steps

Step 1

This step involved deciding which domains would be measured by Mahi Oranga. The expanded Transactional Model of Occupational Wellbeing (presented in Chapter 3) was chosen as the theoretical model for this project and informed the decision about which domains to include. It was decided to include the following three broad occupational domains: ‘work demands’ (conceptualised as sources of stress that drain resources), ‘resources’ (conceptualised as coping strategies that build resilience and strength), and ‘individual outcomes’ (conceptualised as strains or wellbeing). The ‘resources’ domain was expected to focus on culturally relevant coping strategies, as informed by the individual moderators from the expanded Transactional Model of Occupational Wellbeing. These three broad occupational domains became three separate sections within Mahi Oranga.

Step 2

This step involved deciding which dimensions within each of the three occupational domains needed to be measured. The structure of Osipow and Spokane’s (1992) revised Occupational Stress Inventory (OSI-R) was the first source to provide guidance for Mahi Oranga’s dimensions. The OSI-R is a strongly Western, highly individualistic tool, and individual items may not be representative of Māori values, however given that some responses from the consultation phase indicated that Māori health

and disability sector employees experience some aspects of occupational stress in the same way as non-Māori, it was considered appropriate to use relevant concepts from the OSI-R for the purpose of Mahi Oranga. Based on responses from the consultation phase, four of the OSI-R concepts emerged as potentially relevant. From the Occupational Roles Questionnaire (ORQ) section of the OSI-R, the concepts of ‘role overload’ and ‘role conflict’ were considered as dimensions in the ‘work demands’ domain of Mahi Oranga. From the Personal Strain Questionnaire (PSQ), the concept of ‘vocational strain’ (renamed ‘work productivity strain’ for use in the draft Mahi Oranga questionnaire) and ‘interpersonal strain’ were suitable for the ‘individual outcomes’ domain. In the ‘resources’ domain of the draft Mahi Oranga questionnaire, the Personal Resources Questionnaire (PRQ) of the OSI-R provided four scales: ‘recreation’, ‘self care’, ‘social support’ and ‘rational/cognitive coping’. These constructs appeared similar enough to the quadrants within Te Whare Tapa Whā to be culturally appropriate for Mahi Oranga. It was decided to create a dimension called ‘Te Whare Tapa Whā’ for Mahi Oranga.

Other researchers have also found evidence in support of role overload as important from mainstream health sector research, for example Moore and Cooper (1996), and in Māori research Simon (2004). Evidence in support of role conflict from mainstream research came from Cooper and Marshall’s (1976) model of stress at work.

In addition to the constructs identified by the OSI-R, two additional dimensions were included in the ‘work demands’ domain of Mahi Oranga to provide a more comprehensive coverage of relevant ideas. Interpersonal conflict, horizontal violence and bullying featured strongly as a source of workplace stress in the mainstream health sector literature (Bentley et al., 2009; Cooper & Marshall, 1976; Foster, Mackie & Barnett, 2004; McKenna, Smith, Poole & Coverdale, 2003). Additionally, because it featured so strongly in the Māori literature (Nursing Council of New Zealand, 2005; Ratima et al., 2007; Simon, 2004; Sisley & Waiti, 1997) and the Chapter 6 consultation phase, it was considered critical to measure levels of cultural safety (or lack thereof caused by institutional racism). The dimensions of ‘interpersonal conflict’ and ‘cultural safety’ were therefore included in the ‘work demands’ domain.

In the ‘individual outcomes’ domain, the dimensions of ‘work productivity strain’ and ‘interpersonal strain’ were considered insufficient to capture the concept of cultural

wellbeing, included in the expanded Transactional Model of Occupational Wellbeing presented in Chapter 3. The dimension of ‘Te Whare Tapa Whā’ was included to address this concern. The first draft domains and dimensions of Mahi Oranga are shown in Figure 7.2 below.

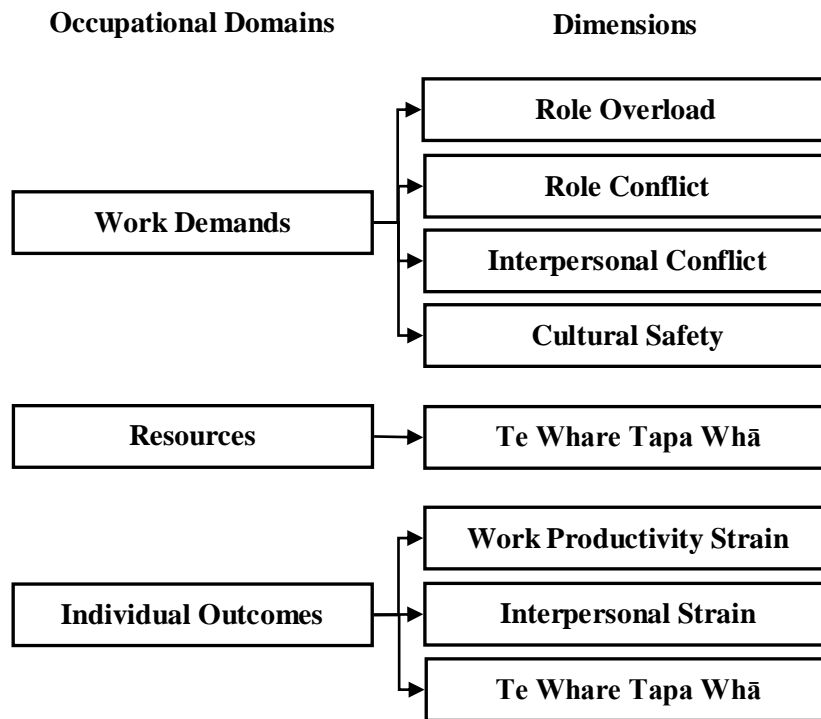


Figure 7.2 The first draft occupational domains and dimensions of Mahi Oranga.

Conceptualising the Dimensions

Having decided which dimensions to include in the first draft of Mahi Oranga, they next needed to be conceptualised based on the literature considered so far. Included in the domain of ‘work demands’ were the dimensions of ‘role overload’ (conceptualised as the extent to which job or role demands exceed personal and workplace resources, and the extent to which a person is able to carry out expected workloads), ‘role conflict’ (conceptualised as the extent to which a person experiences conflict between competing responsibilities in their role), ‘interpersonal conflict’ (conceptualised as the extent to which a person is experiencing conflict with other people [management, colleagues, clients/patients or their whānau]), and ‘cultural safety’ (conceptualised as the extent to which Māori staff feel culturally safe in the workplace).

Included in the domain of ‘resources’ was the dimension of ‘Te Whare Tapa Whā’, in which ‘wairua/spiritual’ was conceptualised as the extent to which a person makes use of and builds strength from regular wairua/spiritual activities, ‘hinengaro/psychological’ was conceptualised as the extent to which a person makes use of and builds strength from regular hinengaro/psychological activities, ‘tinana/physical’ was conceptualised as the extent to which a person makes use of and builds strength from regular tinana/physical activities, and ‘whānau/family’ was conceptualised as the extent to which a person makes use of and builds strength from regular whānau/family activities.

Within the domain of ‘individual outcomes’ were included the dimensions of ‘work productivity strain’ (conceptualised as the extent to which a person is having problems in work quality and/or quantity), ‘interpersonal strain’ (conceptualised as the extent to which a person having problems with relationships at work), and ‘Te Whare Tapa Whā’. For the dimension of ‘Te Whare Tapa Whā’, ‘wairua/spiritual strain’ was conceptualised as the extent of wairua/spiritual problems being experienced by a person, ‘hinengaro/psychological strain’ was conceptualised as the extent of hinengaro/psychological and/or emotional problems being experienced by a person, ‘tinana/physical strain’ was conceptualised as the extent of tinana/physical problems being experienced by a person, and ‘whānau/family strain’ was conceptualised as the extent of whānau/family problems being experienced by a person.

Step 3

This step involved two stages. The first stage was to define each of the four quadrants of Te Whare Tapa Whā for the context of Mahi Oranga, and the second stage was to decide which of these would be relevant for each dimension to be measured. For guidance on the first stage, information was obtained from Kingi and Durie (2000), in which Te Kani Kingi developed a Māori-specific measure of mental health as a PhD project. This measure was called *Hua Oranga*, and was developed for use in the clinical psychology context of Māori mental health. In developing *Hua Oranga*, Kingi and Durie (2000) developed a Māori Outcomes Dimension Framework (MODF), so that the key aspects of wairua, hinengaro, tinana, and whānau could be captured. The framework is presented in Table 7.1 below.

Table 7.1

Māori Outcome Dimension Framework (MODF) (Kingi & Durie, 2000, p. 34).

Wairua	Hinengaro	Tinana	Whānau
dignity, respect	motivation	mobility/pain	communication
cultural identity	cognition/behaviour	opportunity for enhanced health	relationships
personal contentment	management of emotions, thinking	mind and body links	mutuality (reciprocity)
Spirituality (non-physical experience)	understanding	physical health status	social participation

This framework appeared flexible enough for use outside of the mental health context that it had originally been developed for. Nothing in the framework seemed to exclude use in an occupational health context, nor did it appear that anything additional needed to be added to accommodate use in the occupational health context. This framework was therefore adopted to define the components of the MODF for use in the draft Mahi Oranga questionnaire.

To ensure that the Mahi Oranga questionnaire was focussed on Māori-specific aspects of occupational wellbeing, the MODF components needed to be the focus when developing quantitative questions. The number of questions per component of MODF was guided by Costello and Osborne's (2005) recommendation that factors with five or more strongly loading items is desirable. Feedback from the consultation phase of this research (Chapter 6) indicated that participants preferred a Likert scale of measurement. In order to provide an initial structure for the draft Mahi Oranga, a template for question development was created (see Table 7.2 below). Definitions from the MODF components were included in the columns on the left, with the central column reserved for questions (yet to be developed) and the right column included a 5-point Likert rating scale options. Space was provided at the bottom for two qualitative questions.

Table 7.2

Template for question development including MODF components and definitions plus space for questions and Likert scale ratings.

Wairua/Spiritual ♦ dignity, respect ♦ cultural identity ♦ personal contentment ♦ spirituality (non-physical experience)	1.						
	2.						
	3.						
	4.						
	5.						
Hinengaro/Psychological ♦ motivation ♦ cognition/behaviour ♦ management of emotion/thinking ♦ understanding	1.						
	2.						
	3.						
	4.						
	5.						
Tinana/Physical ♦ mobility/pain ♦ opportunity for enhanced health ♦ mind and body links ♦ physical health status	1.						
	2.						
	3.						
	4.						
	5.						
Whānau/Family (includes workplace whānau/family) ♦ communication ♦ relationships ♦ mutuality (reciprocity) ♦ social participation	1.						
	2.						
	3.						
	4.						
	5.						
1.							
2.							

The second stage of step 3 was to decide which MODF components would be relevant to measure in each dimension identified at step 2. Within the ‘work demands’ domain, for the dimensions of ‘role overload’ and ‘role conflict’, all four components of the MODF were included. For the dimension of ‘interpersonal conflict’, only the wairua/spiritual, hinengaro/psychological and tinana/physical components of the MODF were included. In this case, whānau (both at home and at work) was regarded as an implicit aspect of interpersonal conflict, and therefore the whānau/family MODF component was not included. For the dimension of ‘cultural safety’, the wairua/spiritual and hinengaro/psychological components of the MODF were included. With respect of the tinana/physical and whānau/family MODF components of the ‘cultural safety’ dimension,

feedback from the consultation phase of this project as well as personal experience indicated that cultural safety predominantly impacts the wairua and hinengaro quadrants of Te Whare Tapa Whā. It was therefore decided not to include the tinana/physical and whānau/family MODF components in the ‘cultural safety’ dimension.

Within the ‘resources’ domain, and the dimension of ‘Te Whare Tapa Whā’, all four MODF components were included. Within the ‘individual outcomes’ domain, for the dimensions of ‘work productivity strain’ and ‘Te Whare Tapa Whā’, all four components of the MODF were included. For the dimension of ‘interpersonal strain’ only wairua/spiritual, hinengaro/psychological and tinana/physical components of the MODF were included because whānau/family was considered implicit in interpersonal strain. The first draft showing domains, dimensions and components of Mahi Oranga are presented in Figure 7.3 below.

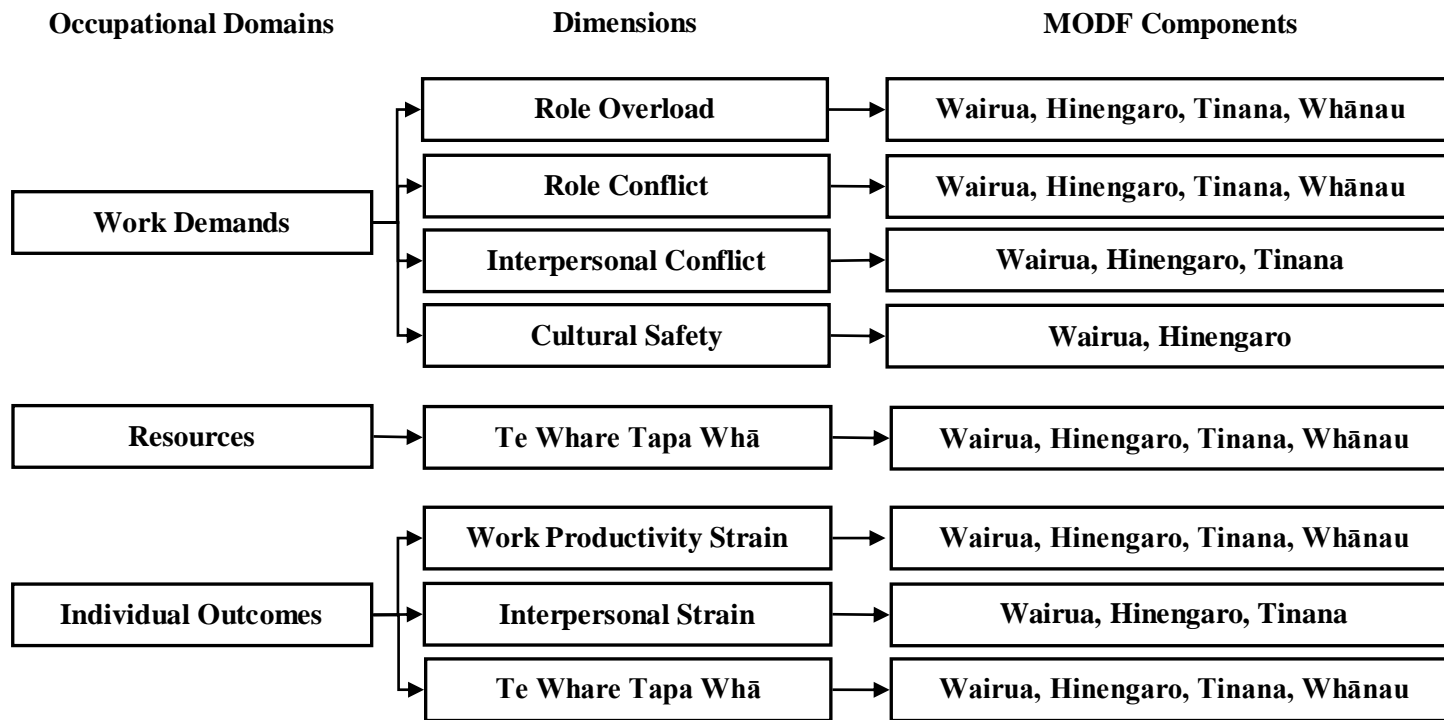


Figure 7.3 The first draft occupational domains, dimensions and components of Mahi Oranga.

Step 5

This final step involved developing quantitative and qualitative questions to populate Mahi Oranga. A comprehensive template for question development (see sample Table 7.2 above) was constructed to include all three domains and seven dimensions of Mahi Oranga. A number of the participants involved in the consultation phase had indicated a willingness to give feedback on the draft Mahi Oranga questionnaire, so the researcher developed two or three sample quantitative questions per MODF component. Some of the sample questions were informed by a selection of items contained in the OSI-R (for example those in the ‘role overload’ dimension) and adapted to include a Māori cultural perspective. Others (for example those in the ‘cultural safety’ dimension) were informed by Māori cultural understanding of how the dimension would impact the MODF components. Two to three spaces per MODF component were left blank to allow participants to suggest questions based on their workplace experience. The researcher also left the qualitative questions blank at this stage to allow participants to include suggestions.

The draft Mahi Oranga questionnaire, which at that stage still included definitions for each of the domains, dimensions, and MODF components, was then emailed to all 13 consultation phase participants (Chapter 6), inviting them to provide feedback and suggestions for questions if they wished. Participants were given two weeks to provide their feedback and suggestions, after which the draft Mahi Oranga questionnaire was further revised.

