How occupational therapists in Aotearoa/New Zealand have taken up ideas in the international occupational therapy literature

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Acknowledgements

Abstract

Occupational therapy literature is full of ideas and information to guide occupational therapists in how to practice and what to think about, with new ideas being layered on top of old. This exploratory study looked at how occupational therapists in a metropolitan District Health Board, in Aotearoa/New Zealand, took up ideas from international literature as a theoretical and ethical basis for the work they do.

This topic is, centrally, about knowledge transmission and application, which, in the context of occupational therapy, refers to the combination, distribution and interchange of validated information, which is then applied in a clinical setting with the aim of providing a high quality service (Tetroe, 2007). To understand the scope of the knowledge occupational therapists are expected to translate, from within the profession, I conducted a review of international English language literature published over a twenty-year period, looking for ideas that have become prominent over that period. I found that there were ideas connected to practice models, occupation and enablement, intervention strategies, assessment, communication, clinical reasoning, culture and politics. There was little discussion of how occupational therapists brought any of these ideas together to inform their practice and be able to articulate themselves to colleagues and clients their reasons for enabling and engaging clients in occupations.

The literature search revealed very little about how New Zealand occupational therapists connected with the worldwide theoretical underpinnings of the occupational therapy profession. As a result, I believed that the time was right to examine this aspect of the relationship between the development of the profession in Aotearoa/New Zealand and the information available in the wider world.

For this study, I used a qualitative descriptive methodology. I interviewed ten participants, selected by purposive sampling, who were occupational therapists of varied age and experience. The method for data collection was one-on-one, face-to-face interviews, conducted at the participants' workplaces. I used content and thematic analysis for data analysis, which yielded seven themes:

1. Sourcing ideas and ideas implicit in occupational therapy
2. Providing occupational opportunities
3. Providing enablement, justice and safety for clients
4. Use and uptake of occupational theory, tools and strategies
5. Occupation and medicine: an uneasy alliance
6. Engagement with clients and colleagues
7. Recognition of culture

The study revealed that this group of participants sourced ideas primarily from colleagues but also used courses, online sources, books and literature, which included articles. They took up ideas that were both intrinsic and extrinsic to occupational therapy as well as ideas that applied to their particular practice specialty versus broader occupational therapy concepts. They used an occupational base but also incorporated a mechanistic approach when working alongside colleagues who worked in a biomedical model. However, they were limited in take up of ideas by national and local political guidelines. Participants were strongly culturally sensitive and focused their practice to incorporate this approach.

My findings are in agreement with the literature on knowledge uptake, in that knowledge acquisition is a vital and empowering part of current practice. If clinicians are to provide effective, evidence-based interventions for their clients, there should be an emphasis on lifelong learning, opportunities in the workplace to engage in continuous learning, sharing of knowledge and application of learning in the clinical situation. Key limitations of this study were that it was small, with participants coming primarily from physical practice in one District Health Board. It is as yet unknown whether the ways these participants take up ideas aligns with what other practitioners might be doing in other situations. Additionally, due to the constraints of the study, the full impact of the local context and the cultural background of the participants were not examined. As this is an exploratory study, further research is required to investigate this area of interest more widely with participants from different practice areas, cultures and geographical areas.

Chapter One: Introduction to the Study

Introduction

This exploratory study explored the ideas and theory informing the practice of ten participants working in a publicly funded health service in Aotearoa/New Zealand. These participants were from a variety of practice settings, of various ages, with different practice experiences and had been qualified for different amounts of time. I was interested in how the ideas discussed in the international occupational therapy literature were incorporated into the participants' practice. I considered that topic to be important because there is international cross-professional agreement supporting ongoing, lifelong learning. Continuous learning is essential because of the rapid pace of new information appearing in the literature regarding the effectiveness of the modalities used in practice; practitioners need to keep up-to-date with what are the most effective and best treatments for their particular client base. However, what is known about health professional's engagement in knowledge acquisition is limited. Although there is some research on the uptake of research evidence, none of it explores how knowledge comes together, how knowledge is integrated, what is taken up, what is let go, and how new knowledge is layered on top of old. As the literature reports practice knowledge gaps and limited ability of occupational therapists to confidently engage in an evidence-based practice, I also wanted to look at the possibility of knowledge gaps in New Zealand practice. Finally, I was interested to find out whether there are any ideas used in occupational therapy practice that are unique to Aotearoa/New Zealand and conversely, if there are specific concepts those practitioners did not incorporate. Therefore, in broad terms, I was aiming to examine knowledge acquisition and uptake in the complex practice world of occupational therapists.

Using the modern definitions of *take up* as being "to gather from a number of sources", and "to accept or adopt as one's own" (Take-up, n.d.), my research question was: How do occupational therapists in Aotearoa/New Zealand take up ideas from the international literature?

The reason for this research was to identify the concepts and ideas that occupational therapists in Aotearoa/New Zealand saw as underpinning what they do. There appeared to be little or no research in the New Zealand context about how occupational therapists take up ideas, make sense of them, and transfer these to their everyday work. As a result, I saw a need for research that described what occupational therapists are committed to, and which theoretical perspectives underpin occupational therapy practice in Aotearoa/New Zealand. Without that foundation, it would appear difficult to have a professional identity based on having confidence about professional commitments, thoughtful practice and being up to date with current practice trends.

This research aimed to identify the ideas occupational therapists both value and apply, and it is axiomatic that knowledge helps them know exactly what and who they are. The importance of this knowledge lies in their need to be clear, to understand the depth of their role as health professionals, and to be confident in what they do in providing high quality, valid interventions with their clients. Clarity and confidence about what they do, and why, enables occupational therapists to maintain a professional standing, provide effective service delivery and understand their legal and professional responsibilities to their clients.

Before I interviewed the participants, I completed a literature search to identify some of the main ideas coming through the international literature. I also studied current occupational therapy and occupational science theory as well as cultural safety practices and writings on clinical reasoning. This provided a basis on which I could construct the research question and the study. I selected a qualitative descriptive approach because this method would help make sense of what participants in the study described, in relation to taking up ideas from the international literature. Analysis of the data was intended to uncover what ideas are important in shaping practice and professional identity. Currently this is a subject about which little is known (DePoy & Gitlin, 2005; Kielhofner, 2006; Patton, 2002).

My story as a researcher

I have been a qualified occupational therapist for approximately 30 years and have now practiced in three countries. I originally thought that upon completion of my occupational therapy diploma, in the United Kingdom in the early 1980s, I would know what to do as an occupational therapist for the rest of my professional life. That belief changed once I began my first job: I found that a lot of what I had learned at occupational therapy school was obsolete, particularly crafts, when I was told "we don't do that any more". I quickly realised I needed to continue learning so that my knowledge and skills were always current.

While still in the United Kingdom, together with attending short occupational therapy-specific workshops, I commenced a part-time Open University degree, to try to keep up with the ideas coming into the health sector that would also influence my occupational therapy practice. Following a move to the United States of America, this became a 13-year odyssey of distance learning, before final completion of my degree to honours level. Along the way I discovered the most useful learning was related to "Health Promotion" and "Critical Practice in Healthcare". The learning introduced me to the preventative approach in health and the fact that we, as care providers, needed to respond to changes in health delivery. I later completed a Postgraduate Diploma in Health Science and this encouraged me to examine occupational therapy knowledge and ideas at a deeper level.

My early on-going education was during the period when occupational therapists were tending to focus on the 'bottom up' approach, where the focus was on the components of 'doing'. This was particularly evident where I worked in the USA, and, no doubt, it was easier to capture intervention outcomes for the copious insurance forms that played a part in obtaining and maintaining funding for the client to remain in therapy. Towards the end of my time in the USA, Claudia Allen was publishing work (this was the late 1990s, and the idea of Occupational Science was also in its infancy) focusing on a client's "global functioning" – a top down approach – and identifying the best environment and support in which that person could perform optimally. I learned as much as I could, including attending workshops given by Claudia personally. The Allen model changed my thinking radically and still today affects how I interpret aspects of occupation, particularly related to cognition.

In 2004, I came to Aotearoa/New Zealand. Within the context of Aotearoa/New Zealand legislation, specifically the HPCAA, ("Health Practitioners Competence Assurance Act," 2003), I once again adapted my practice. Now therapists were "client-centred" – looking at what the client wanted to do, rather than what the therapist *thought* the person should do. Aotearoa/New Zealand had embraced new theory and processes from Canada called the Canadian Model of Occupational Performance (CMOP) (Townsend & Polatajko, 2007). Therapists also engaged in "supervision" because there was acknowledgement of the need for dedicated time where a clinician could meet with a professional supervisor and reflect on practice. This would enable a supervisee to review successes, identify areas of growth and look at how things might have been done better after the fact, to learn from experience. It provided a safe place to think about and discuss issues and plan what to do next. Supervision was considered a way to make sure a clinician was competent and practicing safely as well as being able to express any emotions associated with clinical decisions. With an avalanche of new concepts, I was beginning to feel that I "didn't know what I didn't know". It was time to rectify that and adapt again. I asked myself the following questions:

- How is occupational therapy practiced in Aotearoa/New Zealand?
- How do we "do" occupational therapy?
- What theoretical perspectives do we use?
- What knowledge do we need to take up?

In the end, these questions led me to my thesis question: to study how occupational therapists take up ideas in the international literature, as it touched on many of the other questions I posed to myself.