7.2 Revising the Draft

Of the 13 participants who received the draft Mahi Oranga questionnaire, two returned their feedback within the specified time, and a total of 15 suggestions were made for quantitative questions. No feedback was received about the overall structure or dimensions, so it was assumed that participants were satisfied with what had been done to date. However, since one of the secondary aims of this research was to ensure Mahi Oranga be designed to meet the needs of Māori health and disability sector employees, the lack of sufficient feedback during the draft development stage meant achieving this aim would require longer term work. Responses gained during the pilot phase (presented in the

following two chapters), along with subsequent validation studies will eventually answer this question.

All of the suggested questions were included in the revised questionnaire, although in some cases the suggested questions were reworded and/or moved to a more appropriate component of the MODF. After feedback was received, various question spaces remained blank for some of the dimensions and MODF components, so further research was done to determine whether to retain or remove those dimensions and components. The dimensions that came under scrutiny at this stage were the 'role conflict' dimension in the 'work demands' domain, and the 'interpersonal strain' dimension in the 'individual outcomes' domain. Guidance about whether to retain or remove these dimensions came from three sources, including Cooper and Marshall's (1976) model of stress at work, the health sector literature, and feedback from the consultation phase. With respect to the dimension of 'role conflict', although it appeared as a source of occupational stress in Cooper and Marshall's (1976) model of stress at work, the literature summarised by Jex (1998) indicated that it was not strongly related to job performance, so it was removed from the revised Mahi Oranga questionnaire. With respect to the 'interpersonal strain' dimension in the 'individual outcomes' domain, it was decided that this would be adequately covered by the MODF component of whānau/family within the 'Te Whare Tapa Whā' dimension and so it was removed from the revised Mahi Oranga questionnaire.

Although the dimensions of 'role overload' and 'interpersonal conflict' in the 'work demands' domain were not under scrutiny at this stage, further evidence was found to support their inclusion. Jamal (1984), found role overload to be negatively correlated with overall job performance, job motivation, and level of patient care (but not self-reported effort). In light of this the dimension of 'role overload' was retained in the revised Mahi Oranga questionnaire.

Interestingly, some of the suggested questions from participants indicated that aspects of organisational structure and climate from Cooper and Marshall's (1976) model of stress at work had been overlooked during the first draft, so needed to be considered during revision. Although evidence for the direct link between organisational constraints and job performance has been mixed (Jex, 1998), it was found to be positively correlated with counterproductive behaviours, including interpersonal aggression, hostility,

complaining, theft and sabotage (Chen & Spector, 1992; Storms & Spector, 1987). Since other counterproductive behaviours in the form of horizontal violence, bullying and interpersonal conflict have been widely reported in the health sector literature, it was decided that the dimension of ‘organisational constraints’, conceptualised as the extent to which organisational factors constrain a person’s ability to do their job, would be included in the revised Mahi Oranga questionnaire. Furthermore, it was decided that all four components of the MODF would be impacted by organisational constraints, and were therefore included as well.

Having finalised the dimensions, further consideration was given to the clarity of the three broad domain names, and whether they accurately reflected what would be measured. The ‘work demands’ domain was renamed ‘workplace demands’, but still conceptualised as sources of stress that drain resources. The ‘resources’ domain was renamed ‘coping strategies’ and slightly re-conceptualised as strategies that build resilience and strength. Analysis of the questions in the dimensions of the ‘individual outcomes’ domain revealed that they were predominantly related to strain, so that domain was renamed ‘strain outcomes’ and reconceptualised as individual and organisational strain.

Consideration was also given to the names and conceptualisations of the seven dimensions. All dimensions and their conceptualisations within the ‘workplace demands’ domain were considered clear, and accurately reflected what would be measured. Within the ‘coping strategies’ domain, the conceptualisation of the ‘Te Whare Tapa Whā’ dimension was simplified to mean the extent to which a person makes use of and builds strength from regular wairua/spiritual activities, regular hinengaro/psychological activities, regular tinana/physical activities, and regular whānau/family activities. Within the ‘strain outcomes’ domain, the ‘work productivity strain’ dimension was renamed ‘organisational strain’, and the conceptualisation slightly amended to mean the extent to which a person was having problems with work quality and/or quantity that impacted organisational outcomes. The ‘Te Whare Tapa Whā’ dimension within the ‘strain outcomes’ domain was re-examined, and since MODF components were embedded in the dimension (which ensured a Māori focus), that dimension was renamed ‘individual strain’ and reconceptualised as the extent of spiritual, psychological, physical and family problems being experienced by a person.

The finalised Mahi Oranga framework, including the domains, dimensions, MODF components and conceptualisations are shown in Figure 7.4 below.

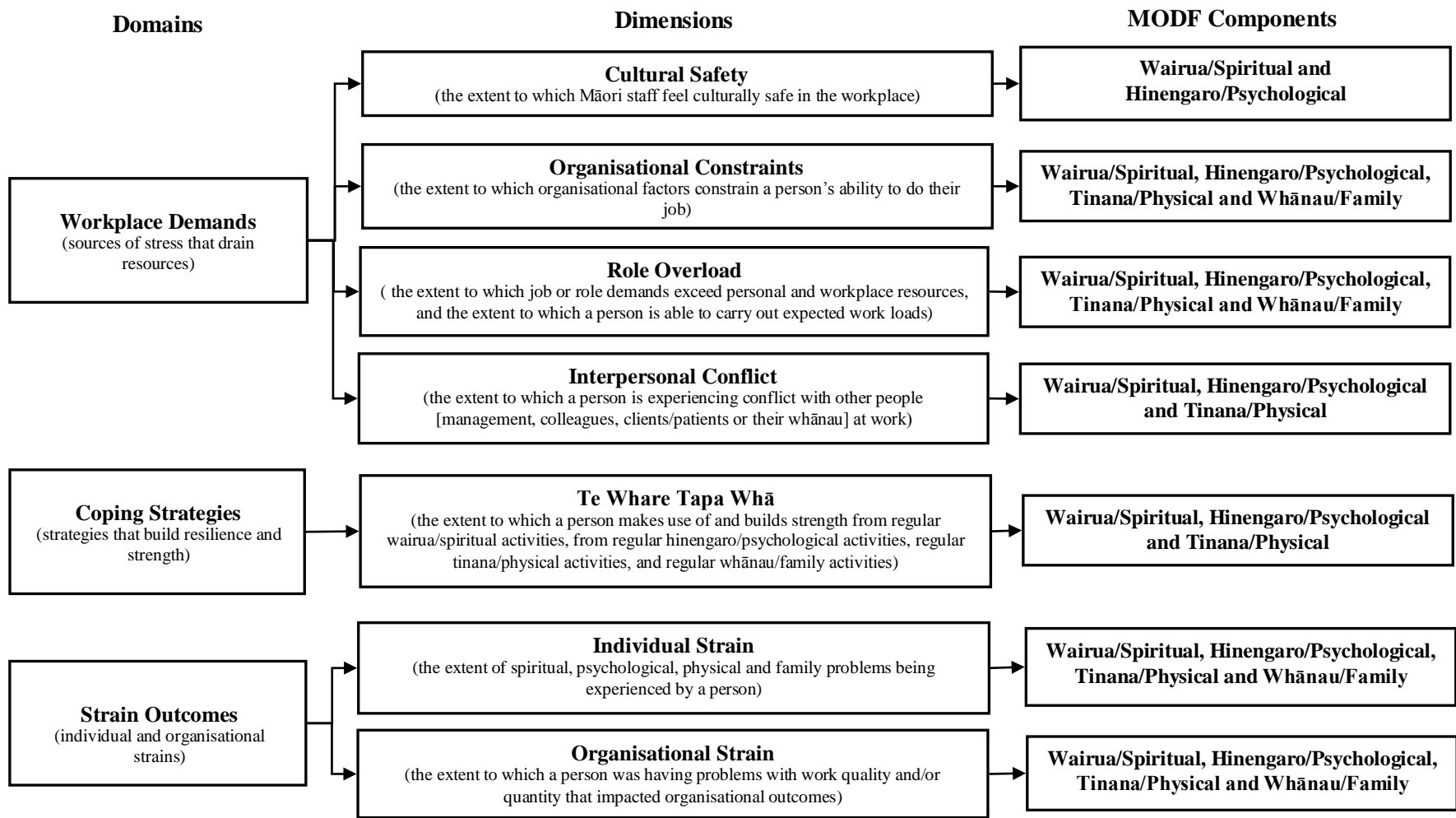


Figure 7.4 Finalised Mahi Oranga framework, including domains, dimensions, MODF components and conceptualisations.

Having finalised the Mahi Oranga framework, the next step was to generate further questions to complete the questionnaire. A range of literature, including existing measures and scales was reviewed to gain insight into the types of issues and questions asked, so that decisions could be made about their relevance to the health and disability sector, and their cultural appropriateness for Māori. Literature that discussed development of scales included Hart et al. (1993), who discussed the development of the Police Daily Hassles and Uplifts Scales, and Spector and Jex (1998) who discussed the development of the Interpersonal Conflict at Work Scale, the Organizational Constraints Scale, the Quantitative Workload Inventory, and the Physical Symptoms Inventory. The measures and scales reviewed included Pearlin and Schooler's (1978) Occupational Strain, Occupational Stress, and Occupational Coping scales, Cohen, Kamarck and Mermelstein's (1983) Perceived Stress Scale, Nowack's (1990) Stress Assessment Inventory and Cognitive Hardiness Scales, Roesch and Rowley's (2005) Stress Appraisal Measure, and Carver's (1997) Brief COPE. Finally Skinner and Brewer's (2002) Cognitive Appraisal Scales, and Sarason, Levine, Basham and Sarason's (1983) and Sarason, Sarason, Shearin and Pierce's (1987) Social Support Questionnaire. This literature was assessed to determine whether it was relevant to Mahi Oranga, and measure and scale concepts (rather than items) were used to guide question development for Mahi Oranga. When developing the questions, Māori cultural perspectives and kupu Māori (Māori words) were incorporated as necessary.

Having generated quantitative questions for the revised Mahi Oranga questionnaire based on the above Western measures related to occupational stress and coping, attention turned to qualitative questions. In line with the kaupapa of this research to allow the voice of Māori health and disability sector workers to be heard, it was important that the qualitative questions allowed respondents to identify not only the problems and/or strengths they were experiencing in the workplace, but also to identify potential initiatives to address any problems. It was therefore decided that within each dimension, two qualitative questions would be included: one to identify problem or strength areas, and one to identify suggestions to improve the situation. Qualitative questions were generated on this basis.

Having populated the revised Mahi Oranga questionnaire with questions, the final stage of revision required consideration of what demographic data was necessary during the pilot study while still protecting respondents anonymity. It was considered that collecting data regarding the job title of respondents would provide important information about which part of the health and disability sector, and the positions within the health and disability sector, that they came from without necessarily identifying the organisations they worked at. Also important was information about age, gender, work setting and work environment. The demographics section of Mahi Oranga therefore contained categorical questions relating to the respondents age (under 20 yrs, 20 – 29 yrs, 30 – 39 yrs, 40 – 49 yrs, 50 – 59 yrs, 60 – 69 yrs, 70+ yrs), gender (male or female), work setting (urban or rural), and work environment (kaupapa Māori or mainstream), and a space for respondents to record their job title.

In total, the revised Mahi Oranga questionnaire contained five demographic questions, 124 quantitative questions and 12 qualitative questions. The ‘workplace demands’ domain contained 63 quantitative questions (10 in the ‘cultural safety’ dimension, 20 in the ‘organisational constraints’ dimension, 20 in the ‘role overload’ dimension, and 13 in the ‘interpersonal conflict’ dimension) and eight qualitative questions (two in each of the dimensions). The ‘coping strategies’ domain contained 20 quantitative and two qualitative questions in the ‘Te Whare Tapa Whā’ dimension. The ‘strain outcomes’ domain contained 40 quantitative questions (20 in the ‘individual strain’ dimension, and 20 questions in the ‘organisational strain’ dimension), and four qualitative questions (two in each dimension).

Having finalised the pen and paper version of the questionnaire, the next step was to create an online version to ensure easier access for respondents.

7.3 Creating the Online Version of Mahi Oranga

Ethics Application

Prior to making Mahi Oranga available online, ethics approval was sought and gained from the New Zealand Health and Disability Multi-Region Ethics Committee (HDEC) within the Ministry of Health (see Appendix B for ethics approval reference

MEC/10/26/EXP). The main ethical considerations for this phase of the project were the privacy and anonymity of the respondents and organisations, and Māori cultural issues. The privacy and anonymity considerations were dealt with by not including questions that would identify individuals or organisations, and by using the online platform SurveyMonkey.com for data collection. The Māori cultural consideration was dealt with through the researcher (who is Māori) having the support and guidance of kaumātua and kuia throughout all phases of this thesis research.

The revised version of Mahi Oranga, with some additional sections was uploaded to SurveyMonkey.com. The first section included a pepeha (recital of the researcher's genealogical connections) introducing the researcher and brief information about the research to inform respondents of who was undertaking the research and why. It also included a statement regarding informed consent and confidentiality and anonymity of responses as required by HDEC. The second section included the questions relating to respondents demographics. The third section included the quantitative and qualitative questions relating to 'workplace demands', 'coping strategies', and 'strain outcomes'. The final section thanked the respondents for participating in the questionnaire, and provided details about how to register for a copy of the feedback report. A copy of the online version of Mahi Oranga is provided in Appendix C.

7.4 Chapter Conclusion

Development of Mahi Oranga was an iterative process, informed by a wide range of sources. Clearly those sources based on previously published research with Māori staff in the tertiary and health sectors as well as the consultation phase of this research project were critical to ensure the cultural and practical validity of Mahi Oranga, which was one of the aims of this research. However, acceptance of Mahi Oranga among mainstream Industrial/Organisational psychologists, human resource professionals, and end users such as managers working in the health and disability sector could not be ignored. Ensuring Mahi Oranga was also founded on findings within the mainstream literature on occupational stress, particularly that related to the health sector, was another critical step in its development. In addition, referring to existing Western measures of occupational stress

and coping during the development phase, along with the scale reliability work conducted during statistical analysis (presented in Chapter 8) may provide some reassurance to mainstream professionals and end users that Mahi Oranga is not only culturally valid, but also meets the evidence-based criteria that are expected of all researchers and professional practitioners. That said, this will not be the “final” version of Mahi Oranga, and future versions will continue to be founded on Māori cultural and Western research evidence.

The next chapter will provide details of the data collection and method, results and discussion relating to the statistical analysis of the quantitative questions. Details of the method, results and discussion relating to the thematic analysis of the qualitative questions will be provided in Chapter 9.

Chapter 8 – Mahi Oranga: Pilot Phase and Quantitative Results

Since research about the experience of occupational stress for Māori working in the health and disability sector in Aotearoa New Zealand is limited, the analysis and results presented in this chapter breaks new ground. This chapter will present the method, results and discussion of the quantitative analysis of responses received during the pilot phase of Mahi Oranga.

8.1 Method

8.1.1 Respondents

There were 180 responses to the survey. Of these, 50 completed only the demographics section of Mahi Oranga and were excluded from the analysis. A further 22 completed the demographic and part of the workplace demands sections but not the coping strategies and strain outcomes sections of Mahi Oranga, so were retained in the analysis for qualitative data reporting (presented in Chapter 9) but excluded from the statistical analysis presented here, leaving 108 respondents.

The majority of respondents were female, aged between 40 – 59 years. The age range of respondents was 20 – 29 years to 70+ years. There was a much higher proportion of respondents from an urban work setting than from a rural work setting, and a slightly higher proportion of respondents from a kaupapa Māori work environment than from a mainstream environment. There were approximately equal numbers of respondents from the kaupapa Māori and mainstream work environments in the urban setting, but the rural work setting was under-represented in the sample as shown in Table 8.1 below.

Table 8.1

Gender, age, work setting, work environment, and work setting/work environment of respondents.

n = 108	Number	Percentage
Gender		
Male	20	18%
Female	85	79%
Missing responses	3	3%
Age		
20 - 29 years	7	6%
30 – 39 years	16	15%
40 – 49 years	38	35%
50 – 59 years	32	30%
60 – 69 years	11	10%
70+ years	2	2%
Missing responses	2	2%
Work Setting		
Urban	86	80%
Rural	19	17%
Missing responses	3	3%
Work Environment		
Kaupapa Māori	60	56%
Mainstream	46	42%
Missing responses	2	2%
Work Setting/Work Environment		
Urban/Kaupapa Māori	45	42%
Urban/Mainstream	41	38%
Rural/Kaupapa Māori	14	13%
Rural/Mainstream	5	5%
Missing responses	3	2%

Respondents represented a range of disciplines within the health and disability sector, including nursing, mental health, alcohol and other drugs (AOD), community health, health promotion, general practitioner, dental therapy, social work, rongoā (traditional Māori healing) practitioners, health researchers, and a lecturer in nursing education. Respondents were located from as far south as Invercargill, to as far north as Kaikohe.