Additionally, since I found that little was known regarding this topic, I decided that an exploratory study was appropriate. This would aim to produce a descriptive account of what ideas occupational therapists take up from the literature, and how they incorporate them into practice. As it was a qualitative descriptive study, findings would be presented in the participants' own words, sourced from their natural work settings of hospital, home and community.

Underlying assumptions

From completing a literature search and from discussions with colleagues, I was able to articulate a number of personal perspectives related to my research question. Occupational therapists themselves appeared unclear about their professional identity and what it is to be an occupational therapist. Occupational therapists are natural storytellers and story-makers and they use these skills to create "their own personal myths and follow their own individual path to enlightenment" (Kelly & McFarlane, 2007, p. 196). They know what best to do in a given situation on a certain day; their clinical reasoning is complex, encompassing "motives and values and beliefs – a world of human meaning" (Mattingly, 1991a, p. 983).

In their practice, occupational therapists need to use theory as a basis of clinical practice (Wood, 2004). The literature suggested that occupational therapy is so diverse and interpreted in so many different ways that it would be difficult and likely impossible to come to agreement on its true identity, assuming one exists (Kelly & McFarlane, 2007). There is acknowledgement that practices should be different around the world in response to local community need and local culture, and that should shape occupational therapists' thinking. Other authors assert that cultural needs are a primary concern (Gray & McPherson, 2005; Watson, 2006), and this could be seen as challenging the idea of an 'ideal' practice. However, some apparently universal principles do arise: reflective practice and supervision (Herkt & Hocking, 2010) are seen as a necessary part of occupational therapy practice, and the use of occupational language is required (Wilding, 2008) in order to be occupation focused. This is not to say that there should be only a few theoretical perspectives in use by all occupational therapists; it is a question of being aware of the diversity of theoretical models and how they can be used to benefit the profession and the work undertaken with clients.

I believed there was a strong connection between what occupational therapists perceived they did and what knowledge they felt they needed to search for and take up. I felt a good knowledge base would help increase confidence in practice because it would help individual occupational therapists to understand and articulate the conceptual basis of what they do. In turn, it could probably be assumed that both professional colleagues and clients would respect the value and

role of occupational therapists as a profession, if occupational therapists were recognised as having and using a sound knowledge base for the practice interventions. I wanted to hear what occupational therapists identified as the conceptual freedoms and constraints influencing their practice and whether they could describe their vision for the future path of the profession. I was interested in what occupational therapists said about how ideas influenced them and how worldwide literature contributed to how they saw themselves. Additionally, I wanted to identify what themes in the literature the participants took up and whether there were some ideas that did not appear to be relevant to occupational therapists in Aotearoa/New Zealand.

Intent of study

Ideally, I wanted to conduct this research within a District Health Board (DHB), so that the resulting themes could be used to provide a framework and support for professional development programmes available to occupational therapists working within that organisation. I hoped the findings would help identify what ideas and knowledge were being used and also where continuing professional development could be initiated to support therapists to become more informed in areas identified as important, but where less was understood about the subject. I felt that the results of the study might then be used in a positive way to create a strong feeling of identity and confidence amongst the occupational therapists at the DHB level. My overall aim was to empower the occupational therapists to be able to articulate clearly, to their colleagues and their clients, what they did and why. Articulation of what occupational therapists do by occupational therapists themselves has been observed to be a common issue with occupational therapists around the world (Wilding, 2008). To this end, all the participants were recruited from one DHB.

Context of the study

Occupational therapy is a regulated health profession in Aotearoa/New Zealand, under the Health Practitioners Competence Assurance Act (HPCAA), 2003. This legislation made provision for the establishment of the Occupational Therapy Board of New Zealand (OTBNZ), which prescribes the scope of practice and demands evidence of ongoing professional development to maintain competence. Within the Aotearoa/New Zealand health and disability services, there are government strategies and policies, District Health Board guidelines, referral processes and financial constraints that influence what occupational therapists actually do. The New Zealand Health framework comprises of a mixed model of care. Firstly, there is government-funded healthcare provided locally by DHBs. These provide non-accidental healthcare, including care for long-term chronic conditions, elective surgery, palliative care,

mental health and forensic care. Secondly, running in parallel to the DHBs, is the Accident Compensation Corporation (ACC), which is an insurance based, no fault, comprehensive provision for accidents, provided for both New Zealand residents and overseas visitors. Finally, there is private healthcare available, so Aotearoa/New Zealand residents do have choices if they do not wish to access public funded healthcare. Occupational therapists work under the umbrella of both organisations as well as in the private arena in Aotearoa/New Zealand. However, this study is focused on occupational therapists working within a DHB.

The profession's texts and journals reveal that there is little research based in the Aotearoa/New Zealand context about the link between what occupational therapists do in their everyday work and the key 'universal' ideas that were promoted in the literature, from which the following is a sample:

- Acknowledging occupation as the core of practice (Schmid, 2004; Watson, 2006).
- Engaging in clinical reasoning (Heyes Fleming, 1991; Mattingly, 1991a, 1991b).
- Reflective practice and use of supervision (Herkt & Hocking, 2010; Wood, 2004).
- Flexible, culturally responsive and pluralistic approach to practice (Mackey, 2007; Thomas, 2009; Wright & Rowe, 2005).
- Use of occupational language (Wilding, 2008).

In this exploratory study, participating occupational therapists were given the opportunity to talk about the ideas they used to inform their everyday practice. This provided me with data so that I could come to an initial understanding about the ideas behind practice. I was then able to describe emerging themes related to the ideas that the participants identified from the international literature that influenced their practice. I believe that this study has provided a platform for future research, which could look at how occupational therapists take up all these ideas and combine them into a coherent whole, in spite of the tensions and stresses imposed by the environments in which they work.

Overview of the thesis

In this chapter, I have summarized the emphasis and the context of this study, which is to look at how occupational therapists in Aotearoa/New Zealand have taken up ideas in the international literature. I have described why this study is of interest to me and my belief that its larger purpose is to inform occupational therapists in New Zealand about the ideas from the literature that appear to be important to a group of participants working in the health service.

Chapter two reviews the literature relevant to the research question and provides the rationale for the study. Several ideas are prominent in the international literature and their origin and

underlying assumptions, models and frameworks are described. Additionally, there is some discussion regarding the literature associated with knowledge acquisition and the relationship to occupational therapy practice.

In chapter three, I discuss the methodology of the study, for which I selected a qualitative descriptive approach, and justify why this was an appropriate choice. This chapter also details how the study was conducted, including how the participants were recruited and selected, the ethical considerations, the techniques I used to analyze the data and the strategies I put in place to ensure the rigor of the study.

In chapters four and five, I present the themes, distilled from the data provided by the participants. Consistent with the international literature, I have used the word "client" when I refer to consumers, and where "patient" or "whairora"[1] are used. This reflects the particular preference of the participants when I have quoted them.

Finally, chapter six summarizes the findings of the study and compares them to the ideas uncovered in the initial literature search. The limitations of the study are discussed, implications both locally and nationally are considered and recommendations identified, based upon the findings.

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[1] [Tangata] *whaiora*: literally [people] in search of wellness

Chapter Two: Review of the Literature

Introduction

My question is "How have occupational therapists taken up ideas in the international literature?" This study originated because a search of both international and New Zealand literature revealed no articles specifically discussing what ideas occupational therapy clinicians actually take up and use in their practice. This lack of literature is substantiated by Colquhoun, Letts, Law, MacDermid and Missiuna (2010), who commented that in a review of articles addressing knowledge transmission and application strategies, none of the studies looked at occupational therapy and how occupational therapists took up theory, and applied it to practice. Their conclusion was that there needed to be further investigation to identify what would be the best theories for occupational therapists with regard to knowledge transmission and application (Colquhoun, Letts, Law, MacDermid, & Missiuna, 2010).

Knowledge acquisition, translation and application

My research topic looks at the importance of taking up new knowledge, defined as: "the theoretical or practical understanding of subject" (Knowledge, n.d.). Since ideas come from knowledge, it is also appropriate to review the understanding of what knowledge is, how knowledge is acquired and how it is transitioned appropriately into everyday practice. There is a wide range of terminology around "knowledge", which I have summarised in Table 1:

Table 1. Terms relating to knowledge

Term	Definition
Knowledge	Facts, information, and skills acquired through experience or education; the theoretical or practical understanding of a subject (Knowledge, n.d.)
Knowledge creation	Formation of new ideas through interactions between explicit and tacit knowledge in individual human minds
Fragmented knowledge	"…the notion that knowledge is a growing collection of substantiated facts or "nuggets of truth" (Pope, 1982, p. 5).
Knowledge acquisition	Knowledge obtained from resources which are external to an organization
Knowledge translation	"A dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve [and] provide more effective health services and products and strengthen the healthcare system" (Tetroe, 2007, p. 1).
Knowledge transmission	"The process through which [an] …individual, group, department, division… learns from the experience of others. Thus, they can learn not only directly from their own experience, but also indirectly from the experience of others" (Argote, Ingram, Levine, & Moreland, 2000, p. 3).
Knowledge application	"Use [of] a concept in a new situation or unprompted use of an abstraction. Applies what was learned in the classroom into novel situations in the work place" (Clark, 2004)
Knowledge gap	"…differentials in information acquired and retained by people through a learning process" (Gaziano, 1997, p. 238).
Theory-practice gap	The differential between practice knowledge and theoretical knowledge (Hall, 2005).