8.1.2 Procedure – Data Collection

Invitations to Māori working in the health and disability sector to participate were communicated by email. The email contained a link to Mahi Oranga, an invitation to participate, and an invitation to forward the email to other Māori health workers who might

be interested in participating. There were three waves of invitations sent. The first wave was sent to phase one participants, and the second wave was sent to the researcher's personal whānau and professional networks. The third and final wave was sent to Māori health provider organisations identified from a web search. Respondents were given four weeks to complete the Mahi Oranga questionnaire online at SurveyMonkey.com. The data was automatically stored by SurveyMonkey as it was being collected and protected via password entry. The data was then imported into SPSS Version 18. The final section of the SurveyMonkey version of Mahi Oranga thanked respondents for completing the questionnaire, and invited them to email the researcher to register their interest in receiving feedback on the results of the research. Four respondents requested a feedback report, which was emailed to them on 11 September 2010.

8.2 *Quantitative Data Analysis and Results*

8.2.1 *Missing Data and Reverse Coded Questions*

Missing Data

A missing data analysis was conducted in SPSS to ensure any missing question responses did not overly affect subsequent data analyses. According to Tabachnick and Fidell (2007) the acceptable level of missing data is 5%. Twenty five questions exceeded the 5% threshold, of which six were later removed as they did not load, or did cross-load in the factor analysis. The missing data percentages for the remaining 19 questions ranged from 5.6% to 9.3% (see Table 8.2), and since there were only 108 respondents, these questions were retained in order to maximise the sample size.

Table 8.2

Questions with missing data percentages that exceeded the 5% threshold.

Missing %	Question/Item	Kept	Removed
5.6	Non- Māori staff accept responsibility for and enact bi-cultural competence and practice at mahi	√	
5.6	Māori staff accept responsibility for and enact bi-cultural competence and practice at mahi	√	
5.6	I feel conflicted about what my employer expects me to do and what I think is right or appropriate	√	
5.6	Managers do not always have the knowledge, skills or abilities to be culturally appropriate	√	
5.6	Management cares more about money than clients/patients		√
5.6	My job description accurately reflects the mahi I do	√	
5.6	My workplace complies with Occupational Safety and Health (OSH) regulations	√	
5.6	I do not receive sufficient guidance from my manager(s)	√	
5.6	The environment I work in is physically safe	√	
5.6	I have stopped attending non-workplace activities I enjoy because I have too much mahi to do	√	
5.6	I experience rude treatment from management and/or colleagues at mahi	√	
5.6	I have lost my appetite	√	
5.6	I am having more arguments with whānau and/or friends	√	
5.6	I am having more arguments with my work colleagues	√	
6.5	I have sufficient professional or clinical supervision to ensure my professional safety in my mahi	√	
6.5	I am encouraged to take regular breaks during my work day	√	
6.5	I have stopped attending workplace activities I enjoy because I have too much mahi to do	√	
6.5	I feel physically unsafe when I am with management		√
6.5	I feel physically unsafe when I am with clients/patients and/or their whānau		√
8.3	The speed that I am expected to work at keeps me physically safe	√	
8.3	I have aches and/or pains I can't explain	√	
9.3	Management encourages staff to make use of Employee Assistance Programs (EAP) at work when we need it	√	
10.2	Sometimes, my Māori colleagues are not to be trusted		√
10.2	I am drinking alcohol, and/or smoking cigarettes, and/or using drugs more because I feel stressed		√
19.4	I take the medication I need to maintain my health		√

Reverse Coded Questions

Thirty one questions throughout Mahi Oranga were worded such that they needed to be reverse-scored. Twenty eight of those were within the workplace demands domain (12 in the organisational constraints dimension, 10 in the role overload dimension, and six

in the interpersonal conflict dimension), and the remaining three were in the individual strains dimension of the strain outcomes domain. These were re-coded before factor analysis was conducted.

8.2.2 *Assessing the Data for Factorability*

Sample size is an important consideration when assessing the data for factorability. According to MacCallum, Widaman, Zhang and Hong (1999), an adequate sample size is determined by the extent to which the factors are over-determined and the level of communalities of the measured variables. When at least three or four measured variables represent each factor (over-determination), and communalities are an average of .70 or higher, then sample sizes as small as 100 can provide accurate estimates of population parameters. For this data, all of the MODF components within each dimension included five items, with the exception of the tinana component of interpersonal conflict which included three items. Over-determination has therefore been achieved. Communalities at the question level ranged from .169 to .997 and average communalities at the dimension level ranged from .514 to .980 as detailed in Table 8.3 below. Although the communalities criteria has not been met for this data, because Mahi Oranga is in development, and the sample size of 108 respondents is regarded as small, all questions/items were retained, so care should be taken when interpreting these results.

Table 8.3

Communality Ranges.

	Communality Range	Average Communality
Workplace Demands:		
Cultural Safety	.503 - .706	.616
Organisational Constraints	.351 - .762	.559
Role Overload	.365 - .819	.630
Interpersonal Conflict	.169 - .825	.514
Coping Strategies:		
Te Whare Tapa Whā	.280 - .847	.590
Strain Outcomes:		
Individual Strain	.384 - .831	.648
Organisational Strain	.923 - .997	.980

Further assessment of the factorability of the data included examining the correlation matrix, the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy, and Bartlett's Test of Sphericity (Pallant, 2011). When assessing the correlation matrix, there must be at least some correlation coefficients of .30 and above. When assessing the KMO, the value threshold must be .60 or above. When assessing Bartlett's Test of Sphericity, the significance value should be .05 or smaller. All three of these thresholds were met as shown in Table 8.4 below. So, despite the relatively low communalities, assessments of the remaining three factorability criteria were acceptable and factor analysis proceeded.

Table 8.4

Factorability Assessments: Correlations, KMO and Bartlett's.

	At least some correlations over .30	KMO	Bartlett's
Workplace Demands:			
Cultural Safety	√	.859	.000
Organisational Constraints	√	.810	.000
Role Overload	√	.778	.000
Interpersonal Conflict	√	.802	.000
Coping Strategies:			
Te Whare Tapa Whā	√	.784	.000
Strain Outcomes:			
Individual Strain	√	.855	.000
Organisational Strain	√	.966	.000

8.2.3 *Exploratory Factor Analysis*

Given that development of an occupational stress measure based on an indigenous or Māori model of health and wellbeing had not previously been done, exploratory factor analysis was used because the underlying factor structure was not known. In order to proceed with the data reduction process, decisions needed to be made regarding the factor extraction method to use, the rotation approach, the factor loading value, and the number of factors to extract. These decisions depend on the characteristics of the data, and the goal of the research.

According to Costello and Osborne (2005) maximum likelihood (ML) or principle axis factoring (PAF) extraction methods will give the best results. However, according to

Fabrigar, Wegener, MacCallum and Strahan (1999), ML relies on the data meeting the normality assumption, whereas PAF is the better method to use if the data violates the normality assumption. Since the data in this sample violated the assumption of normality, the PAF extraction method was used.

According to Costello and Osborne (2005) and Fabrigar et al. (1999), the goal of rotation approaches is to simplify and clarify the data structure. Orthogonal approaches to data reduction assume the data are uncorrelated, whereas oblique approaches allow the data to be correlated. Since the questions in Mahi Oranga were founded on Te Whare Tapa Whā, in which the four quadrants are correlated, an oblique approach to factor rotation was used. The two choices of oblique rotation in SPSS are direct oblimin and promax. According to Costello and Osborne (2005) both oblique rotation techniques tend to produce similar results. Therefore, in order to determine which oblique rotation approach to use, analyses were conducted using PAF and direct oblimin, then PAF and promax. Using direct oblimin, the maximum iterations setting had to be increased to 50 before the data converged. Using promax, the data converged using the default SPSS setting of 25 maximum iterations. Promax produced a more simple and clear data structure than direct oblimin, so therefore promax was used.

According to Spicer (2005) the goal of inspecting factor loadings is to assist interpretation of the factors so they are reliable and noteworthy. The most common threshold for factor loadings is .30 because it accounts for approximately 10% of the variance in a factor. However, the value that best reflects the statistical significance ($p < .01$) and size of contribution is the appropriate value to use. For this data, it was decided that a factor loading of .40 was the appropriate value to use.

According to Fabrigar et al. (1999), when deciding how many factors to extract, there needs to be a balance between keeping relatively few factors (parsimony) and ensuring the correlations are adequately explained (plausibility). A range of options are available to assist the decision regarding the number of factors to extract. According to Pallant (2011), the most common are Kaiser's criterion (the eigenvalue rule in which factors with eigenvalues greater than 1.0 are retained), and the scree test. Costello and Osborne (2005) and Fabrigar et al. (1999) agree that the least accurate method of the two is Kaiser's criterion, therefore the scree test was used to determine the number of factors to

extract from this data. In addition, Pallant (2011) asserts that a factor with less than three items is weak and unstable, and should not be extracted. However, given that Mahi Oranga is under development, it was decided that factors with at least two items would be extracted.

Eigenvalues and percentage of variance explained were computed by SPSS during factor analysis and then Cronbach's alpha coefficients on the dimensions/scales and factors/sub-scales were computed to assess their internal consistency. The threshold for Cronbach's alpha is .7 (Spicer, 2005), and all seven scales and some sub-scales met this threshold. Although some sub-scales failed to meet Cronbach's alpha threshold, because Mahi Oranga is under development it was decided to retain these sub-scales and treat them with caution. The Cronbach's alpha if item deleted computation was also assessed. Although some items did reduce the scale reliability if they were deleted, the overall scale would still have met the Cronbach's alpha .7 threshold so all items were retained. The factors were then named.

Workplace Demands

The cultural safety scale comprised 10 items, with two factors called 'supportive organisational systems' (five items) and 'cultural safety behaviours' (five items). The organisational constraints scale comprised 13 items, with four factors called 'unsupportive organisational systems' (five items), 'role ambiguity' (three items), 'work environment' (three items), and 'perceived quality of management' (two items). The role overload scale comprised 19 items, with five factors called 'work overload' (four items), 'lack of workplace social support' (six items), 'lack of organisational systems' (three items), 'lack of physical safety' (four items), and 'work-life balance' (two items). The interpersonal conflict scale comprised eight items, with three factors called 'disrespect from peers or clients' (four items), 'disrespect from management' (two items), and 'lack of trust' (two items). When it came to the Te Whare Tapa Whā (coping strategies) scale, this comprised 15 items with five factors called 'hinengaro' (four items), 'whānau support – peers and family' (three items), 'wairua support' (three items), 'tinana support – management' (three items), and 'tinana – own behaviours' (two items). In terms of strain outcomes, the individual strain scale comprised 19 items with five factors called 'hinengaro strain' (seven items), 'wairua strain' (three items), 'whānau strain – isolation' (four items), 'whānau strain

– conflict’ (three items), and ‘tinana strain’ (two items). The organisational strain scale comprised 20 items with a single factor extracted.

The number of items, eigenvalues, percentage of variance explained and coefficient alpha scores for factor analysed scales and sub-scales are presented in Table 8.5.

Table 8.5

Mahi Oranga scale statistics.

Scale domain, dimension and subscale label	No. of Items	Eigenvalues	Percentage of variance explained	Coefficient α
Workplace Demands				
Cultural Safety	10			.91
Supportive Organisational Systems	5	5.49	54.9%	.88
Cultural Safety Behaviours	5	1.18	11.7%	.86
Organisational Constraints	13			.85
Unsupportive Organisational Behaviours	5	7.11	35.4%	.84
Role Ambiguity	3	2.08	10.4%	.74
Work Environment	3	1.51	7.6%	.64
Perceived Quality of Management	2	1.39	7.0%	.63
Role Overload	19			.84
Work Overload	4	5.49	27.5%	.86
Lack of Workplace Social Support	6	4.56	22.8%	.85
Lack of Organisational Systems	3	1.80	9.0%	.69
Lack of Physical Safety	4	1.19	5.9%	.69
Work-Life Balance	2	1.07	5.3%	.91
Interpersonal Conflict	8			.85
Disrespect from Peers or Clients	4	5.25	40.4%	.83
Disrespect from Management	2	1.65	12.7%	.64
Lack of Trust	2	1.11	8.5%	.66
Coping Strategies				
Te Whare Tapa Whā	15			.84
Hinengaro	4	6.92	34.6%	.72
Whānau Support – Peers and Family	3	2.19	11.0%	.77
Wairua Support	3	1.47	7.3%	.73
Tinana Support – Management	3	1.41	7.1%	.75
Tinana – Own Behaviours	2	1.15	5.7%	.70
Strain Outcomes				
Individual Strain	19			.92
Hinengaro Strain	7	8.34	41.7%	.97
Wairua Strain	3	2.11	10.5%	.88
Whānau Strain from Isolation	4	1.62	8.1%	.84
Whānau Strain from Conflict	3	1.27	6.4%	.66
Tinana Strain	2	1.02	5.1%	.77
Organisational Strain	20	19.23	96.1%	.93

8.2.4 Building the Scales

The seven Mahi Oranga scales were computed as the mean of the items. It was decided to focus on the scale level at this stage, and proceed to building sub-scales once satisfactory content validation has been achieved at the scale level.

Scales were checked for normality and outliers. For the seven Mahi Oranga scales, the Kolmogorov-Smirnov scores indicated that the interpersonal conflict, individual strain, and organisational strain scales were not normally distributed (Kolmogorov-Smirnov scores less than .05). With respect to outliers, Pallant (2011) advises to compare the mean and the 5% trimmed mean of the affected scales. If the two scores are similar, then the outliers can remain in the analysis. There were two outliers on the interpersonal conflict scale, with a mean of 3.23 and 5% trimmed mean of 3.24, so the two cases involved were retained in the analysis. There were four outliers and two extreme cases on the individual strain scale, with a mean of 1.90 and 5% trimmed mean of 1.86, so all cases involved were retained in the analysis. There were two outliers and one extreme case on the organisational strain scale, with a mean of 1.46 and 5% trimmed mean of 1.39. The extreme case was investigated further, and the respondent's quantitative response pattern along with the qualitative comments, indicated they were experiencing high levels of work demands and individual strain. Given the case concerned was genuine, and since the mean and 5% trimmed mean were still similar, all cases were retained in the analysis.

The standard descriptive tests of means, standard deviations, skewness and kurtosis were conducted, and are presented in Table 8.6 below.

Table 8.6

Number, range, mean, standard deviation, skewness and kurtosis statistics for Mahi Oranga scales.

	N	Range		Mean	Std Dev	Skewness		Kurtosis	
		Min	Max			Statistic	Std Error	Statistic	Std Error
Age	106	2	7	4.28	1.111	-.073	.235	-.126	.465
Cultural safety scale	91	1.40	5.00	3.5330	.99756	-.261	.253	-.852	.500
Organisational constraints scale	86	1.85	4.31	3.1190	.49679	-.232	.260	.043	.514
Role overload scale	81	1.68	4.16	2.9955	.56497	-.115	.267	-.352	.529
Interpersonal conflict scale	95	1.75	4.38	3.2289	.47709	-.501	.247	.264	.490
Te Whare Tapa Whā scale	85	2.00	5.00	3.6345	.71230	-.062	.261	-.512	.517
Individual strain scale	79	1.32	4.11	1.9041	.39474	2.873	.271	12.448	.535
Organisational strain scale	75	1.00	3.80	1.4560	.51419	2.156	.277	6.321	.548
Valid N (listwise)	29								

8.2.5 *Bivariate Correlations*

Correlation matrices were produced to determine the Pearson product-moment correlation coefficients between age with each of the seven scales, and amongst each of the seven scales. Cohen's (1988) thresholds of $r = .10$ to $.29$ (small), $r = .30$ to $.49$ (medium) and $r = .50$ to 1.0 (large) were used to determine the strength of correlations.

There were no significant correlations between age and any of the seven Mahi Oranga scales. However, there were 15 significant correlations between the Mahi Oranga Scales at the .01 level and one significant correlation at the .05 level. Between the four workplace demands scales, there were moderate to strong positive correlations among the scales indicating that as one workplace demand increased, so did the others. Cultural safety was positively correlated with organisational constraints, role overload, and interpersonal conflict, organisational constraints was positively correlated with role overload and interpersonal conflict, and role overload was positively correlated with interpersonal conflict.

Between the Te Whare Tapa Whā (coping strategies) scale and the four workplace demands scales, there were moderate positive correlations, indicating that as workplace demands increase, respondents develop and use more coping strategies to deal with those demands. Te Whare Tapa Whā was positively correlated with cultural safety, organisational constraints, role overload and interpersonal conflict.