Continuous lifelong learning (and the implied practical understanding) is an expectation of many professions, and is included in occupational therapy competency and registration requirements in many countries. It is needed so that clinicians can "practice effectively in their evolving environment" (Guillemin, McDougall, & Gillam, 2009, p. 197). Therefore, knowledge acquisition is vital. More recent research has looked at aspects of continuing professional development, and concluded that for the individual, there were often both personal motivational and ethical aspects connected to participation in lifelong learning (Haywood, Pain, Ryan, & Adams, 2012). However, it was stressed that workplaces should encourage learning by requiring evidence-based policies and professional development requirements to be built into clinical governance frameworks. The workplace is now seen as one of collaboration, fulfilling both service and personal goals by recognising and valuing those employees who were motivated to engage in professional development, so there was also a need for support of both managers and colleagues when undertaking learning (Haywood et al., 2012). These goals would be achieved by providing funding, study leave, career progression, mentoring, protected time and clinical backfill, to enable setting and completing learning objectives. Haywood et al. (2012) also

discussed the formation of small study groups and face to face evidence-based learning. Other literature has emphasised "attending courses, …conferences" (Applegarth, Dwyer, Moxham, & Happell, 2012, p. 1741) "reading journals and books" (p. 1741), accessing "printed materials" (DiMauro, 2000, p. 60) and belonging to "professional organisations" (DiMauro, 2000, p. 62).

On the other hand, Sherratt (2005) suggested that occupational therapists were not going to the literature to inform their practice, although evidence-based practice had been promoted in articles and was an expectation of clinical governance guidelines. To bridge this theory-practice gap, he suggested the use of journal clubs as a means to encourage practitioners to access the literature. He also argued that they were useful because they were a way of initiating discussion about what ideas are effective in practice and how services could be improved. He also indicated journal clubs are a way for clinicians to learn how to critique literature and to be in touch with current research findings (Sherratt, 2005).

Other methods by which knowledge is acquired stressed the importance of contextual knowledge and skills, which are "…dynamic and changing over time" (Applegarth et al., 2012, p. 1741) and are often learned while working or via professional development opportunities. Some authors suggested ways of taking up knowledge could be by "buddying", "observing", "questioning", (Applegarth et al, 2012, p. 1742), and via interpersonal networks (DiMauro, 2000). In other words, knowledge was also picked up experientially on the job from colleagues as well as through the literature. This informal type of education is where "people deliberately inform, persuade, tell, influence, advise and instruct" (Jannings & Armitage, 2001, p. 55), and is often unplanned and spur-of-the-moment. Another way of learning is online, and a more recent article has mentioned online blogging and use of internet to provide courses (Haywood et al., 2012). Alternatively, an Enterprise Information Portal (EIP) has been suggested as another way of obtaining "depth and breadth of knowledge" (Ryu, Kim, Chaudhury, & Rao, 2005, p. 245). The idea behind this computerised system seems to echo other literature; to learn skills specifically for the gathering of knowledge; to then take up ideas to expand one's own knowledge base, then, finally, to share knowledge with others. Finally, although practitioners clearly wanted to participate in acquisition of knowledge, focussing on "evidence-based practice" to provide "clinical effectiveness" (Upton & Upton, 2006, p. 127), there were many barriers preventing occupational therapists from engaging in learning such as "lack of time, research skills, training and funding" (p. 127).

Concepts that go alongside how occupational therapists take up ideas in the international literature and knowledge acquisition are the processes of knowledge translation, transmission and application. In the health professions context, knowledge translation may be defined as:

"Any process that contributes to the effective and timely incorporation of evidenced-based information into the practices of health professionals in such a way as to effect optimal healthcare outcomes and maximize the potential of the health care system"

(Lang, Wyer, & Eskin, 2007, p. 915)

The authors suggested that knowledge translation should be used as a way to position the value of robust evidence in healthcare and academic organisations. It should be collaborative, multidisciplinary, evidence-based and form part of healthcare and clinical practice policy, being reflected in outcome measures. However, this process of "putting knowledge into action" (Straus, Tetroe, & Graham, 2011, p. 6) appears challenging to implement across all healthcare arenas and requires changes of policy and practice. Knowledge transmission and application is complex and there are several models aimed at describing the steps required to progress from knowledge creation to knowledge in action. One such model is the knowledge to action cycle (Graham & Tetroe, 2007), which looks at how knowledge is created, identified, reviewed, selected, adapted, monitored and evaluated and sustained. There is also recognition that there are gaps in knowledge bases and that these will need to be addressed before such a model is utilised, because it may affect what is taken up, as well as there being a monetary cost to implementing the model.

The term "knowledge application" (Berta et al., 2010, p. 1326) has been used to describe the method used to put knowledge translation and transmission into practice, with a recommendation in the literature that both organisational and clinical leaders should be involved in implementing its development in the workplace (Berta et al., 2010). Similarly, another study recommended that by participating in research, occupational therapists could help to decrease the knowledge-practice gap (Finlayson, Shevil, Mathiowetz, & Matuska, 2005). Another concept linked with knowledge translation and application is known as the learning-knowledge gap. It may be defined as "between what is known from high-quality clinical research and what is consistently done in clinical practice" (Lang et al., 2007, p. 915). New graduates have reported specific knowledge-practice gaps in the area of knowing "how to be" an occupational therapist (L. Robertson & Griffiths, 2009), and to remedy this, graduates should have access to role models, supervision and learn how to "reconstruct" (p. 131) knowledge.

For seasoned practitioners and new graduates alike, evidence-based practice is currently promoted as the best way to provide clients with high quality treatment. To be evidence-based means that practitioners need to have the knowledge and skills to critically review literature and make a decision as to whether the findings support their intended modalities as being effective interventions for the client concerned. The literature indicated concerns that there was a possible learning knowledge gap with respect to occupational therapists, particularly their understanding

and knowledge of how to be evidence-based. Recent authors have recommended that there should be opportunities for practitioners to empower themselves by working together in groups to look at and reflect on research and theory and relate it to practice settings (Welch & Dawson, 2006). To find out how a group of occupational therapists rated their skills in evidenced-based practice, McCluskey (2008) conducted a survey of Australian occupational therapists. The study revealed that of 67 respondents, half appraised themselves as having insufficient knowledge and skills to be able to conduct an effective, critical evidence-based inquiry. She discovered that the participants believed they had limited skills in conducting database searches and critically appraising literature as well as little knowledge of electronic databases (McCluskey, 2008). Encouragingly, an even more recent study implied that although the participants similarly indicated a limited knowledge of using evidence in their practice, and identified barriers in their work environments, they actually were interested in and wanted to be evidence-based and tried in a limited way to be so (Lyons, Casey, Brown, Tseng, & McDonald, 2010).

Finally, there have been concerns that occupational therapists have not been using occupation-based models as a basis for their clinical practice, and worse still, using impairment-based assessments and interventions (Kielhofner, 2005). Additionally, it appeared that they did not see the need for theory to underpin practice. However, Kielhofner discussed the idea of "engaged scholarship", which is an initiative to "discover new ways of addressing and solving everyday life problems of people and society" (Kielhofner, 2005, p. 233). He argued that one of the major concepts associated with engaged scholarship is to review how knowledge is created. He recommended a collaborative approach between researchers and clinicians so that "the knowledge we generate needs to add not only to what we know, but also to what we know how to do" (p. 238).

The link between theory and practice
Within the occupational therapy literature, a study reported that occupational therapists "… rely more on their clinical experience, colleagues and informal continuing education experiences to guide their practice as opposed to using research evidence" (Menon, Korner-Bitensky, Kastner, McKibbon, & Straus, 2009, p. 1030). In order to understand people as occupational beings, recent international literature has questioned and reworked occupational therapy beliefs and assumptions, as well as models and frameworks of practice. The literature has linked theoretical perspectives with practice, and addressed how occupational therapists should be conducting their practice using these underlying theoretical principles. It would follow that, in order for occupational therapists to practice safely and ethically and within their scope of practice, it is necessary to have a sound body of knowledge and a theoretical basis on which to ground the work they do with their clients, however the evidence cited above suggests that occupational

therapists may not be taking up ideas in the literature as it is suggested they should. One link between theory and practice appears to be the ability to engage in clinical reasoning.

To illustrate this link between theory, reasoning and practice, I have assembled Table 2 with specific application to occupational therapy, adapted from a flow chart published by Johnson and Webber (2001) which originally described the inter-relationships among theory, reasoning and nursing practice (Johnson & Webber, 2001, pp. xxii-xxiii):

Table 2. Link between theory and reasoning and application in OT practice

Purpose of theory	Components of theory	Types of theory used in occupational therapy	Reasoning/ ways of thinking	Uses of theory in practice when clinical reasoning is applied	Overall goal of theory when applied in the clinical situation
Answer questions; Solve problems; Understand, describe and explain phenomena	Established knowledge: theory, facts, principles, laws	OT theory: Frameworks Beliefs Models (Turpin & Iwama, 2011; Kielhofner, 2004; McColl, Law, Stewart, Doubt, Pollock, & Krupa, 2003)	Types of reasoning: Theoretical Scientific Clinical Procedural Interactive Conditional Narrative (Mattingly 1991a; Heyes Fleming, 1991; Sinclair, 2007)	Control Influence Predict Explain Understand Relate Identify	Improved healthcare and quality of life for clients
	Speculative theory: hypotheses, propositions, concepts and ideas examined by research	Theory taken up from sources outside OT; e.g. from other professions such as client-centeredness	Application of reasoning in critique and selection of theory; Creation of an OT language (Wilding 2008); Understanding tacit knowledge (Mattingly 1991a)		

This table illustrates the importance of clinical reasoning because it connects theoretical ideas with occupational therapy practice. As can be seen, the table commences with the purpose of theory then discriminates between established and speculative theory. It moves on to identify theory specific to occupational therapy and acknowledges that theory is taken up from sources outside occupational therapy. The table then lists some types of reasoning occupational therapists use to connect their theoretical knowledge to practice and why reasoning is an important process within practice, such as being able to consider clinical issues on several levels, depending on the reasoning processes utilised, to be able to critique and select theory suitable to the current practice situation and to be able to select appropriate language to communicate intervention recommendations to clients and colleagues. Clinical reasoning is the way both

theoretical and tacit knowledge (practical knowledge shared from clinician to clinician (Heyes Fleming, 1994) is synthesised and selectively applied in clinical situations. This suggests that clinical reasoning is an important conduit in the take up of ideas from occupational therapy literature and therefore a crucial component of knowledge transmission and application. Finally, the overall goal is to provide a high standard of care to clients.