There were small to moderate negative correlations between the Te Whare Tapa Whā (coping strategies) scale and both strain outcomes scales (individual strain and organisational strain), indicating that as coping strategies increased, strain outcomes decreased.

Between the organisational strain scale and three of the workplace demands scales, there were small to moderate negative correlations, indicating that when those workplace demands increased, organisational strain increased as well. Organisational strain was negatively correlated with cultural safety, role overload, and interpersonal conflict. Finally there was a strong positive correlation between the two strain outcomes scales, indicating that as individual strain increases, so too does organisational strain and vice versa.

Correlations are presented in Table 8.7 below.

Table 8.7

Mahi Oranga scale correlation matrix.

Variable/Scale	1	2	3	4	5	6	7	8
1: Age	1							
2: Workplace Demands – Cultural Safety	.189	1						
3: Workplace Demands – Organisational Constraints	.016	.578**	1					
4: Workplace Demands – Role Overload	.117	.610**	.455**	1				
5: Workplace Demands – Interpersonal Conflict	.011	.556**	.550**	.619**	1			
6: Coping Strategies – Te Whare Tapa Whā	.180	.509**	.464**	.338**	.410**	1		
7: Strain Outcomes – Individual Strain	-.121	-.204	-.001	.064	-.060	-.273*	1	
8: Strain Outcomes – Organisational Strain	-.202	-.516**	-.124	-.348**	-.424**	-.459**	.748**	1
<i>Mean</i>	4.28	3.53	3.12	3.00	3.23	3.64	1.90	1.46
<i>Std. Deviation</i>	1.11	1.00	.50	.57	.48	.71	.40	.51
<i>N</i>	106	91	86	81	95	85	79	75

** Correlation is significant at the .01 level (2-tailed)

* Correlation is significant at the .05 level (2 tailed)

Independent Samples T-Tests

Two-tailed independent samples t-tests (2-tailed) were conducted to compare the categories of gender (male/female), work setting (urban/rural) and work environment (kaupapa Māori/mainstream) for each of the seven scales. Six significant differences were found. One was between work setting (urban/rural) and organisational strain (significant at the .01 level). The remaining five were between the work environment (kaupapa Māori/mainstream), and cultural safety, organisational constraints, role overload, interpersonal conflict and coping strategies (Te Whare Tapa Whā). Three of these were significant at the .05 level and two were significant at the .001 level. The eta squared (η^2) values were manually calculated to establish the effect size (Pallant, 2011), and Cohen's (1988) criteria were used to interpret them (.01 = small effect, .06 = moderate effect, and .14 = large effect).

Respondents working in urban settings ($M = 1.49$, $SD = .54$) reported higher organisational strain than their rural counterparts ($M = 1.22$, $SD = .21$). There was more cultural safety for respondents working in a kaupapa Māori environment ($M = 3.81$, $SD = .98$) than for their mainstream counterparts ($M = 3.11$, $SD = .87$). Respondents working in a kaupapa Māori environment ($M = 3.21$, $SD = .50$) reported having more organisational constraints than their mainstream counterparts ($M = 3.00$, $SD = .47$). There was more role overload for respondents working in a kaupapa Māori environment ($M = 3.11$, $SD = .58$) than for their mainstream counterparts ($M = 2.84$, $SD = .51$). Respondents working in a kaupapa Māori environment ($M = 3.39$, $SD = .42$) reported having more interpersonal conflict than their mainstream counterparts ($M = 3.03$, $SD = .47$). Respondents working in a mainstream environment ($M = 3.45$, $SD = .63$) reported having fewer coping strategies (Te Whare Tapa Whā) than their kaupapa Māori counterparts ($M = 3.76$, $SD = .76$). Results of the independent samples t-tests are presented in Table 8.8 below.

Table 8.8

Independent samples tests.

	T	Df	95% Confidence Level		eta ² effect size
			Lower	Upper	
Work Setting (urban/rural)					
Organisational Strain	2.872**	50	.07927	.44855	.104
Work Environment (kaupapa Māori/mainstream)					
Cultural Safety	3.508***	89	.30666	1.10769	.121
Organisational Constraints	2.011*	84	.00237	.42392	.046
Role Overload	2.180*	79	.02350	.51654	.057
Interpersonal Conflict	3.952***	93	.18029	.54444	.144
Te Whare Tapa Whā	1.959*	81	-.00489	.62044	.033

*** Correlation is significant at the .001 level (2-tailed)

** Correlation is significant at the .01 level (2-tailed)

* Correlation is significant at the .05 level (2 tailed)

8.3 Discussion of Quantitative Results

Factor Analysis

The results of the factor analysis revealed no underlying structure in the ‘organisational strain’ scale, therefore more development work will need to be conducted to make this a more meaningful scale (and sub-scales). The expanded Transactional Model of Occupational Wellbeing from Chapter 3 will need to be re-visited so that questions related to job performance can be refined. In addition, questions targeted at other organisational outcomes such as organisational commitment, organisational citizenship behaviours, turnover and absenteeism, can be developed to better represent these issues. In addition, in hindsight the outcomes measured by Mahi Oranga focussed strongly on strain outcomes, but did not include a specific focus on wellbeing outcomes. Since an absence of strain does not necessarily mean the presence of wellbeing, further research will include development of a ‘wellbeing outcomes’ dimension and scale. Future factor analysis development could also include following up with confirmatory factor analysis. Further Mahi Oranga development will also include attempting to stabilise some of the shorter sub-scales with low internal consistency. It is also worth noting that targeting Māori cultural coping strategies in that domain, and Māori cultural strain outcomes in the individual strain dimension resulted in culturally responsive factors. Future research with respect to Māori cultural coping strategies could develop that concept as a theoretical model, as distinct from Western theories and models of coping strategies.

Scale Correlation Results

The correlation results between the seven Mahi Oranga results were unsurprising in that all as one workplace demand increased so too did the others, when some workplace demands increased so too did strain outcomes, and when individual strain increased so too did organisational strain. These findings highlight the need for organisations to do what they can to reduce those organisational demands that are within their control to reduce strain outcomes for their staff and for organisational productivity. That is not to say that all workplace demands can, or should be eliminated altogether, but those that are causing

problems for staff should be addressed as a proactive “fence-at-the-top-of-the-cliff” approach to stress management.

In addition, as coping strategies (Te Whare Tapa Whā) increased, strain outcomes decreased. These results confirm that coping strategies moderate the level of strain outcomes, and highlights the need for individuals to develop and use a range of coping strategies to help decrease strain outcomes, but more importantly for organisations to do their part in providing awareness and access to culturally responsive services to help staff develop and maintain effective coping strategies.

Interestingly, as workplace demands increased, respondents developed and used more coping strategies to deal with those demands. While this is reassuring, it provides more support for the case of organisations doing their part in reducing workplace demands where possible, as well as individuals and organisations taking responsibility for developing and maintaining a range of culturally responsive coping strategies.

T-Test Results

Given that respondents working in urban settings reported higher organisational strain than their rural counterparts, more research needs to be done to establish why urban settings are so prone to problems. The implication is that productivity and job performance is probably suffering, which means there may be negative impacts on tangata whaiora seeking health services in urban areas.

The finding that there was more cultural safety for respondents working in a kaupapa Māori environment than for their mainstream counterparts was not surprising, but the ‘flip-side’ means that Māori health professionals working in a mainstream environment are less culturally safe. These findings support previous research (Ratima et al., 2007; Simon, 2004) revealing the presence of institutional racism in the health and disability sector in Aotearoa New Zealand, but seems to suggest that this is only an issue in mainstream health settings. The implication is that our mainstream health providers need more awareness, knowledge and skills to address this issue to provide a safer working environment for Māori health workers.

Respondents working in a kaupapa Māori environment reported having more organisational constraints than their mainstream counterparts, which is likely to be related

to levels of government funding. This can mean that kaupapa Māori health providers are having to do more with less. The Honourable Tariana Turia, as Associate Minister of Health, has acknowledged the government's funding specifically to the Māori health and disability sector workforce (Māori health workforce funding, 2008, May 23), but also champions the need for further funding to increase capacity and capability within that workforce.

There was more role overload for respondents working in a kaupapa Māori environment than for their mainstream counterparts, which is likely to be related to the nature of the way that Māori health workers work to provide effective outcomes for Māori communities and tangata whaiora. Sisley and Waiti (1997) found that Māori teachers felt responsible for providing better academic outcomes for tauira Māori (Māori students) so that they could compete equally in the job market with their non-Māori counterparts. Ratima et al. (2007) found that one of the biggest retention factors for Māori in the health and disability sector was the contribution they could make to Māori health, working with Māori people and making a difference to their iwi/hapu and being a role model for Māori. This speaks to the (perhaps) different motivations of Māori health workers, and especially those in a kaupapa Māori environment for whom there may be a strong organisational culture of achieving better health outcomes for tangata whaiora and the wider Māori community.

Respondents working in a kaupapa Māori environment reported having more interpersonal conflict than their mainstream counterparts, which is concerning, especially in light of the fact that they also have higher levels of cultural safety. The problem here may lie, to some extent, in the psychological contract and expectations that a kaupapa Māori environment is a preferred place of work for Māori health workers than a mainstream environment. Māori working in the health and disability sector may expect the levels of manaakitanga (caring and showing respect for others) and whakawhanaungatanga (relationship building) to support and sustain them, but in fact issues such as iwi/hapu conflict and tribalism (as reported from the consultation phase of this research in Chapter 6) may be the cause of higher levels of interpersonal conflict. In addition, if management do not have the skills to manage that conflict effectively, it can become a source of stress, which can have negative impacts on health outcomes for Māori. The implication for

managers in kaupapa Māori environments is that they need to take leadership to address this issue, and to gain the skills and ability to deal effectively with such conflict. In light of this finding, further development could be done with Mahi Oranga. It might be useful to add a whānau component (and related question items) to the cultural safety scale so that interpersonal conflict with management and colleagues due to a lack of cultural safety can be identified separately from other causes of interpersonal conflict. The interpersonal conflict scale can then focus on relationship disruptions that occur for other reasons, such as bullying or ineffective communication.

The finding that respondents working in a mainstream environment reported having fewer coping strategies (Te Whare Tapa Whā) than their kaupapa Māori counterparts may reflect the lower access to cultural supervision and Māori peer support in mainstream environments, highlighting the importance of cultural safety in the workplace. Management in mainstream health environments needs to be made aware that providing a range of workplace supports for their staff, especially culturally responsive supports, will increase Māori health workers ability to cope with the workplace demands they face.

8.4 Chapter Conclusion

The biggest limitation of this study was the low sample size of 108 respondents, and a lower response rate from Māori working in a rural health setting, and therefore some of these results should be treated with caution. In addition, these results may not be generalisable outside of the public sector, where government policy requires consideration of the principles of the Treaty of Waitangi. In terms of the aim of this research to establish reliability, validity and norm reference data, all of the scales have internally consistent reliability, but more work needs to be done to stabilise the internal consistency of the seven sub-scales that fell below the .7 threshold. Further development work also needs to examine test-retest reliability, and scorer reliability will also need to be assessed in due course. To some extent, cultural (face) validity has been achieved, although content validity, especially with the organisational strain scale, needs more work. Construct validity (convergent and discriminant) was not assessed during the course of this thesis project, so will require further research and development. Other forms of criterion-related

validity will need to be established when Mahi Oranga begins to be used in practice. Given the small sample size, it was not considered appropriate to attempt to establish norm reference data for the various roles of Māori working in the health and disability workforce (based on job title descriptions), so that will require further research and development.

The Aotearoa New Zealand health and disability sector seems constantly to be facing funding cuts, and funding for initiatives to improve Māori health outcomes is no exception. While most people agree about the importance of finding more cost efficient ways to provide health services, especially when governments have a limited budget with which to provide those services, these efficiencies should not come at the expense of effective outcomes. The Ministry of Health, in its *Health workforce development: An overview* document (Ministry of Health, 2006a), have set an organisational development goal of “health services developing the organisational culture and systems which will attract and grow their workforce and meet service needs” (p. viii and ix). Furthermore, two of the stated actions of that goal are to “improve leadership capacity and practice (particularly by under-represented workforce groups” and to “improve healthy workplace environments and practices (e.g. magnet hospitals)” (p. viii and ix). This information may provide industrial and organisational psychology and human resource practitioners with some organisational impetus to create healthy workplaces for their under-represented Māori health workers.

The next chapter will provide details of the method, results and discussion relating to the thematic analysis of the qualitative questions of Mahi Oranga.

Chapter 9 – Mahi Oranga: Pilot Phase Qualitative Results

This chapter will present the method, results and discussion of the qualitative analysis of responses received during the pilot phase of Mahi Oranga. Results are organised into three sections, covering workplace demands, coping strategies, and strain outcomes. In each section, the results will be organised around the headings of each of the four quadrants of Te Whare Tapa Whā (wairua, hinengaro, tinana, and whānau), followed by a heading on initiatives to address workplace demands, coping strategies, and strain outcomes.

9.1 Method

9.1.1 Respondents

Although 108 respondents provided complete quantitative data (Chapter 8), qualitative data was provided by 130 respondents (see Table 9.1 below). The demographic make-up of the 130 respondents was similar in all other respects.

Table 9.1

Gender, age, work setting, work environment and work setting/work environment of respondents.

n = 130	Number	Percentage
Gender		
Male	24	19%
Female	103	79%
Missing responses	3	2%
Age		
20 - 29 years	9	7%
30 – 39 years	19	15%
40 – 49 years	46	36%
50 – 59 years	39	30%
60 – 69 years	12	9%
70+ years	3	2%
Missing responses	2	1%
Work Setting		
Urban	100	77%
Rural	25	19%
Missing responses	5	4%
Work Environment		
Kaupapa Māori	71	55%
Mainstream	55	42%
Missing responses	4	3%
Work Setting/Work Environment		
Urban/Kaupapa Māori	52	40%
Urban/Mainstream	49	38%
Rural/Kaupapa Māori	18	14%
Rural/Mainstream	7	5%
Missing responses	4	3%

9.1.2 Procedure – Data Analysis

The qualitative data analysis was conducted using the six phases of Braun and Clarke’s (2006) method of thematic analysis in the same manner as the data from the consultation phase as detailed in Chapter 6.

9.2 Results: Workplace Demands

Some respondents noted that they experienced no workplace issues related to cultural safety, organisational constraints, role overload, or interpersonal conflict. Clearly, some health organisations are providing healthy workplaces, and need to be congratulated

for having the knowledge and willingness to do so. However, for most health organisations, there is still room for improvement.

9.2.1 Wairua (Spiritual)

The workplace demand that had the biggest impact on wairua was cultural safety. It was pleasing to note that some respondents were positive about the level of cultural safety in their workplace [R111].

[R111] *“Cultural safety in my mahi is not an issue. My managers are very supportive of what I need to do for my mahi.”*

However, most respondents reported problematic issues related to cultural safety at work. One recurring theme was the experience of institutional racism and tokenism. Respondents reported that managers and colleagues often lacked understanding of and respect for Te Ao Māori (the Māori world), including the different world view, values, tikanga (customs and protocols) and practices of Māori [R16] [R110], Treaty of Waitangi principles [R98], and exploitation of Māori staff for organisational or departmental ‘tick the box’ objectives [R79] [R98]. In addition, some organisations committed to contracts that did not align with tikanga Māori [R41], and did not prioritise Māori approaches [R115], which also reflected institutional racism.

[R16] *“Migrants being offered management roles and bringing their cultural values with them and not being willing to understand tikanga Māori.”*

[R110] *“Lack of knowledge, understanding and due respect for Māori protocols and practices.”*

[R98] *“Being the token gesture. For tauiwī, they don’t recognise the importance and the significance of the Treaty of Waitangi and the bi-cultural partnership and what bi-cultural partnership is.”*

[R79] *“Lack of consideration for Māori needs that do not fit their criteria, and tokenism for the sake of funding.”*

[R98] *“Being seen as the token Māori just so that departments can pass accreditation after they have failed audit processes.”*

[R41] *“Contracts that are not aligned to tikanga Māori – tikanga Pākehā – reporting statistical information sometimes does not take into account whānau.”*

[R115] *“Lack of cultural response. Mainstream tend to put cultural approaches second or even third on the ‘to do’ list.”*

Another theme related to cultural safety was a lack of cultural support in the workplace. Respondents described cultural support as including cultural supervision [R09], having access to a cultural advisor (which could include kaumātua or kuia for advice) [R01] [R18], and other Māori colleagues in the workplace [R23].

[R09] *“Little or no cultural supervision.”*

[R01] *“No cultural advisor on-site.”*

[R18] *“Not having a full-time kaumātua or chaplain.”*

[R23] *“Not allowing me to spend time with other Māori staff in the organisation.”*

The final theme related to cultural safety was the use of inexperienced and inappropriate staff leading cultural training [R98].