As occupational therapy is a relatively young profession compared with other science-based disciplines, research into occupational therapy practice at this time could be regarded as comparatively limited in scope. This situation is slowly changing, and there is today a body of literature from which ideas can be sourced. However, if there are no studies to indicate what is of interest to practitioners, neither the profession's clinicians nor its academics know what ideas have actually made their way into mainstream practice, if there are knowledge gaps and what methods are used by clinicians to access the ideas.

To gain an overview of what ideas are in the international literature, I conducted a literature review to develop a more in-depth knowledge basis for my question, and to provide some direction to the study. It was also important to know if there were ideas that had not been taken up, leading to a knowledge gap. The review aimed to survey the *breadth* of ideas that have been presented in the literature, rather than to critically review the research behind those ideas or how sound the theory might be. Additionally, there have been many authors who have researched certain areas and addressed the range of theories informing the profession, so I have selected the most prominent or most frequently cited to give a sense of the broader literature. The authors Mattingly, Heyes Fleming and Kielhofner, whose work is cited later in this chapter, are good examples of this selection: they are both prolific and frequently cited.

From the literature review, I was able to identify a list of twelve key ideas:
- Occupational therapy basic assumptions and beliefs
- Practice models
- How theory changes
- Occupation and enablement
- Occupational strategies
- Assessment, including standardised vs. non-standardised assessments
- Client-centred practice and communicating with clients
- Communication with colleagues
- Clinical reasoning and its complexities
- Culture
- Creativity
- Politics

As my area of specialty is in physical health, the literature I selected tended to be biased towards that field of practice although much of the literature cited can be equally applied to occupational therapy in general.

Searching for the ideas informing practice

I conducted an initial wide literature search in 2011. It covered the Medline, Proquest, Scopus, Psych Info, and Web of Science databases, using a combination of the search terms *occupational therapist, nature, culture, acute, reasoning, Clare Hocking, Clare Wilding* and *Mattingly, creativity.* I hand searched on-line occupational therapy journals by going through the contents lists and printing out articles that looked like they might inform my question, from the years 2006-2011. They were the American, Australian, Canadian and British Journals of Occupational Therapy, as well as sourcing articles from the New Zealand Journal of Occupational Therapy. My supervisor, Clare Hocking, supplied one pre-press chapter she had written for a book, and the professional leader at my DHB sourced some other articles she felt would be useful for me to read. I searched the AUT library for specific papers not on-line and used my personal library of articles and book publications gathered over thirty years as an occupational therapist.

I subsequently made a more specific search using the AUT and EBSCO, CINAHL and Medline health databases, with keywords *occupational therapy* and *knowing* plus *Hocking, Clare*, on 10th May 2012, using the date range 2002-2012. I made another search iteration in the range 2008-2013 on 28th March 2013, using the same databases and using the key words that had emerged over the previous months of review and participant interviews: *storytelling; clinical reasoning; occupational therapy assessment; cultural safety; occupation; creativity; politics; communication* and *client-centred*. On 1st June 2013, I conducted a final search with the same databases, but using the words: *practice, knowledge, gap* and *occupational therapist.*

The literature search, while providing me with a great deal of information, did not entirely answer my research question because it did not tell me what ideas therapists in Aotearoa/New Zealand were taking up or how they put together all the different ideas being discussed in the professional literature.

Examining the key ideas

Occupational therapy basic assumptions

In examining the literature, I found that in its short life, occupational therapy practice has transitioned through several stages of development where, at the same time, the core *beliefs*, defined as "an acceptance that something … is true" (Belief, n.d.), have been modified to fit

with the paradigm of the period. By reviewing literature as far back as 1976 from prominent writers in the field of occupational therapy, the initial recognition of a link between health and "daily activities" was seen to develop into the concept of "mind, body, environment and engagement in occupation" and then changed to a focus on impairments and biomechanical issues (Turpin & Iwama, 2011). Finally, there was a call for a return to recognizing occupation as the central concept of occupational therapy theory and distancing the profession from the biomedical model, as it is focused on impairments (Kielhofner, 2002) rather than a holistic approach to health. Occupation, it is believed, is what makes occupational therapy practice unique. However, many practitioners still work alongside colleagues who use the biomedical model and sometimes find themselves working within it, because of the particular environment in which they work, such as a large acute teaching hospital. This biomedical model is based on the beliefs that to be healthy, a person should be free of disease, pain and any other physical defects. The body is likened to a machine and so therefore can be repaired (Taylor & Field, 2003). The biomedical model breaks the whole down into components. It does not take into consideration the effect of any external factors or the position of the whole person, and treatment is "done to" them, rather than taking a partnership stance.

In contrast, occupational therapy has based its practice on much wider assumptions. According to Kielhofner (2004), there were four early guiding principles of occupational therapy which, apart from a period in the 1930s – mid 1960s, when a more mechanistic, biomedical approach was taken up, have come through to the present day (Kielhofner, 2004):

- Occupation is essential to human life and affects health
- There must be a balance between all aspects of occupation
- There is a link between mind and body
- Occupation can be used as a means to restore health and not being occupied is unhealthy

This concept of occupation as the centre of what occupational therapists do is supported strongly in the literature. Hooper, (2006), asserted that we can now revisit these assumptions and with abstract thinking and the use of reflection, examine both their validity and how we know they are valid (Hooper, 2006). In fact, the idea that occupation is fundamental to health has been revisited and confirmed by Townsend and Polatajko (2007) who stated unequivocally: "Occupation is an important determinant of health, well-being, and justice" (Townsend & Polatajko, 2007, p. 3). Additionally, Stav, Hallenen, Lane and Arbesman (2012) substantiated this statement in their research paper when they said "the results … support occupational therapy's historical ideologies and core philosophies linking occupational engagement to improved health and well-being" (p. 301).

What is troubling, though, is the claim that "occupational therapists…do not understand the construct [of occupation] and do not address the occupational needs of their clients" (Molineaux, 2004, p. 5). He suggested that occupational therapists can take the role of "gap fillers" (p. 6) due to role blurring and that there is still a reliance on the biomedical, mechanistic approach to providing occupational therapy interventions. However, Molineaux does end on a hopeful note that there is growing evidence supporting the link between occupation and health and advises occupational therapists to "remember where you are coming from" and "start where you mean to finish" (p. 11). The literature, therefore, strongly supports the idea of occupation as the core of practice, but there are concerns about whether this is understood and practiced by all occupational therapists.

Occupational therapy practice models

Moving on to occupational therapy models, the same occupational beliefs filter through to inform occupational theory, based on the understanding of the connection between occupation and health. Additionally, some theory has been taken from other professions (e.g. psychology), and has been combined to guide occupational therapists more generally in their practice. This has generated a variety of conceptual practice models that occupational therapists are thought to use. Kielhofner identified seven conceptual models commonly used by occupational therapists that in his opinion, were based on theory, research and application (Kielhofner, 2004):

1. Biomechanical Model (biomedical theory)
2. Canadian Model of Occupational Performance (CMOP) (occupational therapy-based)
3. Cognitive Disabilities Model (occupational therapy: adapted from psychological theory)
4. Cognitive-Perceptual Model (psychology models)
5. Model of Human Occupation. (MOHO) (occupational therapy)
6. Motor Control Model (biomedical)
7. Sensory Integration Model (occupational therapy: adapted from psychology).

At about the same time as Kielhofner was writing, another publication was released, from occupational scientists in Canada, described as the "The Taxonomy of Occupational Therapy" (McColl et al., 2003). Once again, the idea that occupation is central to the profession was emphasised. The authors suggested the reason to have theory is to "understand humans and their occupations" and "be able to predict and change human functioning and occupational performance" (McColl et al., 2003, p. 13). Their beliefs supported Kielhofner's stance on occupation as they wrote that occupation applies to all humans and is fundamental to health, that it changes according to individual need and that occupation can be used as a therapeutic medium. When McColl et al. talked about occupational theory, they imagined a toolbox from which appropriate tools (theories) were taken as needed. Their taxonomy identified model categories within a toolbox as:

- Conceptual – thinking about and understanding experiences
- Practice – provision of interventions that make a difference
- Occupation – related specifically to what people do and engage in
- Basic theory – people and their natural world.

The models were then further subdivided into categories related to person (physical, psychological-emotional, cognitive-neurological, sociocultural) and environment. Together this formed the taxonomy of occupational therapy. As this taxonomy indicated, models were diverse, numerous and covered a range of issues occupational therapists were likely to encounter. In addition to the taxonomy, occupational language was clarified and used when referring to occupational theory. The taxonomy suggested that for occupational therapists, no single model would be sufficient to provide what was needed, and the literature indicated that practitioners tended to use a number of them at one time (Ikiugu, Smallfield, & Condit, 2009). What was required, however, was that therapists needed to reflect on what models they were using so they were able to express *why* they were doing what they were doing. One way this could be structured was a framework whereby a primary model chosen by the therapist and client became the 'Organizing Model of Practice (OMP)' (Ikiugu et al., 2009, p. 169), and the 'Complimentary Models of Practice (CMP)' could then be slotted in to the main model. CMPs help guide specific assessment and intervention related to client issues.

Models help the therapist bring balance and process to the way of working with a client. For instance, the CMOP-E is a generic model and can be used with all clients and in many situations (Townsend & Polatajko, 2007). It could be used as the OMP on which to hang other selected models (Ikiugu et al., 2009). The CMOP Occupational Performance Process Model guides the therapist stage by stage through the process of intervention, automatically including an occupation focused, research-based, client-centred approach. It allows CMP to be included in the early stages of treatment planning that deal with specific areas of concern, such as the Cognitive Disabilities Model. I have developed the table below based on the work of Ikiugu et al (2009, p.165) to show this more clearly. Table 3 shows how the OMP and CMP, when applied together, enable a treatment plan to be constructed that will connect a person's overarching occupational goal with interventions best suited to reach that goal.

Table 3. Simple example of how models could fit together

Model Type	Model heirarchy	Example of applied model(s)
Organising model of practice (OMP)	Primary overarching perspective: The person as an occupational being	CMOP framework to organise the clinician's actions (physical, affective, motor)
Complimentary models of practice (CMP)	Secondary models hung on OMP as required to address specific concerns Such as: Cognition Motor abilities	Cognitive disabilities model Neurodevelopmental models

Application of models	Findings	Outcome objectives
OMP	**What the person wants to be able to achieve in his/her environment**	To be able to participate fully in occupations at home
CMP	Cognitive issues	Identify best environmental situation for person to be able to perform occupational tasks at cognitive level
	Physical issues	Practice occupational tasks selected by client that promote particular motor movements

One problem, however, is that western models have been challenged because an alternative train of thought suggests that they don't sit well with all cultural perspectives. A supporting argument is that there is focus on individuals rather than population health (Turpin & Iwama, 2011). Population health focuses on the issues that affect the health of groups of people, rather than individuals. Additionally, Turpin and Iwama pointed out that non-western cultures tend to think collectively rather than individually, therefore there should be an emphasis placed on models recognising that different groups have different health needs due to their socioeconomic status, environment, nutrition, living and work conditions.

In occupational therapy models, although there is awareness of culture, there is only one non-western model, the Kawa River Model (Iwama, 2006), that was explicitly developed from an Eastern perspective. Although initially there appeared to be a lot of excitement about the concept, there have been few additional studies or references to substantiate the value of the model. Nevertheless, Maori occupational therapists have used Iwama's work to validate their framework in terms of being responsive to Maori from an occupational therapy perspective with respect to service provision and workforce development. The framework is described in the document, Te Umanga Whakaora (Te Rau Matatini, 2009).

Updating and changing theory

Already, it can be seen that history has demonstrated the need for theories to be flexible enough to change over time as research and new ideas expanded what we know. Kielhofner (2004) agreed that models are (and should be) subject to change with new research findings. He also argued that new models could be formulated, while others may fade away, and thus implying

that occupational therapists needed to make sure they keep updated with changing occupational therapy theory (Kielhofner, 2004). How models change is shown by the CMOP, recently updated as the Canadian Model of Occupational Performance and Engagement (CMOP-E). The updated version aims to change the focus of Occupational Therapy from "therapeutic use of activity" to "… enabling all people to be engaged in meaningful occupation and to participate as fully as possible in society" (Townsend & Polatajko, 2007, p. 2). It remains a generic organising model of practice (OMP).

The second example is the Cognitive Disabilities Model, a complimentary model of practice (CMP), which has gained currency in the US, but at the same time is under continuous refinement. This model looks globally at the effects of cognitive impairment and the optimal environment for the person to perform their occupations (Allen et al., 2007). The model was originally aligned with the 1980 International Classification of Impairments, Disabilities and Handicaps (ICIDH), (World Health Organization, 1980), but was updated to encompass the 2001 International Classification of Functioning, Disability and Health (ICF), (World Health Organization, 2001). Perhaps reflecting a societal change over the previous two decades, alignment with the ICF shifted the emphasis from focusing on disease and resulting disability to describing levels of health and participation (Stewart, 2002), with emphasis on how a person is able to perform an activity within an environment. The associated assessments have been updated, the most recent being the Allen Cognitive Level Screen–5, to provide more accuracy.

A third example that illustrates continual refinement is the Perceive: Recall: Plan: Perform (PRPP) system of task analysis, associated with the Occupational Performance Model developed in Australia (Chapparo & Ranka, 1997). This instrument required several phases of development. It has several different options of application and can also provide outcome measures. In considering just these three occupational therapy specific models and their related assessments as examples, there seems to be a need for mechanisms to track changes in the literature base so that practitioners can keep up to date with both the theory behind and the application of ideas.

Continuing with this theme of changing theory over time, from the stance of knowledge transmission, it would be useful to understand how and why occupational theories are changed or how new knowledge is layered upon old. A review of the literature suggested there is little known about knowledge transmission with respect to occupational therapy and that key barriers to knowledge transmission in this profession are yet to be identified. On an individual basis, though, knowledge transmission may involve consideration of not only the work environment but also the practitioner's own learning styles and characteristics (Menon et al., 2009).

A recent approach to looking at models, that appeared to be building on established occupational beliefs, is the notion of "facilitating context dependent participation through occupation" (Turpin & Iwama, 2011, p. 2). The authors explained this concept by recognising the established idea that the person's environment plays a part in what he/she does and that taking part in things a person wants to do in his/her environment is important. They also recognised that sometimes participation is not possible for various reasons. They addressed the cultural aspects and acknowledged that many occupational therapy models were from a Western perspective and were primarily biopsychosocial from a theoretical stance, except the aforementioned Kawa Model. What is different, though, is that Turpin and Iwama placed many of the well known models in the continuum of time and explained that emphasis has traditionally been placed on individuals rather than populations.

Population health is an emerging way of looking at health.The CMOP-E explicitly defines populations as part of its focus (Townsend & Polatajko, 2007). This idea of looking at a population's environment and how it affects participation does not appear to have been widely written about within occupational therapy until then, but was addressed previously by Wilcock and Hocking (2004). They argued that a population perspective would enhance the link between occupation and health and that health promotion and public health planning would ensure that barriers to participating in occupation would be broken down and people could then participate in occupations within their environments, thus promoting health through occupational justice (Wilcock & Hocking, 2004). As this is a fairly recent concept, and the literature from occupational therapy is not abundant, it may be an idea that has yet to be fully taken up.

Occupation and enablement – a focus on 'doing'

The return of the focus on occupation and enablement was historically a significant change in direction for the occupational therapy profession. Perhaps one of the most important reasons for an occupational focus and having goals related to enabling participation in occupation is that by identifying the occupations and interests of clients, the clients are turned into real people and they are protected from the depersonalization that can occur in hospitals and care facilities. It is too easy to think of people "in terms of their diagnosis" (C. Robertson & Finlay, 2007, p. 74).

Historically, occupational therapy has transitioned through several stages of development. Originally, the discipline was occupation-based, but later went through a period of mechanistic practice, where interventions were bottom up and component driven (Kielhofner, 2004). However, there was a drive to return to occupational therapy's roots, so more recently, the international literature, led by both occupational therapists and occupational scientists, informed occupational therapists of ways to incorporate occupation and enablement into practice and take

a top down approach to their assessments and interventions (Hocking, 2009; Kielhofner, 2004; McColl et al., 2003; Polatajko, Craik, Davis, & Townsend, 2007). Prolific literature was produced from Canadian researchers and theorists which eventually developed into the Canadian Model of Occupational Performance (CMOP). Over time the model has been refined and expanded and seems to be a major influence for occupational therapy internationally. For instance, in New Zealand, I have discovered from working with occupational therapy students that the occupational therapy educational programmes promote the use of the Canadian Model of Occupational Performance (CMOP) as a theoretical underpinning for practice. However, there are other frameworks such as the Model of Human Occupation (MOHO), the American Occupational Therapy Framework (AOTF) and the Occupational Performance Model, Australia (OPMA) which are also occupation focused and promote enablement. They each have different components in their frameworks to achieve that. For instance, the International Classification of Functioning (ICF) was incorporated into the AOTF 2nd Edition, and the OPMA clearly recognises the link between occupation and the components of occupation, such as cognition, sensorimotor and biomechanical. The MOHO is well established, with a large body of research and continuous refinement over thirty years.

Occupational strategies

Recent authors have identified five therapeutic strategies occupational therapists use during occupational interventions (Price & Miner, 2007):

1. Grading an intervention so that it is at the right level for the person to be able to engage in at the time, through activity analysis.

2. Cognitive strategies, such as verbal prompts to step through a process, so the client can learn what might be learned intuitively from other people or giving choices to the client so there is involvement in the decision-making.

3. Doing an intervention together. This could promote practicing something the client is nervous about doing.

4. Use of strategies to communicate the therapist's confidence in the client's ability, such as verbal and non-verbal positive reinforcement and physical intervention to encourage the client to persevere with their attempt to perform an occupation if they showed signs of stopping.

5. Use of narrative in guiding the client to or away from the goal. This can take many forms such as storytelling and story making, praising or even ignoring.