[R98] *“I have recently come across non-Māori [staff] teaching things Māori based on going to a study day on aspects pertaining to Māori, and then they think that they are all of a sudden an expert on things Māori.”*

9.2.2 Hinengaro (Thoughts and Feelings)

The workplace demand that had the biggest impact on hinengaro was organisational constraints, although role overload was also an important but less reported issue. Most respondents reported problematic issues related to organisational constraints, and their impact on hinengaro at work. One recurring theme was the need for organisations to have strong leadership. Some of the ways this theme manifested in the workplace included a lack of consistency [R57], lack of transparency [R17] [R17], favouritism of

some staff [R69] [R02], and a work environment that sets up competition between Māori staff [R103].

[R57] *“Lack of consistency in process and procedures.”*

[R17] *“Honesty and rules maintained across the board. No more special deals behind closed doors.”*

[R17] *“Special privileges given behind closed doors to staff, such as a whole week of leave for study.”*

[R69] *“Favouritism of incompetent staff.”*

[R02] *“Nepotism.”*

[R103] *“A work environment that creates competition amongst Māori staff.”*

Another theme related to organisational constraints that impacted hinengaro was the lack of appropriately trained or skilled (competent) staff. In contrast to a lack of knowledge or skills related to Te Ao Māori from the previous section, this theme was more concerned with the lack of professional/technical knowledge and skill for staff to do the job, and included staff at all levels of an organisation. Examples included managers who lacked management skills [R75] [R03], and staff who lacked technical knowledge, skill, or experience [R53] [R69] [R37]. Also, some organisations focused on cultural training, but neglected clinical training for staff [R97].

[R75] *“Manager who doesn’t know how to manage.”*

[R03] *“Our CEO, in some instances, lets their personal relationships with staff impact their professional decisions.”*

[R53] *“Management not up-to-date with current mental health issues and networks.”*

[R69] *“Under-educated senior staff.”*

[R37] *“Limited skill/expertise, or experience of staff.”*

[R97] *“Our Māori health service has become so focussed on ‘cultural’ only training instead of complementing this with clinical training opportunities (dual competencies).”*

Another theme related to organisational constraints that impact hinengaro is the lack of recognition of and value given to mātauranga Māori (Māori knowledge) when it comes to provision of health services. This includes not recognising training/qualifications that use Māori therapeutic models [R07] (although this issue could be limited to the AOD discipline), and Māori staff being challenged by non-Māori staff about how to appropriately care for tangata whaiora [R113].

[R07] *“No acknowledgement of training within Māori therapeutic models, such as rongoā Māori. This training has been done in my own time, and at my own expense, but because it is not AOD training, it is not recognised.”*

[R113] *“Relationships and working in parallel with clinical expertise and being recognised for the clinical cultural level of expertise aligned to Western approaches.”*

Another theme related to organisational constraints that impact hinengaro was staff having insufficient resources to do their mahi. Examples included a lack of adequate work and storage space, or work space being old and run down [R31] [R65] [R28] [R90], and insufficient budgets to provide necessary resources [R70]. Included in the resources theme was the physical location of Māori health services. In some cases this meant isolated offices or services, and in other cases this meant challenges in combining accessibility for tangata whaiora with privacy [R83] [R100].

[R31] *“Organisational lack of space for staff. We have increased staff, but not the space. Sometimes cramped conditions.”*

[R65] *“Storage of service resources inadequate.”*

[R28] *“My office is old and unpainted but to update furniture is a huge hassle.”*

[R90] *“Physical premises are old and need updating.”*

[R70] *“Not enough money for materials needed.”*

[R83] *“Isolated from team members. Isolated from working environment.”*

[R100] *“Being stuck in a little corner behind screens out of sight, but too public for me to feel comfortable on the phone.”*

The final theme related to organisational constraints that impact hinengaro was organisational bureaucracy. Examples included over-measurement of work outcomes [R100], constantly changing processes [R72], constant meeting attendance (‘all hui and no do-i’) [R94], and the number of management layers [R108].

[R100] *“The corporate need to measure everything I do is difficult due to the nature of Māori and the way in which we support each other.”*

[R72] *“Constantly changing processes e.g. to access resources such as cars, training, reimbursement etc.”*

[R94] *“Attending meetings that have no real impact on my mahi because I am the [Māori Resource Position] and yet not being able to get on and do my mahi.”*

[R108] *“So many management layers, takes a long time to get things done.”*

A smaller number of respondents reported problematic issues related to role overload and their impact on hinengaro at work. One theme related to the under-representation of Māori in some specialties within the health and disability sector [R45], another related to mainstream organisations and staff expecting Māori staff to know how to solve all Māori health issues [R102], and the final theme related to the exploitation of Māori staff and lack of reciprocity by non-Māori organisations [R102].

[R45] *“The capacity of staff within our unit - we need more Māori researchers!”*

[R102] *“Too much mahi and the expectation that [we] as a Māori organisation have the answers to everything that affect Māori communities.”*

[R102] *“Too many mainstream organisations ‘use’ us as the touch stone of Māori consultation for their own tick boxes. We are ‘done to’ and there is very little reciprocity given to continuing a long term relationship that benefits Māori communities.”*

9.2.3 *Tinana (Physical)*

For workplace demands that impacted tinana, those relating to role overload were most commonly reported. It was encouraging to hear from some respondents that their workload was manageable [R69].

[R69] *“Although intense, workload is always manageable.”*

However, for many other staff, their workload was higher than they could manage, with some responses referring to the fact that staff used their own time to catch up on their workloads [R60], and that staff were experiencing stress as a result of increased workloads [R17].

[R60] *“Paperwork. Unscheduled events interrupting planned mahi and catching up with that mahi in my own time.”*

[R17] *“The client workload is expected to increase to meet the contract requirements, however there are no changes to the workplace environment – just more work to do. It creeps into my sleep and I wake with a knot in my stomach some days.”*

9.2.4 *Whānau (Extended Family, including Work Colleagues)*

For workplace demands that impacted whānau, those relating to role overload and interpersonal conflict were most commonly reported. In the case of role overload workplace demands that impacted whānau, it was encouraging to note that supportive managers made a positive difference to staff [R88].

[R88] *“I don’t feel overloaded as I manage my own workload with the support of my manager.”*

However, for many other staff, role overload was a common feature of work. It impacted on whānau at work when resentment built because of perceptions that colleagues were not carrying their fair share of the workload [R71]. In addition, it impacted on whānau at home when trying to balance work and study commitments [R23], when trying to balance work and commitments to Māori communities [R22], and managing workloads dependent on contacting tangata whaiora [R26].

- [R71] *“Other colleagues pulling their weight and doing the equivalent mahi.”*
- [R23] *“Working full time and taking on study in Master of Arts takes time away from my family, but we are encouraged to up-skill all the time.”*
- [R22] *“The 24/7 requests from marae areas and the normal whānau, marae and hapu commitments.”*
- [R26] *“Trying to fit in case management demand i.e. emailing and phone contact with clients at hours that suit them e.g. 5.30pm. This can often cut into my personal time.”*

In the case of interpersonal conflict, it was encouraging to hear from some respondents that they either did not experience conflict at work, or that processes were in place to resolve conflicts that did arise [R35].

- [R35] *“I don’t experience conflict, and if I ever do, the value of whakawhanaungatanga is applied.”*

However, for many other staff, interpersonal conflict at work was experienced, such as bullying (including gossip and undermining) [R17] [R106] [R07], a lack of kotahitanga (solidarity) among Māori colleagues with divisions sometimes reported along iwi or hapū lines [R28] [R113] [R53], ineffective or disrespectful communication from management or others [R48] [R24] [R03], disagreements about best ways to treat tangata whaiora and differences of opinion about things Māori such as tikanga [R26] [R78].

- [R17] *“Issues of bullying have been raised and covered over. Bullying is by a manager.”*
- [R106] *“Being the subject of gossip and not being communicated with directly.”*
- [R07] *“When someone (usually case managers) tries to undermine mahi that they don’t fully understand.”*
- [R28] *“Egos, personality, hidden agendas...Māori are worst towards their own and will eat you alive. Often this is at the expense of what is good for the patients and kaupapa.”*
- [R113] *“Māori back-biting.”*

- [R53] *“Internal iwi hapū conflicts which then become personal.”*
- [R48] *“The use of emails to give instructions.”*
- [R24] *“The tone used when communicating – there is a sense of abruptness or barking”*
- [R03] *“My manager who is a poor communicator.”*
- [R26] *“Disagreements about case management and intervention.”*
- [R78] *“Having a difference of opinion with other staff where tikanga is concerned.”*

9.2.5 Organisational Initiatives to Reduce Workplace Demands

In addition to identifying workplace demands, respondents also identified ways in which organisations could reduce those demands, some of which were already implemented successfully in respondents’ organisations. Ways that organisations can provide healthier workplaces for Māori staff are discussed below, organised around the headings of cultural safety, organisational constraints, role overload, and interpersonal conflict.

Cultural Safety

Ways of reducing workplace demands related to cultural safety for Māori staff included building a culture of respect and valuing Te Ao Māori through building cultural competence for all staff in the workplace. Respondents noted that knowledge and support of Māori issues and approaches needed to start at senior management level [R115], and employing a cultural advisor would have helped educate and support management as well as take pressure off Māori staff whose expertise was providing health care rather than cultural knowledge [R56]. Staff education and training was a major sub-theme, with a range of suggestions including Treaty of Waitangi training [R16], bicultural codes of practice training [R54], and education about cultural safety [R98].

- [R115] *“Senior level management need to understand kaupapa driven approaches and show their support at strategic and operational levels.”*

- [R56] *“Make an effort to understand Māori/indigenous protocols and procedures. Employ someone specifically to deal with these issues instead of relying on staff. Involve a cultural person to speak for staff having problems as it is too hard to try and explain cultural things to supervisors.”*
- [R16] *“Managers to attend regular Treaty workshops to become more responsive to Māori needs.”*
- [R54] *“Each individual being trained in bicultural codes of practice and what it actually means for Māori to be dislocated from their practice norms.”*
- [R98] *“Know what cultural safety is and how it is defined.”*

Respondents indicated that once cultural competence has been built through education and training, the next important step would be to provide culturally safe work environments. The key theme here was respect for things Māori, from small things like correct pronunciation of names and words, use of Māori greetings with tangata whaiora, and more use of te reo Māori in general [R50] [R80] [R13], to major issues such as accepting and valuing Māori cultural expertise on appropriate care for tangata whaiora [R26], and acknowledging the importance of providing culturally appropriate and safe services to tangata whaiora [R110].

- [R50] *“Mis-pronunciation of names and te reo Māori.”*
- [R80] *“Utilising Māori greetings when approaching Māori cliental for example.”*
- [R13] *“Korero te reo.”*
- [R26] *“Non-Māori clinicians not understanding cultural implications of client/whānau presentation (especially when I’m formulating ideas with clinicians), which often invalidates my experience of being Māori and means I am unheard in the workplace.”*
- [R110] *“Accept and acknowledge that Māori values and practices have value and enhance our practice.”*

Provision of cultural support in the workplace was another theme. Suggestions included employing cultural advisors to educate and support management [R88], and providing cultural supervision and advisors for staff [R80].

[R88] *“They have recently employed a cultural advisor and that has made a big difference. His presence has also made European staff realise that things need to change.”*

[R80] *“Having a Māori support person for staff to have supervision with and get that cultural support or advice when dealing with Māori cliental.”*

Suggestions were also made about how to provide more culturally appropriate services to tangata whaiora, including more community based services [R61].

[R61] *“Move service from a clinic to a marae setting.”*

Organisational Constraints

Ways to reduce organisational constraints included integrating Māori philosophies throughout the infrastructure and operation of the organisation. From an infrastructure perspective this included increasing understanding of tikanga Māori at all levels including governance (Board of Trustees) and managers [R41], as well as the need for more tikanga-driven policies, procedures and processes [R35], better documentation outlining cultural practice [R41], and appointment of more Māori to staff and management positions [R38]. From an operational perspective, this included supportive colleagues and management who would communicate regularly about current situations, and provide cultural activities and supervision [R14] [R88].

[R41] *“Board of Trustees and manager who understand tikanga Māori.”*

[R35] *“The organisation has based all policy and procedures on Māori values and are professional and practical.”*

[R41] *“Policies, tikanga whakamua document outlining cultural practice.”*

[R38] *“Māori in management. Retention of current Māori staff and a recruitment drive for more Māori versus overseas applicants.”*

[R14] *“The awahi the team provides.”*

[R88] *“Even though my manager is European, she is very understanding and supportive most of the time. She is always willing to listen and endeavours to meet me half way, which I appreciate... We have staff meetings weekly, and multi-disciplinary meetings fortnightly. We have regular waiata practice and cultural supervision.”*

Another theme to reduce organisational constraints was to increase access to resources. One suggestion was to increase budgets so the necessary resources could be accessed [R30] [R28], and to ensure existing resources were more easily accessible [R65]. With respect to physical location issues, one suggestion was to relocate services to a more easily accessible location [R83].

[R30] *“Having more access to pūtea can certainly enhance our mahi”*

[R28] *“It’s also the little things – having appropriate stationery/resources.”*

[R65] *“Access to team leader...and physical resources e.g. service car, computer etc.”*

[R83] *“Need to be on ground level where the general public can see me and also will be more easily accessible for patients and whānau.”*

Role Overload

Ways in which organisations could improve demands related to role overload included having sufficient numbers of staff to do the work [R01], and administrative support or delegation of tasks so that clinical staff could get on with clinical work [R94] [R80].

[R01] *“Fully staff so I can reduce my casework.”*

[R94] *“Administrative help and support, and another me in the community.”*

[R80] *“More delegation of simple tasks and monitoring of patients to the assistants.”*

Another theme to reduce workplace demands was ensuring staff were competent. This included relevant skills [R86], as well as access to supervision and professional development to gain or maintain necessary skills [R10] [R34].

[R86] *“Managers who know what they are doing.”*

[R10] *“Being able to attend supervision on a regular basis.”*

[R34] *“Training/professional development.”*

A final theme to reduce workplace demands was to reduce bureaucratic processes. Examples include collecting only necessary data for reporting [R53], which would reduce documentation and paperwork and allow staff more time to work with tangata whaiora [R53].

[R53] *“Unnecessary reporting and note taking documentation i.e. one report per month should be sufficient if the appropriate data is captured.”*

[R53] *“Less focus on documentation and more on hands on mahi ki te tangata whaiora.”*

Interpersonal Conflict

Ways in which organisations can reduce workplace demands related to interpersonal conflict included building a culture of honesty, respect and openness in the workplace [R17], including a culture of professionalism [R22], and eliminating bullying (including gossip) [R107] [R106]. Respondents also commented on management taking a proactive approach to conflict resolution [R60], and the need for good communication [R04]. Teambuilding was also a common theme, in particular for management to actively encourage staff to build and enhance relationships [R26].

[R17] *“Honesty and feeling respected, hui, team building, consistency, openness, care and consideration.”*

[R22] *“Professional conduct towards each other.”*

[R107] *“Don’t bully or try to make me feel whakamā.”*

[R106] *“Eliminate the gossip.”*

[R60] *“Improve communication, and for management to deal with personal conflict.”*

[R04] *“Clear communication and more communication. Being transparent with your staff.”*

[R26] *“One of the things I enjoy about my workplace is there is an emphasis on enhancing staff interpersonal relationships outside of client sessions. This enables us to repair relationships when disagreements occur.”*

9.3 Results: Coping Strategies

As with workplace demands, some respondents reported satisfaction with their existing range of coping strategies, and identified those that helped them most to deal with workplace demands. Some respondents also indicated a desire to learn more about coping strategies to add to their kete (basket) of resources for use in the workplace.

9.3.1 Wairua (Spiritual)

For coping strategies relating to wairua, respondents commonly talked about their use of karakia (prayer), waiata (singing), and humour [R72] to cope with work situations. Some respondents also talked about regularly returning to their papakāinga (home base) [R103], and one respondent talked about reliance on Māori values [R7].

[R72] *“Karakia, waiata, humour, and stimulation from self-directed learning.”*

[R103] *“Returning home [North] bi-monthly.”*

[R7] *“Not compromising my Māoriness. Tikanga. Tika/Pono/Aroha.”*

9.3.2 Hinengaro (Thoughts and Feelings)

For coping strategies relating to hinengaro, participants commonly talked about assessing the situation and coming up with a plan to address it [R24], recognising when stress is starting, letting others know, as well as recognising their limitations [R37], and catching up on unfinished work in their own time [R60].

[R24] *“Stop, think, breathe, assess and then work out a time management plan as to what is important and what are the least important tasks.”*

[R37] *“Recognising the onset of stress, taking a break, speaking out about workload, prioritising, and recognising my limits.”*

[R60] *“I come to work an hour earlier to work uninterrupted.”*

9.3.3 *Tinana (Physical)*

For coping strategies relating to tinana, participants commonly talked about getting exercise and taking breaks [R28], and food [R76].