Price and Milner (2007) also argued that it is important for therapists to take stock and acknowledge these processes in the course of occupational treatment interventions because

these strategies show that initiating "doing" with a client is a complex undertaking. Through the use of strategies, the therapist is able to enable the client to participate in occupations within their personal social worlds. I looked for further literature that would give more insight into the effectiveness of strategies and whether it was actually the strategies that produced a favourable result from an intervention, but was unable to locate any literature. So it would seem that strategies are more beliefs based on practice experience than researched ideas. Interestingly, both the Allen Cognitive Disabilities Model and the Perceive: Recall: Plan and Perform System (PRPP), (Chapparo & Ranka, 1996), have used the concept of activity analysis in their assessments, which may be an indication that belief and trust in these strategies is deeply ingrained in the profession.

Assessment

The literature search suggested that assessment forms a large part of what occupational therapists actually do, and I wanted to know what ideas were informing what is done when performing assessments. Assessment involves collecting information, analysing it and coming to a conclusion, and an occupational therapist is generally concerned with assessment of the level of the client's abilities to engage in occupations. Again, historically, like theory, occupational therapists have placed different emphasis on the processes they use to carry out their assessments. During the mechanistic period, components of tasks were of primary interest, but the current trend for assessment is to reason and assess from the top down, that is to say, looking at a person's occupational performance as a whole or globally, rather than investigating the components of a performance, as a bottom up assessment (Hocking, 2009).

Once the initial assessment is completed and goals set, therapists are then able to use the information to plan appropriate interventions with the client, aiming at working towards the client goals. Hocking (2009) also asserted that assessment must include getting to know the client, looking at occupations of specific interest to the client and to consider the environment in which the occupations are going to be performed. She emphasized the importance of cultural factors on a person's performance and stressed the need to be client-focused, evidence-based and to practice ethically.

Some recent research also contends that it can be challenging to "choose the right assessment for the right purpose" and that "a broad range of assessment tools is required" (Eliasson, 2012, p. 22). Occupational therapists do have many choices for their individual 'tool box' of assessments, and therapists can also use non-standardised assessment that is often in the form of observing and reporting what a person can do when performing an occupation. These tend to be used when personal activities of daily living and household occupations are involved. Other non-standardised assessments are developed by facilities to suit their particular purposes.

Alternatively, other options involve the use of standardised assessments. Examples are the assessments from the Cognitive Disabilities Model, such as the Allen Cognitive Level Screening Tool (ACL) (Asher, 2007), the Assessment of Motor and Process Skills (AMPs) (Asher, 2007), which has been incorporated into the MOHO (Kielhofner, 2002), and the Perceive, Recall Plan and Perform System of task analysis (Chapparo & Ranka, 1996), part of the Occupational Performance Model (Australia) (OPM (Aus)) (Chapparo & Ranka, 1997).

Once again, the literature is in favour of an occupation-focused approach. The kind of assessments selected for use with clients may give an indication of how occupation-focused clinicians try to be, but at the same time being aware that there are external factors that may influence the assessment choice to veer toward a more biomedical assessment, such as colleagues in the multidisciplinary team who request specific non-occupational therapy assessments such as the mini mental status examination (MMSE).

Communicating with clients – client-centred occupational goals

To be client-centred is to pay attention to the client's identified goals and to incorporate them into occupational therapy interventions, (Maitra & Erway, 2006). A client-centred approach, according to the literature, is more complex than might be first thought. The wish and capability of both the client and the occupational therapist to participate in the process is paramount (Maitra & Erway, 2006). Other challenges, highlighted by Mortenson and Dyck (2006), include problems with team pressure, safety issues, referrals from a professional perspective rather than client-driven, conflicts between client centredness and clinical pathways/care maps, resource limitations, time restrictions, and prioritisation of patients.

However, the literature suggests that there are positive aspects of a client centered approach. Client-centred decisions on discharge destinations have been found to be more likely to occur if occupational therapists provided interventions with the goal of returning home (Moats, 2006). This is because decision-making around discharge destination can take the form of either risk avoidance or autonomy promotion. Risk avoidance decision-making is usually driven by the medical team and the client gets little input into the conversation. Conversely, occupational therapists use of autonomy promotion enables the client to control the decision-making and make decisions regarding risk-taking in the home. Autonomy promotion does, however, need to be carried out carefully, as, nearly twenty years ago, it was recognized that there were times when the wishes of the client may not be appropriate and others may need to step in and guide the decision-making (Gage & Polatajko, 1995). An example is when a person has cognitive issues affecting judgement and ability to make decisions around personal safety and the safety

of others. It has been suggested that the occupational therapist can provide limited choices to enable the client to participate in the decision-making, and can also facilitate interventions such as home visits, focusing on the meanings in the client's home by storytelling while negotiating the home (Moats & Doble, 2006). An alternative proposal was that instead of initially focusing on client-centredness, therapists may feel more comfortable thinking and reflecting on "a continuum of practice" (Mortenson & Dyck, 2006, p. 269). This would allow therapists to identify barriers to client-centred practice. Practitioners could explore what it meant to practice within the particular environment and then look at how policies might be changed to promote client-centredness.

The literature indicated that occupational therapists in the inpatient setting found it the most difficult to work in a client-centered way and the explanation for this was that their clients were often not able to participate or were not motivated to participate in goal setting. These findings also suggested that clients who were younger and male were more likely to participate in goal setting (Maitra & Erway, 2006). These findings resonate with my own experience of practicing in physical occupational therapy, where clients are recovering from being unwell or from surgery, and where there is a strong presence of the biomedical model creating challenges to a client-centered approach. It may be a situation where finding personal meaning comes into play (Aiken, Fourt, Cheng, & Polatajko, 2011), and occupational therapists interpret for themselves whether they are practicing in a client centered way by reasoning around the process and by guiding and supporting the client through change, wellness, or to end of life (Higgs & Titchen, 2001).

Communicating with colleagues

Teamwork in an acute medical setting can be a varied experience for occupational therapists. The current climate for multidisciplinary teamwork can create stress for therapists if their perception of their role is different from the rest of the team and their clinical judgment is questioned (C. Robertson & Finlay, 2007). When working in multidisciplinary teams, Shiri (2006) argued that it is necessary to have clear roles, because "a lack of identity can lead to role confusion or ambiguity, which impacts negatively on team functioning" (Shiri, 2006, p. 6). She indicated that this can affect the operation of the team and the job satisfaction of the therapist, and further that it is necessary for occupational therapists to have a strong sense of whom they are and what they do in order to work well within a team.

It is known that therapists can have difficulty clearly explaining their role to colleagues and clients. At least two recent researchers proposed that it might indeed be challenging because "occupational therapy concerns itself with the mundane, with the everyday life of patients" (Wilding & Whiteford, 2007, p. 191). As early as 1991, Mattingly called for a review of the

occupational therapy professional language to better reflect the complexities of what we do (Mattingly, 1991a). That was echoed when Wilding and Whiteford (2007) recommended that therapists used 'occupational language'. 'Occupational language' is a professional vocabulary that helps occupational therapists to think clearly about the use of occupation in interventions, to communicate knowledge clearly with other professionals and to explain what occupational therapy is to clients and colleagues (Creek, 2010). In the same paper, Wilding and Whiteford also stressed the importance of report writing, using occupation-based headings and occupation-based terminology in the text (Wilding & Whiteford, 2007). A further paper by the same authors described a study where Australian occupational therapists in an acute medical facility used occupational language. It was reported to be empowering in that they felt they understood their role more clearly and had more of a sense of identity (Wilding & Whiteford, 2008). However, alternative research has suggested that the presence of medically influenced colleagues sometimes can make it challenging to practice and communicate from an occupational perspective (Estes & Pierce, 2012).

In summary, the literature seems to support the idea that occupational therapists will be more confident if they can clearly articulate what their professional role is by use of occupational language when communicating with other team members and clients. Nevertheless, this can be challenging and there is evidence to suggest that therapists are selective about when they use occupational language and with whom.

Clinical reasoning and its complexities

Table 1, in the introduction to this chapter, indicated the links between theory and practice, with clinical reasoning as the conduit connecting the two. Clinical reasoning has been considered to be a major idea in occupational therapy. Clinical reasoning has a large body of research and commentary associated with it from an occupational therapy perspective, and I have referred to the more prominent writers, Mattingly, Fleming and Kielhofner, who have identified processes describing what is still currently thought to be how occupational therapists conduct their clinical reasoning.

It could be argued that it is the ability to clinically reason that enables occupational therapists to know what to do with clients, but trying to explain clinical reasoning in words as used by occupational therapists is challenging. In the literature, one way of defining clinical reasoning is to think of it as using "theory to understand a client and to develop a plan of therapy with a client" (Kielhofner & Forsyth, 2002, p. 162). The authors described the therapeutic reasoning process as consisting of four phases: the use of theory as a platform off which to spark questions leading to knowledge about the client, the use of these questions to learn about the client, the

use of the gathered information to form a client scenario, and the formulation of goals and plans tailored to the client.

This explanation, although clear, outlines a process similar to what I have observed occupational therapists do with their clients on a daily basis. However, it appears too simple in its explanation of what happens when we engage in clinical reasoning. It is concrete rather than abstract. Therefore I looked to another source for more discussion on clinical reasoning.