[R28] *“I do yoga four times a week and make sure I get regular breaks.”*

[R76] *“Eat healthy. Stay fit.”*

9.3.4 *Whānau (Extended Family, including Work Colleagues)*

Whānau was, by far, the most commonly reported coping strategy for respondents. This included spending time with or talking to a range of whānau supporters [R74], spending time with specific whānau [R102], and talking with work whānau [R03].

[R74] *“My husband, friends, family, and a work mate.”*

[R102] *“Spending time with my mokopuna – they keep it real for me”*

[R03] *“Talking with colleagues I trust.”*

9.3.5 *Initiatives to Build Staff Coping Strategies*

In addition to identifying coping strategies that worked well, respondents also identified coping strategies they needed to learn more about. Both organisations and individual staff could potentially enhance staff coping strategies. Organisations could help staff cope with workplace demands by providing workshops or training on the importance of seeking help [R17], access to help [R61], time management [R11], and conflict resolution [R16].

[R17] *“It’s not OK to keep myself isolated, it can be dangerous.”*

[R61] *“Where to find help.”*

[R11] *“Time management. Learning to say ‘No’, without feeling guilty.”*

[R16] *“Any conflict resolution training.”*

Individual staff could also help build and develop more coping strategies to add to their kete (basket) of resources, and whānau (including extended whānau, work colleagues, and friends) could be a good resource to gain this knowledge and confidence from. Some respondents wanted to learn more about a range of coping strategies [R12], not to ignore the early warning signs of stress [R65], developing confidence to use coping strategies [R03], learning not to take things personally [R64], and becoming more comfortable saying ‘No’ [R43].

[R12] *“Read more widely about coping with stress, and not be so off-handed about stress.”*

[R65] *“Act before the stress levels force me to.”*

[R03] *“How to gain the confidence to put them in place.”*

[R64] *“Not to take things personally.”*

[R43] *“To say NO!”*

9.4 Results: Strain Outcomes

As expected, respondents reported a range of strain outcomes as a result of their mahi (work), mostly related to hinengaro and tinana. However, they also reported positive outcomes related to hinengaro as a result of their mahi. In addition, some respondents reported that despite workplace demands the amount and quality of their mahi was not reduced, which is good news for organisations. Some responses related to only one of the MODF components, while there was more overlap amongst the components for other responses. In these latter instances, those responses were included in the component that was most impacted.

9.4.1 Wairua (Spiritual)

All responses for strain outcomes related to wairua were negative, and all were related to cultural safety. Because of the way some Mahi Oranga questions were worded, respondents tended to report **what** workplace demands impacted wairua, rather than **how**

those workplace demands impacted wairua. Examples of individual strain related to wairua included institutional racism [R86], and the lack of kaupapa Māori support [R66].

[R86] *“Institutional racism.”*

[R66] *“The biggest problem for my mahi is working for kaupapa Māori and having very little in the way of kaupapa to support me.”*

An example of organisational strain related to wairua included the reducing number of Māori staff and unsafe cultural practices [R38].

[R38] *“Māori staff moving on. Unsafe cultural practices.”*

9.4.2 *Hinengaro (Thoughts and Feelings)*

Respondents reported a large number of negative and positive outcomes related to hinengaro. The individual strain outcomes included that for one respondent, boredom, the lack of challenge at work, and not having a defined job role was problematic [R28], and another respondent commented that they did not get paid enough [R60]. In some cases negative impacts on one component of the MODF (such as hinengaro) had flow-on negative effects to another component of the MODF (such as work whānau) [R80].

[R28] *“I have the most problem with boredom and the lack of challenge. I find it affects me and I can get quite snappy at home. The lack of a defined job role is frustrating.”*

[R60] *“Finances – I don’t get paid enough.”*

[R80] *“My way of working in a team and communicating with the team. More my mental well-being has been impacted. I feel a lower sense of self and confidence in my work.”*

Examples of organisational strain related to hinengaro included concerns about the impact on workload of restructuring in the health system [R11], and the impact on tangata whaiora of restructuring [R74].

[R11] *“The amount of it – so much. Major restructuring in the health system, which impacts on the workplace.”*

[R74] *“Will we be taken over by health services that do not care about our people, and who do not know their needs for trust and safety? Will Māori needs and cultural aspects be taken into consideration, as I know this impacts on my clients?”*

Respondents also reported a large number of positive outcomes related to individual strain and hinengaro. The main underlying theme was achieving positive outcomes for tangata whaiora, including improved health outcomes for groups [R07], and individuals [R30]. Positive outcomes for tangata whaiora were also achieved through advocacy, including advocating for tamariki (children) [R20], advocating for Māori patients and receiving support from non-Māori colleagues [R97]. For some respondents, what made them feel good about their mahi was being able to contribute to health gains for Māori [R11].

[R07] *“Supporting whānau/hapū into wellness and recovery.”*

[R30] *“Witnessing transformation of clients to wellness.”*

[R20] *“Children being heard.”*

[R97] *“Achieving the best possible health outcomes for my Māori patients. Having the confidence to be a strong advocate for my Māori patient’s health needs and having this supported by my non-Māori work colleagues. I love working with kaumātua.”*

[R11] *“Contributing to Māori health gains.”*

For some respondents, the fact that they even had a job was something they were grateful for [R12], along with their ability to pay bills [R53].

[R12] *“Having a job when I live in isolated areas and employment is difficult to find.”*

[R53] *“Paying my bills.”*

In terms of positive outcomes related to organisational strain and hinengaro, one theme was organisational commitment, including pride in the progress of the organisation [R08], and pride in the team and leadership [R85]. Another theme was organisational citizenship behaviours, including maintaining good relationships with external

organisations [R45]. A final theme was job performance in that some respondents noted that despite the demands in their workplace, the amount and quality of their work was not negatively affected. For one respondent, that meant maintaining a consistent standard of work [R45], and for another that meant exceeding their usual level of work [R82].

[R08] *“To see the organisation progress.”*

[R85] *“Strong supporting team and good leadership.”*

[R45] *“Maintaining relationships with funders and always keeping in regular contact with them regarding the progress of our work.”*

[R45] *“We continually work at our high standard.”*

[R82] *“I am exceeding the level of mahi, but it would be good to be appreciated for the level and complexity of mahi that I do.”*

9.4.3 Tinana (Physical)

All responses for strain outcomes related to tinana were negative, all were individual strain, and examples included health and stress [R37], insufficient sleep [R70], and the connection between workload, long work hours, and tiredness [R01].

[R37] *“Managing my health and stress.”*

[R70] *“Not getting enough sleep and working tired.”*

[R01] *“Huge workload, long hours, tiredness.”*

9.4.4 Whānau (Extended Family including Work Colleagues)

Respondents reported negative strain outcomes related to whānau at both the individual strain and organisational strain levels. With respect to individual strain, respondents reported difficulty with tamariki (children) when working from home [R100], and one respondent reported feeling pressured to stay in the job because of personal financial commitments despite not being happy at work [R28].

[R100] *“My children when I am trying to work at home. They want my attention and I want them to be quiet or go to another room.”*

[R28] *“The lack of a defined job role is frustrating. My partner does not understand and needs me to keep working because of the money.”*

Of the organisational strain responses related to whānau, problems were reported with relationships with management [R03], and colleagues [R54].

[R03] *“The relationship between myself and my manager.”*

[R54] *“Attitudes of other staff in the environment that seem to think they know best approaches in everything.”*

9.4.5 Initiatives to Reduce Individual and Organisational Strain Outcomes

Respondents suggested what they could do to limit individual strain outcomes. These included keeping a positive attitude [R16], being organised [R12], getting sufficient exercise [R77], and spending quality time with whānau [R11].

[R16] *“Having a positive attitude every day.”*

[R12] *“Getting organised.”*

[R77] *“I have no complaints, lots of exercise blows all the cobwebs away.”*

[R11] *“Spending time with my whānau and activities that I enjoy.”*

Respondents also suggested ways that organisations could limit strain outcomes by ensuring management had the necessary skills and abilities to be effective in the workplace [R75], providing staff with the opportunity to discuss matters related to occupational stress in the workplace [R04], developing and expecting a culture of valuing and respecting Māori values and staff [R72], and ensuring there were sufficient staff to manage workloads [R06].

[R75] *“Trained manager.”*

[R04] *“These issues being discussed openly in a forum manner.”*

[R72] *“Being valued and respected by management and colleagues for my knowledge and expertise.”*

[R06] *“Being fully staffed.”*

9.5 Discussion of Qualitative Results

In terms of how Mahi Oranga can be improved, with respect to the qualitative questions in the strain outcomes sections, some respondents reported **what** workplace demands impacted them rather than **how** those workplace demands impacted them. Further development work will need to be done to change the way the questions are asked to elicit responses that tell **how** workplace demands impact at the individual level and the organisational level.

For the remainder of this section, discussion will be structured around the headings of the occupational stress experiences that all staff have in common, what is unique to Māori staff, and culturally responsive coping strategies.

9.5.1 Occupational Stress Experiences: Common to all Staff

In terms of these qualitative results, some of the responses supported the consultation phase findings (Chapter 6) that Māori staff experience occupational stress in some of the same ways as their non-Māori counterparts. Similarities with their non-Māori counterparts included organisational constraints such as insufficient resources and budgets, bureaucratic environments that serve to slow responsiveness to clients/patients, lack of leadership and skills of management and incompetent staff, and policies and processes that do not support effective job performance. Role overload and interpersonal conflict were also areas where occupational stress issues were similar between Māori and non-Māori staff. Role overload in particular seemed to be a common feature in the health and disability sector, and especially as budgets get reduced even further staff are expected to do more with less funding. With interpersonal conflict the common themes for all staff were workplace bullying (including gossiping), professional disagreements about case management and intervention, and poor communication methods and skills of management and colleagues. Although these workplace demands are common to all staff in the health and disability sector, the impact on Māori staff may be more acute because they are under-represented in the health and disability sector workforce, while Māori remain over-represented in the health statistics.

These findings are consistent with the mainstream health sector literature around organisational constraints (Cooper & Marshall, 1976), role overload (Moore & Cooper, 1996) and interpersonal conflict in the form of horizontal violence and bullying (Cooper & Marshall, 1976; McKenna et al., 2003; Foster et al., 2004). It is also possible that some interpersonal conflict is caused by organisational constraints, consistent with the findings of Storms and Spector (1987) and Chen and Spector (1992). The results of the quantitative analysis confirmed there was a correlation between each of the workplace demands, such that as one workplace demand increased, so too did the others. This means that managers need to be mindful of how one workplace demand impacts another and how workplace demands overall can be reduced.

9.5.2 Occupational Stress Experiences: Unique to Māori

These pilot phase findings also supported the consultation phase findings that Māori staff experience occupational stress in uniquely different ways as well. In terms of workplace demands, cultural safety and related institutional racism was an issue specific to Māori staff. Examples such as a lack of understanding and respect for Te Ao Māori (including tikanga, te reo, and Treaty of Waitangi issues) and that Māori staff were expected to be expert in and deal with Māori matters without support from their non-Māori counterparts highlighted the lack of cultural competence of non-Māori staff in the health and disability sector. The example of a lack of cultural support in the form of cultural supervision, access to kaumātua/kuia support and isolation from other Māori peer support highlighted a lack of understanding about how to create healthy workplaces for Māori staff that support effective job performance. The example of inexperienced and inappropriate staff (in this case non-Māori staff) leading cultural training highlighted a lack of comprehensive understanding of cultural safety, and the risks not only to Māori staff and clients/patients, but to the non-Māori staff leading such training. The example of a department exploiting Māori staff so they can pass accreditation after having failed audit processes highlighted the higher importance that Māori placed on whanaungatanga (relationship building that is mana enhancing) and reciprocity in the workplace, especially in relation to achieving better outcomes for tangata whaiora. These last two examples highlight the whānau component of the MODF (see Table 7.1 in Chapter 7), in which

relationships (whanaungatanga) and reciprocity are a key part. Mainstream managers need to understand the importance of these values when dealing with Māori staff and Māori organisations, especially if they wish to maintain long-term relationships. And relationships that are mutually beneficial can only mean better outcomes for both parties.

Although the other workplace demands of organisational constraints, role overload and interpersonal conflict are not unique to Māori staff, the findings of this pilot phase revealed that they are experienced in different ways from their non-Māori counterparts. Examples of organisational constraints experienced differently by Māori staff included work environments that create competition amongst Māori staff, some Māori organisations prioritising cultural training over clinical training, a lack of recognition and valuing through remuneration of Māori cultural knowledge and skills (including knowledge of Māori therapeutic models and methods of healing) not known by their non-Māori counterparts, and a lack of culturally responsive service locations. Examples of role overload experienced differently by Māori included a shortage of Māori staff with specialist skills (for example Māori researchers), expectations and exploitation of Māori organisations by mainstream organisations without any reciprocity, difficulty balancing work and professional development commitments, and difficulty balancing dual commitments to the employer and the Māori community (marae, whānau, hapu, and iwi commitments). Examples of interpersonal conflict experienced differently by Māori staff included conflict that arose with mainstream staff around issues related to cultural safety such as tikanga and why services provided to tangata whaiora need to be done differently to be effective, and difficulty with other Māori staff around internal iwi conflicts and ‘back-biting’. Many of these results regarding the different experiences of Māori staff in relation to organisational constraints and role overload are consistent with Ratima et al (2007) and Sisley and Waiti (1997).

9.5.3 Culturally Responsive Coping Strategies

With respect of culturally responsive coping strategies, clearly Māori staff have an individual responsibility for developing skills in this area, including recognising when they are becoming stressed, developing coping strategies that work for them, and most importantly, using those strategies in a proactive preventative way where possible.

However, there is no doubt that organisations can do more to increase awareness of, and provide access to culturally responsive coping strategies, such as access to cultural supervision and peer support. Mainstream managers may not be aware of the contribution they can make to improving staff wellbeing by allowing Māori staff to have access to cultural supports as a form of culturally responsive coping strategies.

Too often, mainstream managers regard these Māori ways of “being” as less important and productive as, for example, professional networking opportunities. In the end, these attitudes of some mainstream managers reflect their lack of understanding of Te Ao Māori (the Māori world) and how to harness this knowledge in positive ways that not only result in individual wellbeing for Māori staff, but also positive outcomes for the organisation. Equally important is for Māori managers to adopt some mainstream management skills, such as conflict management, to help staff cope with interpersonal conflict and other workplace demands. Ignoring these problems is not going to make them go away, or create healthy workplaces, or result in cultural wellbeing for Māori staff.

9.6 Chapter Conclusion

The health and disability sector is under considerable pressure in terms of shrinking resources and the drive to operate using a capitalist (or at least cost recovery) model of business. While there are positive features of this model of business operation, these systemic demands are creating pressures in terms of workload and job insecurity for staff. There may be disproportionate impact on Māori staff due to their under-representation in the health and disability sector while numbers of tangata whaiora continue to increase (Ministry of Health, 2010).

The lack of a Māori-specific measure of wellbeing at work has meant a lack of awareness that Māori experience occupational stress (and wellbeing) differently from non-Māori, and how these experiences differ. Not only does this mean that causes of occupational stress for Māori working in the health and disability sector do not get addressed, it may mean that tangata whaiora do not receive the best possible care to restore them to health, and that health disparities will continue.

These issues highlight the need for strong leadership in the health and disability sector, and the will to make a positive change. It is the responsibility of all health and disability sector staff to provide the best possible care to all patients. When tangata whaiora receive culturally safe and appropriate care, Māori staff find meaning in their work, take pride in seeing patients restored to health, and in their contribution to reducing health disparities for Māori. When strong leaders in health organisations ensure workplaces are healthy, the benefits extend beyond job satisfaction and increased productivity of Māori staff, to better health outcomes for tangata whaiora. In addition, healthy workplaces can make a significant contribution towards retention of Māori staff in the health and disability sector.

The next chapter will discuss organisational interventions to reduce occupational stress and initiatives to create healthy workplaces. In addition it will outline further research to be conducted as well as implications for practice.

Chapter 10 – Final Comments

Mahi Oranga has the unique ability to identify and measure culturally responsive strengths and areas for improvement related to workplace demands, coping strategies and work outcomes for Māori working in the health and disability sector. The findings of this thesis research also make a unique contribution to the body of knowledge related to occupational stress and wellbeing issues for Māori. In particular, these findings confirm that Māori experience occupational stress and wellbeing in different ways to their non-Māori counterparts, and detail not only how that experience differs, but identifies solutions in the form of stress management interventions to reduce stress and create healthy workplaces.

This chapter will first discuss organisational stress management interventions, including primary, secondary and tertiary levels of intervention. Next it will examine the levels of intervention in the health and disability sector, based on the Ministry of Health's policy documents, then on the findings of the *Rauringa Raua* report (both detailed in Chapter 3), and finally based on the findings of this thesis research. Implications of this thesis research is discussed next, including further development of Mahi Oranga as a concept, and closes with the implications of this research for practice.

10.1 Organisational Stress Management Interventions

10.1.1 Primary, Secondary and Tertiary Level Interventions

When it comes to organisational interventions around occupational stress, they fall into one of three categories: primary, secondary and tertiary level interventions (Caulfield, Chang, Dollard & Elshaug, 2004; Dewe, 1994; Giga, Cooper & Faragher, 2003; Hurrell & Murphy, 1996). Primary level interventions are aimed at the organisation, and are intended to prevent occupational stress happening by reducing the intensity or number of workplace demands. Examples of primary interventions include changes to the physical environment of work, job redesign or changing the characteristics of the job, and improving organisational communication. Secondary level interventions are aimed at both the organisation and the individual, and are intended to moderate the experience of

occupational stress by building resilience and employee coping strategies. Examples of secondary interventions include establishing workplace social support groups, providing employees with more participation and autonomy in their role, workplace wellness programs, and skills training such as conflict management. Tertiary level interventions are aimed at the individual, and are intended to reduce any debilitating effects of occupational stress once it has occurred. Examples of secondary interventions include stress leave, counseling, and employee assistance programs (EAP). Each of these levels of intervention maps on to an aspect of the expanded Transactional Model of Occupational Wellbeing presented in Chapter 3, as well as each of the three domains of Mahi Oranga. This relationship is depicted visually in Figure 10.1 below.

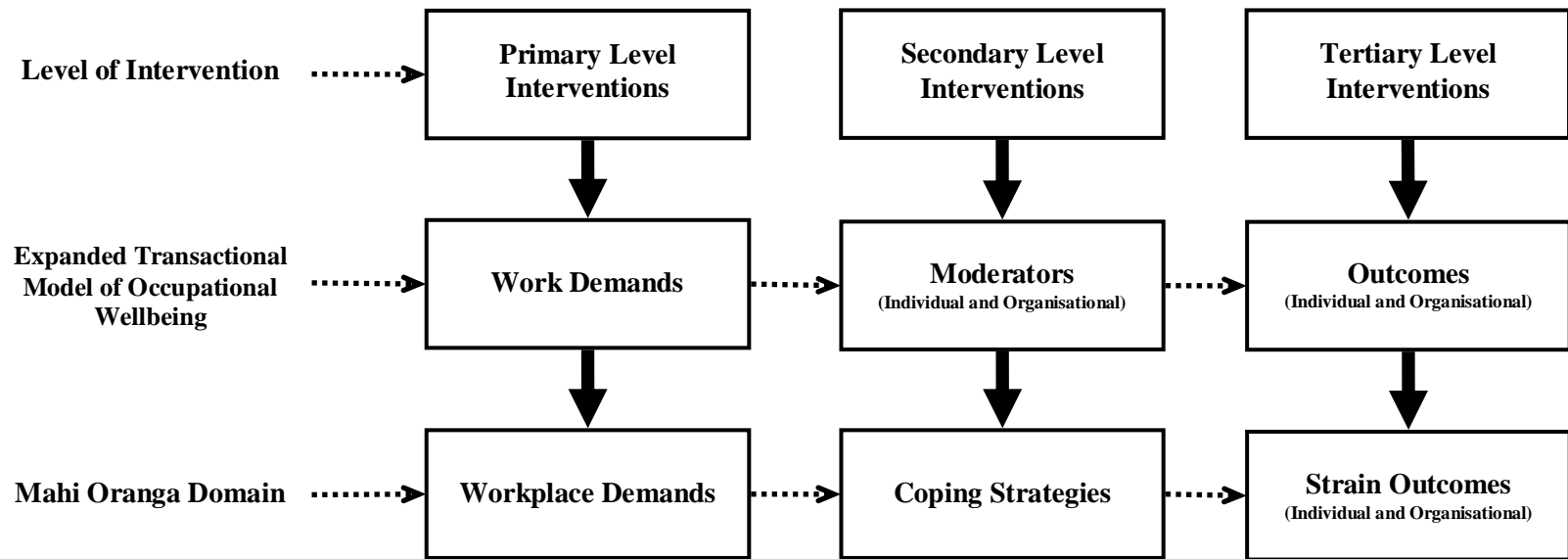


Figure 10.1 Relationship between level of stress management intervention, expanded Transactional Model of Occupational Wellbeing and Mahi Oranga domains.

Dewe (1994) and Giga et al. (2003) argue that stress management programs need to be comprehensive, ensuring that interventions are implemented at all three levels. Unfortunately, the majority of organisations primarily implement tertiary level interventions (Caulfield et al., 2004; Cooper & Cartwright, 1994; Dewe, 1994; Giga et al., 2003; Giga, Noblet, Faragher & Cooper, 2003; Noblet & LaMontagne, 2006), and in some limited cases, secondary level interventions (Cooper & Cartwright, 1994; Giga et al., 2003). The trouble with tertiary level approaches to stress management intervention is that they place the burden and responsibility of occupational stress on individuals, without acknowledging the organisational context within which occupational stress occurs. Even when secondary level approaches are used, they do nothing to change the ‘causes’ of stress (i.e. workplace demands), and so continue to perpetuate placing the burden and responsibility of occupational stress on individuals, albeit the organisation is at least more proactive in their interventions than in using tertiary approaches alone. Dewe and O’Driscoll (2002) conclude that there is a number of reasons organisations focus their stress management interventions at the tertiary and secondary levels, including manager’s views of stress, perceptions of who should accept responsibility for the interventions, what managers regard as effective interventions, whether organisational initiatives are designed as stress management interventions or simply good human resource practices, and the link between occupational stress theory and practice. Dewe (1994) also raises the important point that stress researchers need to give more attention to issues of power, control and ethics in organisations. Industrial/Organisational psychologists and human resource practitioners could probably stand to give more attention to these issues as well. What seems clear is that awareness and knowledge about the complex process of occupational stress, including how it is defined, remain relatively low in many organisations. And, in fairness, in light of the discussion in Chapter 1 about a lack of agreement amongst researchers of some of these issues, it is really no surprise that awareness and knowledge is so low in the ‘real’ world of business.

In terms of Mahi Oranga, there is potential for some of these issues to be raised and addressed with organisations using a three phase process which includes diagnosis, design and implementation, and monitoring. Mahi Oranga would be useful during the diagnosis phase to identify not only the levels of stress or wellbeing being experienced by

Māori staff, but also to identify causes of that stress or wellbeing. In addition to using Mahi Oranga, the diagnosis phase would ideally involve a sociotechnical systems (STS) approach to analysing and diagnosing the causes of occupational stress or wellbeing within the organisation (Chisholm & Ziegenfuss, 1986). Using the STS approach, technical aspects of an organisation's structure and processes (for example the policies and procedures, but also 'technology' such as equipment and software), as well as social aspects of an organisation's structure and processes (for example issues of power, control, ethics, human behaviour and motivation), and the interaction between these two could be examined to identify weaknesses, but also strengths. Key to the STS approach is to ensure the focus remains on one primary goal, such as creating a healthy workplace that ensures the wellbeing of staff and patients. On the basis of the diagnosis, the next phase is to design interventions that start by targeting the causes of occupational stress and proactive initiatives to create healthy workplaces (primary interventions), implement initiatives that help staff build resilience and strategies to better cope with the causes of occupational stress (secondary interventions), and ensure support processes are available if poor health is being experienced (tertiary interventions). The monitoring phase would involve establishing an agreed range of organisational performance indicators at the outset, and measuring these pre- and post-intervention to identify if improvements are achieved. Such indicators could be changes in Mahi Oranga ratings (for example, a reduction in workplace demands, an increase in coping strategies, and either a reduction in strain outcomes or an increase in wellbeing outcomes). Other organisational performance indicators could include increased compliance with policies and procedures, increased employee engagement, reduced turnover, and reduced stress leave and absenteeism. The point is that Mahi Oranga is acknowledged as only part of a more comprehensive, system-wide approach to stress management and creation of healthy workplace interventions. It can also be used as a tool to help educate managers in organisations about a much wider range of occupational stress and wellbeing issues than EAP or workplace wellness programs alone.

10.1.2 Interventions in the Health and Disability Sector

The Ministry of Health (MoH) Policy Documents

So, what does this thesis research reveal so far about the levels of intervention that would benefit Māori (and other) staff working in the health and disability sector? At the primary level of intervention, it is very encouraging to note that the Ministry of Health (MoH) has already identified a number of important issues that need to be addressed, as discussed in detail in Chapter 3. Better still, it has included these in policy documents such as *Whakatātaka Tuarua*, the Māori Health Action Plan for the 2006 to 2011 period, and especially the objective of developing the Māori health and disability workforce within Te Ara Tuarua – Pathway Two, Māori participation in the health and disability sector (Ministry of Health, 2006c). One of the specific action plans to develop the Māori health and disability workforce is to implement *Raranga Tupuake*, the Māori Health Workforce Development Plan 2006 (Ministry of Health, 2006b). The three goals of *Raranga Tupuake* include increasing the number of Māori in the health and disability workforce, expanding the skill base of the Māori health and disability workforce, and enabling equitable access for Māori to training opportunities. The timeframe to achieve these goals are 10 to 15 years (presumably from the date of implementing the policy). In the *Health Workforce Development: An Overview* document (Ministry of Health, 2006a), the MoH has also identified a number of goals for Māori workforce development activities, including organisational development (health services to develop the organisational culture and systems which will attract and grow their workforce and meet service needs), recruitment and retention (health services have a nationally and regionally co-ordinated approach to recruiting and retaining staff, which results in increased capacity and capability of the health workforce), and training and development (all stages of health workforce training are aligned to service needs and promote retention). It is clear from these various policy documents that the MoH is committed to improving health outcomes for Māori, and correcting the under-representation of Māori in the health and disability workforce. While it is laudable that some of the issues related to stress reduction and creation of healthy workplaces have been diagnosed, what is not yet clear is whether effective interventions have been designed, implemented, or monitored. And, based on the findings of this thesis

research, whatever has been implemented so far seems not to be making an impact for Māori health workers at flax roots level.

The Rauringa Raupa Report

In terms of the *Rauringa Raupa* report (Ratima et al., 2007) and its focus on recruitment and retention issues for Māori in the health and disability sector workforce (as discussed in Chapter 3), the barriers to retention they identified provide clear opportunities to develop primary level interventions that may not be explicitly identified in the MoH policy documents. Issues such as a lack of or low levels of Māori cultural competence do seem to be addressed by the training and development action within *Health Workforce Development: An Overview* by establishing a set of cultural competencies within training programs to improve service delivery to cultural groups and recruitment of staff from within them. Issues such as limited or no access to Māori cultural competency training seem to be addressed by goal three of *Raranga Tupuake* which is to enable equitable access for Māori to training opportunities. However, solutions to other retention issues such as limited or no access to Māori cultural support/supervision, and isolation from other Māori colleagues can only be assumed to be addressed within the organisational development goal and action of improving healthy workplace environments and practices (e.g. magnet hospitals) within *Health Workforce Development: An Overview*. Other issues such as dual responsibilities (to employer and to the wider Māori community) and under-valuing of Māori cultural competencies do not seem to have any identifiable interventions within the policy documents. Of course, the biggest reason for this is the different framing of the research question. The objective of *Rauringa Raupa* was to answer a range of questions related to recruitment and retention of Māori in the health and disability sector, such as describing what prevents Māori from staying in the health and disability sector workforce. The perspective of this thesis research is occupational stress and wellbeing for Māori in the health and disability sector. These differences in framing highlight not only the lack of research in the area of occupational stress and wellbeing for Māori, but that different strengths, weaknesses and solutions will be identified depending on the research focus.

Developing Mahi Oranga

A number of primary level interventions aimed at reducing workplace demands and creating a healthier workplace were suggested by the pilot phase respondents as constructive ways forward. Those related to cultural safety included building a culture of respect and valuing of Te Ao Māori, building cultural competence for all staff, and providing cultural support for Māori staff. Those related to organisational constraints included integrating Māori philosophies throughout the infrastructure and operation of healthcare organisations, and improved access to resources. Those related to role overload included being adequately staffed, having competent staff, and reducing bureaucratic practices. Those related to interpersonal conflict included building a culture of respect and professionalism.

Some, like correct pronunciation of Māori names and words, use of Māori greetings and building a culture of respect and professionalism, would be relatively easy for health organisations to implement, but would have considerable positive impacts on Māori staff and tangata whaiora. Others, such as building a culture of respect and valuing of Te Ao Māori, building cultural competence of all staff and increasing staff levels, while not impossible to achieve, are likely to continue to be affected by budgetary and other constraints. However, these issues might be partially addressed if leaders in healthcare organisations consider, for example, cultural safety and cultural competence in the selection and training of their staff.

A number of secondary level interventions (individual and organisational) aimed at increasing coping strategies were identified by respondents. Individual interventions related to wairua included karakia (prayer), waiata (singing), humour, returning regularly to their papakāinga (home base), and reliance on Māori values. Individual interventions related to hinengaro included coming up with a plan to address stress, recognising the onset of stress and taking early action to address it, letting others know when health sector workers are feeling stressed and recognising their limitations. Individual interventions related to tinana included eating healthily and getting exercise. Individual interventions related to whānau (the most used type of coping strategy) included spending time with or talking to a range of work and family supporters, spending time with specific whānau such as a mokopuna (grand children), and talking with trusted work colleagues. Suggestions for

organisational interventions included providing workshops or training on the importance of seeking help, assistance to access that help, and training such as time management and conflict resolution.

One of the biggest issues regarding secondary level interventions provided by the organisation (other than the fact that they didn't really exist) was the lack of understanding of Te Ao Māori (the Māori world), resulting in a lack of awareness of culturally responsive interventions which organisations can provide. Some of those interventions, such as providing access to cultural supports (including kaumātua/kuia, cultural advisors, cultural supervisors, and peer support), if provided at the primary level of intervention to improve cultural safety, may very well reduce the need to provide them at the secondary level of intervention as a coping strategy.

No tertiary level interventions were identified or suggested by respondents because the focus of the questions was on individual and organisational strains. That said, two quantitative questions in Mahi Oranga asked respondents to identify whether management supported sick or stress leave (a tertiary level intervention), and whether management encourages staff to make use of Employee Assistance Programs (EAP) when needed (another tertiary level intervention). This provides an indication that tertiary level interventions are provided within the health and disability sector.

10.2 Implications of this Research

10.2.1 Further Mahi Oranga Development

A number of development opportunities exist for Mahi Oranga as a concept both within Aotearoa New Zealand, and internationally. Within New Zealand, research could be conducted to establish whether other public sector environments in which there are significant numbers of Māori staff, such as the Department of Corrections, New Zealand Police, or even the tertiary education sector would benefit from the same type of investigation conducted in this thesis research for the health and disability sector. It would be informative to establish whether the same or different workplace demands are an issue for these sectors, and therefore whether a different version of Mahi Oranga needs to be

developed for those sectors. If the workplace demands are the same, then development of Mahi Oranga would involve gathering norm reference data for those other sectors.

There is also scope to investigate whether other minority groups in Aotearoa New Zealand require a culturally responsive measure of occupational wellbeing, taking into account their cultural models of health and wellbeing, as well as historical contexts that might shape their experience of occupational stress differently to mainstream New Zealander's. The minority groups could include, for example, the Pacific and Asian workforces identified in the *Health Workforce Development: An Overview* as also being under-represented in the health and disability sector (Ministry of Health, 2006a). Pacific Islanders and Asians also have a unique history in Aotearoa New Zealand, and both groups have (and continue to) experienced racism and political exploitation (Loomis, 1990; Loomis, 1993; Johansson, 2004). Other large immigrant population groups, especially those that come with professional qualifications from their country of origin but find their qualifications are not readily accepted in New Zealand, may also be a focus of interest. There is scope too, to investigate occupational stress issues for refugee communities, and whether the concept of Mahi Oranga could be adapted for their needs.

On the international stage, other indigenous groups such as the Native American Indian and First Nations tribes of North America, the Kānaka Maoli people of Hawai'i, the Australian Aboriginals, and the Pacific Islands people may be interested in adapting Mahi Oranga for the context of their respective cultures and countries. Their paradigms of health and wellbeing, their history of colonisation by a dominant Western culture and of political exploitation, their under-representation in their health sector workforces, and the over-representation of their people in the negative health statistics provide a compelling rationale for a Mahi Oranga equivalent to be developed.

Finally, and back to the Aotearoa New Zealand focus, other Western developed psychometric assessments used here need to be examined further to establish whether there may be unintended consequences for Māori test-takers. This is not to say that all Western developed psychometric assessments result in disadvantage to Māori. However, those predicated on different cultural assumptions (such as notions of what constitutes leadership in the workplace) could certainly bear some scrutiny.