A two-year action research study, completed in 1988 by Mattingly and Hayes Fleming, looked at the clinical reasoning of occupational therapists. Their findings were written up in both journal articles and in 1994, a book, which provided a broader overview. In one paper, Mattingly (1991a) argued that clinical reasoning was more than "the application of theory to practice" (Mattingly, 1991a, p. 980), though she acknowledged this process had its place. She noted that clinical reasoning was historically aligned with the biomedical model, based on biological science, and was seen as primarily diagnostic. She termed this "hypothetical reasoning", used when medical problems need to be addressed. Mattingly also believed that clinical reasoning as applied to occupational therapy was more than that, it was action based; knowing what is the best to do in a given situation on a certain day. It should focus on the patient and how they interpreted their issues in their world. She indicated that reasoning often could not be put into words, thus was increasingly difficult to express as therapists became experts, possessing "tacit knowledge" (p. 979). Additionally, she argued that clinical reasoning in occupational therapy was complex, encompassing "motives and values and beliefs – a world of human meaning" (Mattingly, 1991a, p. 983; Mattingly and Hayes Fleming, 1994, p. 12).

Mattingly's suggestion that clinical reasoning is more complex was expanded by Heyes Fleming (1991), who used data from the clinical reasoning action research study. Her findings identified three types of clinical reasoning occupational therapists used when problem solving in practice. The first, Procedural Reasoning, addressed physical aspects of a client's condition and is similar to the hypothetical reasoning described by Mattingly. The second, Interactive Reasoning, was used when the client needs to be considered as an individual and to elicit engagement in interventions and to know that they are appropriate and acceptable to the patient. Interactive reasoning can tap into client thinking, their particular traits and information personal to them. This knowledge makes treatment more personalized and builds a relationship so that trust, hope, humour and meanings can be shared between client and therapist (Heyes Fleming, 1991).

The third type, Conditional Reasoning, is more than being able to make predictions about therapeutic outcomes (Hayes Fleming, 1994). It is about combining the knowledge gained from

using procedural and interactive reasoning. It involves thinking about the whole picture, how the client was, is, and how the situation could theoretically change with a change in the client's condition or circumstance. It is also about considering the influence of client participation and how this may affect the outcome. It involves reflection and looking deeply at various possibilities. "This thinking process is essentially imagination tempered by clinical experience and expertise" (Heyes Fleming, 1991, p. 1012). The therapist makes a story. Along with clinical reasoning is communication and action between the client and therapist. They imagine a goal and work towards it. They imagine what it was like and compare with how it is at present. They imagine what it will be like when the goal is achieved. They make a story together.

Story-making and storytelling is used personally, with colleagues and clients alike. Mattingly (1991b) suggested narrative reasoning (or storytelling) is an integral part of clinical reasoning. When talking among themselves, therapists are able to engage in "chart talk" (Heyes Fleming, 1991, p. 1012) using the biomedical model. They are also able to engage in storytelling, talking about specific patients and what happened. This can trigger clinical reasoning questions that can be discussed by the group. In addition, they are able to create meaningful stories with their clients involving the therapeutic journey they take together. "It is the journey that brings about personal transformation for both hero (occupational therapist) and helper (client)" (Kelly & McFarlane, 2007, p. 199).

Kelly and McFarlane (2007) also argued that journeying alongside clients towards their goals and making a story together along the way, using clients values and beliefs, is paramount and valuable to both parties. It was suggested this approach was more applicable to a wider range of clients from a variety of cultures, as it is not based on Western occupational therapy assumptions and values. The authors also argued that occupational therapists were natural storytellers and story makers and said that novice therapists could become experts by creating "their own personal myths and follow their own individual path to enlightenment" (Kelly & McFarlane, 2007, p. 196). Building on to these categories of reasoning, therapists might also use the "therapeutic use of self" (Price & Milner, 2007, p. 442), "mindfulness" (Reid, 2009, pp. 185-186) or reflective practice techniques as a means of developing a relationship and gathering information from the client. Therapeutic decisions would be based on clients' goals together with the therapists' prior knowledge and experience, and using clinical reasoning to achieve synthesis.

The concepts of Mattingly and Fleming were the foundation for further research. Sinclair (2007) identified how occupational therapists may be using all of these ways of reasoning at once, or more selectively, one or two at a time as required. Therefore, she argued that "This implied that knowledge includes skills as well as procedures" (Sinclair, 2007, p. 157). The "Sinclair Matrix

of Clinical Reasoning" (pp. 148-149) also suggested that clinical reasoning is developed from novice, through to advanced beginner, competent, proficient and expert. It is a summary of the complexity of concerns and the chaos that can be associated with health environments. Therapists respond in multiple ways according to their level of expertise and what is required of the particular situation. Sinclair cites examples of quick response with reflection afterwards, compared with situations that require slower thinking processes and multiple solution possibilities.

The literature demonstrates clearly how the idea of clinical reasoning had been taken up and added to over time. Through further reading, I know this process is continuing, as Harries (2007) wrote, "I do not feel we have full insight into our reasoning" (Harries, 2007, p. 183). She called for more research into how occupational therapists make clinical judgements, because, she argued, therapists do not have access to the wide breadth of insight into their clinical reasoning, only the extremes of "most important" and "least important" (p. 183). She discussed analytical thinking, which is active, step by step thinking, used more by novice clinicians, and intuitive thinking, that is based on knowledge already known that can quickly be applied, as more the domain of expert clinicians. She also questioned the validity of reflective practice for intuitive, expert practitioners, suggesting it was more useful for those who were novice analytical thinkers. Therefore, the quest for understanding clinical reasoning continues, and is an idea that appears to have captured the interest of researchers, as it seems to be a major influence on how occupational therapists practice both as a group and individually. However, there is no literature addressing whether practicing occupational therapists are developning their practice in any way in response to reading these research results, i.e. whether they are taking it up.

Cultural Sensitivity

The Nursing Council of New Zealand defined a pathway in the process toward cultural safety. It originated from nurses working with Maori patients, realizing "the pain of the Maori experience of poor healthcare" (Papps, 2005). The steps to achieving cultural safety were also defined as:

- "Cultural safety: …safe service is defined by those who receive the service"
- "Cultural sensitivity: …begins a process of self-exploration…of own life experience and realities and the impact these may have on others"
- "Cultural awareness: beginning step toward understanding there is a difference…" (p. 22).

The following definition of cultural safety is more descriptive:

"Cultural safety refers to what is felt or experienced by a patient when a healthcare provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-

making and builds a healthcare relationship where the patient and provider work together as a team to ensure maximum effectiveness of care" (National Aboriginal Health Council, 2008).

These considerations led me on to further exploration of cultural aspects of practice. There have been oblique references in other countries, but Gray and McPherson (2005) maintain that "Cultural safety is a uniquely New Zealand concept" (p. 34). This has become an important feature of working in New Zealand.

Cultural safety is about creating a positive attitude to cultures different from our own and "learning about power relationships between health professionals and clients" (Gray & McPherson, 2005, p. 34). It also arose as a response to the bi-cultural nature of New Zealand, which is bound in the Treaty of Waitangi, 1840. With respect to health, the Treaty has been interpreted as the principles of partnership, protection and participation between the Maori, the indigenous people of Aotearoa/New Zealand and the Government (Moon, 2007). There is recognition that life expectation is lower in the Maori population than the New Zealanders of European descent and that this is due to poor health resulting from social and economic disadvantage. The Aotearoa/New Zealand Health Strategy (2000) aims to address inequality of health by ensuring certain priorities are put in place with regard to Maori and Pacific peoples (King, 2000). Awareness of and participation in health strategies is particularly important to professionals as "the consideration of the client's cultural needs" is a primary concern (Gray & McPherson, 2005, p. 35). Gray and McPherson's study looked at occupational therapists' attitudes to cultural sensitivity. Overall, therapists were found to hold mixed attitudes, and linked to this, there appeared to be some confusion about the concept of cultural safety and associated terms in spite of most participants having some form of training. They recommended that therapists undergo training regularly throughout their careers and that more work must be done before there is confidence that therapists can practice competently with diverse cultures. Supporting the need for training, a US-based study found that prior training in cultural awareness was clearly related to a sense of cultural competency (Suarez-Balcazar et al., 2009).

There are many more references in the international literature indicating the call for practitioners to be culturally aware, and better still, culturally sensitive. It is argued that the inclusion of the concept of cultural sensitivity in occupational therapy would enable "social equity and justice … [by way of being] … inclusive and responsive to diverse client populations" (Gerlach, 2012, p. 156). Watson (2006) perhaps went further by stating that culture is the essence of the occupational therapy profession, that it shapes a person's occupations, and practitioners need to be responsive to cultural practices and incorporate them in interventions. She also suggested practices should be different around the world in response to local community need. She believed the "being" of the culture around them should shape

practitioners' thinking. This in turn affects the "doing" (Watson, 2006, p. 153). Therefore "the therapeutic meaning of occupation may vary" (p. 155), thus creating new models. This opinion has been supported with the suggestion that therapists should be "flexible and responsive to individual need", applied to clients and colleagues alike (C. Robertson & Finlay, 2007, p. 78).