10.2.2 Implications for Practice

The implications for practice must start with the awareness of how few registered Māori Industrial/Organisational Psychologists there are in Aotearoa New Zealand and the urgent need to develop that workforce if the issues raised by this thesis research are to be effectively addressed. Until its disestablishment in 2008, the New Zealand Health Information Service (NZHIS) conducted regular surveys of and reports on the health professional workforce in New Zealand. In the case of registered psychologists the NZHIS's research method involved inviting all those sent an invoice for their Annual Practising Certificate (APC) to "complete a health workforce survey designed to capture characteristics of their profession" (New Zealand Health Information Service, 2006, p. 89). From all the data collected and tracked in the reports, of particular interest for the purposes of this thesis is how many APCs were invoiced to registered psychologists, the overall percentage response rate and number of active (practicing) registered psychologists that responded, and how many of those active respondents were Māori registered psychologists (by number and percentage). This information is presented in Table 10.1 below.

Table 10.1

Trend data indicating the percentage of Māori Registered Psychologists that responded to the NZHIS's survey in 1999, 2000, 2002, and 2006.

Year	Number of licences purchased or APCs invoiced	Overall response rate Percentage	Number of active respondents	Number of active NZ Māori respondents	Percentage of active NZ Māori respondents
1999	1042	59.7%	598	21	3.5%
2000	1124	62.2%	667	9	1.3%
2002	1270	76.2%	907	43	4.7%
2006	2000	58.7%	1154	35	3.0%

Source: New Zealand Health Information Service. (2000, 2001, 2003, and 2007).

Two points of interest emerge from this data. First, that the percentage of active Māori respondents remained fairly static from 1999 (at 3.5%) to 2006 (at 3%). Second, that

there is no indication of how many of those registered Māori psychologists specialise in industrial/organisational psychology. However, given that the majority of Māori psychologists specialise in clinical psychology, it is probably safe to assume only a very small proportion of that already low percentage of 3% are actively practicing within industrial/organisational psychology. Clearly, and as with every other discipline within the health and disability sector, Māori industrial/organisational psychologists were under-represented in the workforce compared with the proportion of the Māori in the total labour workforce during 2006 at 67.3% (Department of Labour, 2006). Based on the trend between 1999 and 2006, there is no reason to assume this situation has changed dramatically.

The other major implication for practice is the lack of awareness amongst organisations and their management, industrial/organisational and human resource professionals, and academics, of the occupational stress and wellbeing issues that affect Māori. If awareness is not raised then very little can be done to address those issues. However, awareness alone will not change organisational culture or improve the work environment for Māori or other staff. There must also be a willingness to effect change, as well as the knowledge, skills and abilities about how to do that. Achieving this will require a multi-pronged approach, including:

- ◆ Publishing the key findings of this thesis research in mainstream industrial/organisational and human resources journals in Aotearoa New Zealand.
- ◆ Giving presentations of the key findings to relevant stakeholder groups, including industrial/organisational and human resource professionals, and at health and disability sector conferences and hui (starting with Māori interest groups and extending to mainstream interest groups).
- ◆ Working in the field directly with organisations and their operational as well as human resource managers when organisational interventions are required.
- ◆ Lobbying tertiary academics lecturing in postgraduate industrial/organisational psychology, human resource management, and general management programs, to include some of these key findings within the curriculum of relevant subjects.

- ◆ Talking to Māori students as early as secondary school, and certainly in undergraduate psychology programs about the need for more Māori Industrial/Organisational Psychologists, and to encourage them to study in this field.
- ◆ Identifying potential funding opportunities to secure study scholarships for Māori students to gain qualifications in this field.

In closing, the following whakatauāki (proverb) is offered as a call to action to all those willing to take up the wero (challenge) of contributing to much needed change, and creating healthy workplaces for Māori (and ultimately others) in Aotearoa New Zealand.

Whakatauāki (Proverb)

Nā tō rourou

With your resource basket

Nā taku rourou

And my resource basket

Ka ora ai te iwi

The people will thrive

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Appendix A: Phase 1 Consultation – Interview Question Template

Phase 1 Consultation – Interview Questions

Contact details to be collected: (and held confidentially)

Name: _____

Organisation you work for: _____

Position/role in organisation: _____

Phone (work): _____

Mobile: _____

Email: _____

Urban/Rural

Mainstream/Kaupapa Māori

Questions/Responses

1. How might this research help you in the workplace? (practical implications)

2. What would the self-report measure look like to you?

3. How would you use the measure in the workplace?

Are you prepared to be involved in the next phase of research?

Yes/No

Appendix B: HDEC Ethics Approval Letter



Multi-region Ethics Committee

Ministry of Health
133 Malesworth Street
PO Box 5013
Wellington 6145
Phone (04) 470 0655
(04) 470 0646
Fax (04) 496 2340

Email: multiregion_ethicscommittee@moh.govt.nz

17 May 2010

Ms Lisa Stewart

26 Totaravale Drive
Glenfield
North Shore City 0629
Auckland

Dear Lisa

Ethics ref: **MEC/10/26/EXP**
Study title: Developing Mahi Oranga - a Māori-specific measure of occupational wellbeing
Investigators: Ms Lisa Stewart

The above study has been given ethical approval by the Multi-region Ethics Committee.

Approved Documents

- Study Protocol, dated 19th of April 2010
- Email Information Sheet, Version 2, dated 17th of May 2010
- Assessment Questionnaire of Māori Occupational Wellbeing, Version 2, dated 17th of May 2010

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report

The study is approved until **31st of August 2010**. A final report is required at the end of the study and a form to assist with this is available at <http://www.ethicscommittees.health.govt.nz>. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date.

Amendments

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Claire Lindsay', written in a cursive style.

Claire Lindsay
Administrator
Multi-region

Email: claire_lindsay@moh.govt.nz

Appendix C: Copy of Mahi Oranga Questionnaire

Mahi Oranga - An Assessment Questionnaire of Māori Occupational Wellbeing		Exit this survey
1. Information about this Mahi Oranga Questionnaire		
<div style="background-color: black; width: 100px; height: 15px;"></div>		12%
<p>Tēnā koe</p> <p>Ko Aotea u tanga nui, Matātua, me Te Arawa ngā waka Ko Matua te Mana Ruapehu, Whakaraia, me Ruapehu ngā maunga Ko Whanganui rawa ko Tākau ngā awa Ko Taupō-Nui-A-Tia te moana Ko Te Ātihaunui-a-Paparangi, Ngā Puhī, me Tūwharetoa ngā iwi Ko Ngāti Kurawhatia ki Pipiriki, Ngāti Rehia ki Tākau Bay, me Ngāti Rongomai ngā hapu Ko Paraweka, Te Whetumarama O Te Ao Hou, me Rongomai Turangi ngā marae Ko Lisa Stewart tōku ingoa</p> <p>This questionnaire is a Māori-specific measure of occupational wellbeing, based on Te Whare Tapa Whā model of health and wellbeing. It was developed to reflect the fact that we as Maori experience occupational wellbeing (and stress) differently to the mainstream population, and existing questionnaires do not capture this difference. This study focuses on Māori Healthcare Professionals because research shows that it is a high-stress occupational group, and the wellbeing of you as a healthcare professional has consequences for the clients/patients/tangata whaiora you care for.</p> <p>The questionnaire will take about 15-20 minutes to complete and all answers are anonymous and confidential. In addition, no individual participant or organisation will be identified in the final report. If there are questions you do not wish to answer please leave those questions blank. <i>Completion of the survey implies consent to participate in this research.</i></p> <p>There are no right or wrong answers, please just select the response that is relevant for you.</p> <p>Kia ora and thank you for completing this questionnaire.</p> <p style="text-align: center;"><input type="button" value="Next"/></p>		

2. Section 1: Demographic Information

25%

1. Age (select one):

- Under 20 yrs 20–29 yrs 30–39 yrs 40–49 yrs 50–59 yrs 60–69 yrs 70+ yrs

2. Gender (select one):

- Male
 Female

3. Job Title:

4. Please select the work setting that applies to you:

- Urban work setting
 Rural work setting

5. Please select the work environment that applies to you:

- Kaupapa Māori work environment
 Mainstream work environment

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3. Section 2: Demands



1. I have sufficient cultural supervision to ensure my cultural safety at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not Applicable
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Training for Māori cultural matters (e.g. Treaty training) is given the same priority as other important training at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Professional codes of conduct and/or ethics conduct are also aligned to Māori cultural values

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Expressing Māori worldviews is respected at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Māori clients/patients are treated in a culturally appropriate manner

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Non- Māori staff value and appropriately enact tikanga Māori practices at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Non- Māori staff accept responsibility for and enact bi-cultural competence and practice at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. Māori staff value and appropriately enact tikanga Māori cultural practices at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Māori staff accept responsibility for and enact bi-cultural competence and practice at mahi						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I have sufficient professional or clinical supervision to ensure my professional safety in my mahi						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
10	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I feel conflicted about what my employer expects me to do and what I think is right or appropriate						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
11	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Managers do not always have the knowledge, skills or abilities to be culturally appropriate						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Policies, processes, and procedures in the workplace ensure I am treated with dignity and respect						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
13	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Professional development (e.g. conference attendance) around issues relevant to Māori is supported by management						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
14	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Māori posters, or artwork, or decorations are on display at my workplace						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
15	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Management cares more about money than clients/patients						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
16	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. The training available to me is relevant to the knowledge, skills, and abilities for my mahi						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
17	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. My job description accurately reflects the mahi I do

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
18	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. Organisational rules and procedures allow me to perform at my best

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. I have the correct information I need to do my mahi well

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. My workplace complies with Occupational Safety and Health (OSH) regulations

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
21	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. The equipment and/or resources I have mean I can be efficient and/or effective at my mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
22	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

23. My organisation does not care about the physical safety of staff

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
23	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

24. My workplace has sufficient lighting and/or heating, and or air conditioning

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
24	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. The nature and/or location of my mahi means I am isolated from colleagues

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
25	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

26. The thing(s) that most affect(s) my cultural safety at mahi is/are:

27. The thing(s) that my organisation can do to improve my cultural safety at mahi is/are:

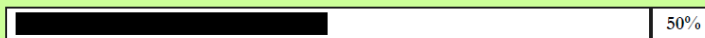
28. The organisational factor(s) that help(s) me most at mahi is/are:

29. The organisational factors(s) that help me least at mahi is/are:

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4. Section 2: Demands



1. I have more than one person telling me what to do at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I am over-managed at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. I do not receive sufficient guidance from my manager(s)

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Networking/whanaungatanga with Māori colleagues is encouraged by management

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Networking with other professional colleagues is encouraged by management

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. I feel competent to do my mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. I feel valued and appreciated in my role

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. I feel supported by management in my role

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
9. I feel supported by my colleagues in my role	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I am not expected to sacrifice my Māori values in order to get my mahi done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The amount of mahi I am expected to do is unreasonable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I have insufficient training for some of the tasks I am expected to do perform	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I do not have the resources I need to get my mahi done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I feel that I need more help to deal with my workload	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I often take on more mahi than I can cope with	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. The environment I work in is physically safe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I have so much mahi I often work through tea/lunch breaks to get it done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
18. Management supports sick and/or stress leave requests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I am encouraged to take regular breaks during my work day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. The speed that I am expected to work at keeps me physically safe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. In order to complete my mahi I have to take it home with me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. My whānau miss out on my time because I have to work so much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. There is a culture of teamwork and reciprocity at mahi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I have stopped attending workplace activities I enjoy because I have too much mahi to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I have stopped attending non-workplace activities I enjoy because I have too much mahi to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

26. The aspect(s) of my mahi that makes me feel most overloaded is/are:

27. The thing(s) that would help bring my workload to manageable levels is/are:

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5. Section 2: Demands



1. I am treated with dignity and respect by management

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I am treated with dignity and respect by my colleagues

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. I am treated with respect by clients/patients and/or their whānau

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Management communicates with me in a culturally appropriate manner

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Colleagues communicate with me in a culturally appropriate manner

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. The way I am treated at mahi motivates me to perform at my best

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Sometimes, management is not to be trusted

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. Sometimes, my non-Māori colleagues are not to be trusted

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Sometimes, my Māori colleagues are not to be trusted

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. I experience rude treatment from management and/or colleagues at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
10	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. I feel physically unsafe when I am with management

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
11	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. I feel physically unsafe when I am with colleagues

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. I feel physically unsafe when I am with clients/patients and/or their whānau

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
13	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. The biggest source(s) of interpersonal conflict at mahi is/are:

15. The thing(s) that would improve levels of interpersonal conflict at mahi is/are:

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6. Section 3: Resources



1. I make time to do things I really enjoy

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I do things that help reconnect me to and restore my wairua

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. I have ready access to kaumātua and/or kuia to guide and support me

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. I have access to cultural advisors and/or supervisors to discuss mahi situations

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. I regularly engage in spiritual or religious practices to maintain or restore my wairua

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. I recognise when I am feeling stressed about mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Management encourages staff to make use of Employee Assistance Programs (EAP) at mahi when we need it

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. I seek advice and support from other people about mahi situations

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. I know what coping strategies work best for me when I am feeling stressed

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. When I am feeling stressed, I know things will get better in time

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
10	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. I regularly participate in activities that keep me physically active

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
11	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Management encourages staff to get regular health checks

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. I take the medication I need to maintain my health

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
13	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. The amount and kind of kai I eat keeps me physically strong and healthy

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
14	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. Management encourages staff to participate in workplace wellness programs

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
15	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. I feel more energised when I have spent time with friends or whānau

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
16	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. I can depend on whānau and/or friends to listen to and support me

Rarely or never true Occasionally true Often true Usually true True most of the time Not applicable

17

18. I feel nurtured and supported by at least one other person at mahi

Rarely or never true Occasionally true Often true Usually true True most of the time Not applicable

18

19. The professional networks I have give me confidence in my mahi knowledge, skills and abilities

Rarely or never true Occasionally true Often true Usually true True most of the time Not applicable

19

20. The Māori networks I have give me confidence in my mahi knowledge, skills and abilities

Rarely or never true Occasionally true Often true Usually true True most of the time Not applicable

20

21. The coping strategies that help me most at mahi are:

22. What I most need to learn about coping strategies is:

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7. Section 4: Outcomes



1. I feel good about myself because of the mahi I do

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I feel strong, and in control of my life at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. I feel strong in my Māori identity at mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. I am finding it harder than usual to connect to my wairua side

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. It is hard for me to find meaning in the mahi I do

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. My mahi makes me feel worried and/or depressed

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. I respond badly in mahi situations that wouldn't usually bother me

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. I am trying to find ways to avoid doing aspects of my mahi

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. The coping strategies that normally work well are not as effective these days

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. I am thinking about finding another job

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
10	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. I have aches and/or pains I can't explain

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
11	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. I am experiencing more sickness than usual

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. I have trouble falling and staying asleep

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
13	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. I have lost my appetite

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
14	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. I am drinking alcohol, and/or smoking cigarettes, and/or using drugs more because I feel stressed

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
15	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. I am having more arguments with whānau and/or friends

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
16	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. I am having more arguments with my work colleagues						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
17	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I am feeling isolated from my whānau and/or friends						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
18	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I am feeling isolated from my work colleagues						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I am feeling isolated from my professional networks						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I feel I have no control over my mahi situation						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
21	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I feel dissatisfied with my mahi						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
22	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I feel I have lost my connection to my wairua side						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
23	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I feel my mahi is a waste of time						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
24	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. The standard of my mahi has dropped						
	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
25	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
26. I have been feeling stressed recently	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. I find it difficult to motivate myself to go to mahi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. I find it difficult to concentrate at mahi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. I have reduced my effort at mahi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. I am less productive at mahi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. I have been physically unwell or in pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. I have been feeling more tired at mahi than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. I have been coming to mahi hungover	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. I have had to take stress leave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

35. The amount of mahi I can do has dropped

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
35	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

36. I am having problems with my whanau and/or friends

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
36	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37. I am having problems with management

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
37	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

38. I am having problems with my colleagues

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
38	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

39. I have been having problems with clients/patients and/or their whānau

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
39	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

40. I have been having problems with my professional networks

	Rarely or never true	Occasionally true	Often true	Usually true	True most of the time	Not applicable
40	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

41. Because of mahi, I am having the most problems with:

42. Because of mahi I feel good about:

43. What affects the amount and/or quality of my mahi most is:

44. What would help to get me back to my usual standard and amount of mahi is:

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8. Kua Mutu



Kia ora and thank you for completing Mahi Oranga.

If you would like feedback on the results of this research, you can email me at lisa.stewart@ihug.co.nz after 31 August 2010 once the results have been compiled.

Mauri ora!

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Done