The more recent emphasis on cultural sensitivity has led to proposals that occupational therapists must always be aware of cultural foundations of theory and question if these are applicable to the client (Rudman & Dennhardt, 2008), to make sure we are not putting up cultural barriers to interventions. Allied to this emphasis is the assertion that occupational therapy is a *culture in its own right* with Western beliefs (Hammell, 2009), and that only by critiquing our own paradigm, can we compare ourselves with and understand other, non-Western cultures. It might also be argued that current Western models are culturally and class specific and based on "unchallenged assumptions and the pronouncement of respected theorists rather than by research" (pp. 8-11). This implies that occupational therapists should be questioning what tools they use in a culturally sensitive environment. According to Muñoz, occupational therapists should "provide culturally responsive caring" (Muñoz, 2007, p. 256), because "people learn from their own cultures how to be healthy, how to define illness, what to do to get better and when and from whom to seek help" (p. 256). She also asserts that therapists should be culturally competent; a term which has various definitions, and Muñoz takes from this that cultural competence is "a complex multidimensional construct that integrates cognitive, affective and behavioural components" (p. 257). She discussed cultural competency models and cites a study where 30 models had been studied, and where the common areas identified as necessary were: cultural awareness, knowledge, skills and encounters/practice (p. 258). Muñoz suggested therapists may want to reflect on what skills they have to assess, treat and communicate with diverse cultures. She felt practitioners should also think about their own cultural beliefs, and recommended continuous cultural knowledge gathering. Therefore, simply put, occupational therapists should be reflecting on their own cultural perspective and how this influences their own practice. They should be consulting with the client and respect the client's cultural beliefs and practices and they should carefully select tools that are culturally appropriate for their individual clients.

On the other hand, some writers question whether the Western models, built on the assumption that occupation is essential to health, apply to any other cultures at all (Rudman & Dennhardt, 2008). Such assumptions may in fact be restricting the occupational identity of the profession, as it looks for occupation-based knowledge, because theory would be coming only from a Western viewpoint and occupation may not be valued that way in other cultures. Furthermore, a study looking at the implementation of the Kawa River Model in Ireland described how clients were able to tell their story – what they did, what it is like at present and what they want to do in

relation to their own culture (Carmody et al., 2007). Whatever the application of the existing models, however, it has passed into the profession's vernacular that it is important to "use the right tools, be[ing] reflective in practice and recognise[ing] every client as a unique individual" when performing culturally appropriate occupational therapy assessments (Thorley & Lim, 2011, p. 9).

In summary, there is a wide range of writing supporting the need for cultural sensitivity to be present in healthcare. A prominent idea is that the Western viewpoint may not be suitable for all situations. From an occupational therapy perspective, there is only one specific non-western model, the Kawa model (Iwama, 2006). However, a review of the literature showed few attempts to build on the model, although the publication of Te Umanga Whakaora (Te Rau Matatini, 2009) clearly acknowledges Iwama's inspiration. While Te Umanga Whakaora illustrates the potential importance of an alternative model to indigenous populations, I can only assume that the Kawa Model, at least, has not yet been taken up extensively. It may be that, at present, cultural sensitivity is incorporated in other ways, possibly by an awareness of population health or by acknowledging and respecting different cultural needs of individuals.

Creativity

Historically, the creative arts were a part of occupational therapy media until the profession entered its mechanistic stage (1940s–1960s), when it was no longer deemed appropriate for occupational therapists to engage their clients in creative interventions (Dickie, 2004). Only five recent articles extolling the benefits of creative media were located. Dickie (2004) said of her study participants, "people were telling me about their quilt making experiences …they felt a need to be creative, and that being creative was meaningful in its own right" (Dickie, 2004, p. 54). Schmid argued that creativity is described by occupational therapists in alternative language, such as "adaptation, innovation, change, first insight, going with the flow, risk-taking, and creativity has its own life" (Schmid, 2004, p. 86). Creativity was described by a participant in Hasselkus' study as "a tool that could get people in touch with other sorts of feelings or feelings that they can't express in any other way" (Hasselkus, 2002, p. 84). Dickie (2004) suggested that creativity can be about finding solutions but "One must think 'outside the box', in order to be creative" (Dickie, 2004, p. 52). Creativity may "include art and craft activities and any of the modern expressive arts" (Schmid, 2004, p. 81). Creative activities have also been found useful when used with palliative clients, prompting them to think of alternative ways of accomplishing something when they are unable to approach the activity the normal way (La Cour, Josephsson, Tishelman, & Nygard, 2007).

A more general suggestion is that crafts may be useful with some clients as long as it is a craft they are interested in and want to do (Harris, 2008). However, Schmid (2004) acknowledged

that although creativity is part of everyday life, occupational therapists had very little literature addressing it and implied this indicated "a denial of its (occupational therapy) own history" (Schmid, 2004, p. 87). The articles that are available do promote and recognize creative media, for instance, as valuable for the profession. Given Hassulkus' (2002) discussion about "expressing feelings" (p. 84), not recognizing creativity as beneficial appears to fall short of claims to be holistic. Egan and Swedersky identified that spirituality can be concerned with assisting clients to "use their own unique gifts and interests" (Egan & Swedersky, 2003, p. 525). Where it has been identified as important to the client, excluding creative media would be tantamount to denying a part of a client's culture or concept of spirituality and perhaps even excluding spirituality for that person; clearly contradicting an holistic approach.

Political aspects

Both local and national politics, defined as "activities associated with the governance of a country or area" (Politics, n.d.), can influence managerial and business expectations regarding efficiency and effectiveness. Occupational therapy practice, as with many other medical and allied disciplines, has been influenced by changes in medical and social care, government policy and health organisations (Clouston & Whitcombe, 2008). For instance, an Australian study that looked at meaning related to occupational therapy practice found that participants were identifying a 'Meaning gap' between the way they understood how occupational therapy ideally should be practiced and its actual execution in the health services sector (Aiken et al., 2011). The study suggested that "environmental constraints, job pressures, time, budgets, and biomedical models" all influenced practice to a greater or lesser degree (Aiken et al., 2011, p. 300).

It would appear that there can be barriers to knowledge transition if there are conflicts of interest, particularly when the legislation challenges the accepted roles of a profession. In all Western health systems, government legislation both influences and sets boundaries for what occupational therapists do. In the UK, such legislation has focused on partnership with service users and inter-professional collaboration (Wright & Rowe, 2005). This has led to discussion around demarcation of professional boundaries and the accusation that the occupational therapy profession does not acknowledge the usefulness of its current role, being too focussed on how it would like to be perceived and protecting its own professional boundaries. Therefore, service user involvement could be threatening for a profession which is unsure or insecure about a defined role, and could affect the relationship between the occupational therapy profession and service users. Mackey reports that in the UK, "career pathways and work roles are redesigned in order to use staff skills more flexibly" (Mackey, 2007, p. 95). Furthermore, some traditional occupational therapy roles are being opened up to assistants or support workers, and inter-disciplinary teams to vertically integrate with workers carrying out tasks which would previously have been parsed out in a horizontal assignment to the traditional job functions.

As occupational therapy knowledge acquisition continues and knowledge gaps are filled in, occupational therapists will have to redefine their roles in response to changes in how governments manage health and population needs, as well as the development of the profession as research reveals more about practice. This may include transferring aspects of current practice to other health workers, thus freeing up time for therapists to concentrate on more complex issues. This blurring of boundaries and retreat from specialization could mean a new identity is required for occupational therapists. It has been suggested that instead of a collective identity, therapists should focus on themselves, working out what kind of occupational therapists they are (Mackey, 2007). The concept of pluralism has been discussed in occupational therapy literature since the early 1980s and is a way of understanding "the many and varied versions of occupational therapy practice" (Greber, 2011, p. 455), an understanding which can be achieved by reflection and clinical supervision (Mackey, 2007). For Greber (2011), pluralism is a powerful concept, bringing flexibility to identity and an ability to respond to the changing requirements of whatever is the prevailing health system. The author, however, warned that occupational therapists may eventually split into two distinct groups: occupation centred, embracing the pragmatic approach, and structuralist, for whom the paradigm places emphasis on function only, concentrating on components, rather than the whole (Greber, 2011). This appears to have begun, likely influenced by the biomedical model, with occupational therapists having split off into separate specialities such as hand therapists and neurodevelopmental therapists, so it might be entirely possible for other groups to develop.

Currently, local DHBs are piloting an initiative whereby equipment issue, generally the domain of the occupational therapist, is being opened up to other disciplines and support workers in an attempt to improve productivity and achieve lower costs. Additionally, the focus of the present government is primary health care, in line with the Ottawa Charter and United Nations conventions, outsourcing services to the community, with an emphasis on preventative medicine and healthcare initiatives. In Canada, occupational therapists are already beginning to be involved in working with communities to enable the prioritization of their health needs. In a study of this initiative, a lot of work was shown to be collaborative, using networking and focussing on the process rather than the outcome. Interventions were with groups and organizations and addressed cultural needs, including minority groups. Eventually, leadership roles were able to be handed over to community members (Lauckner, Pentland, & Paterson, 2007). In Aotearoa/New Zealand, discussion on population health has recently emerged (King, 2000). The Ministry of Health provider, Accessable, is looking at population health when providing equipment for New Zealand residents; how this will change the practice for occupational therapists involved in the assessment and supply of equipment, is not yet known.

So, in summary, the possiblity of future changes in the way that health services deliver healthcare suggests that there is a strong argument for the need to understand how therapists take up new knowledge. They must be able to identify knowledge gaps, acquire knowledge, transmit and apply new knowledge into their practice, so that knowledge uptake can quickly and efficiently occur in response to change.

Is our knowledge fragmented?

Reflecting on the literature, it appears that there are many ideas being proposed. Occupational therapists seem to have a fragmented knowledge base because the concept of occupation is so broad and research is comparatively young in occupational therapy and there are realistically bound to be knowledge gaps. These knowledge gaps will only be filled by continuing research, preferably, as Kielhofner suggested, by a coming together of researcher and practitioner to pool interpretations on findings (Kielhofner, 2005). In this way, knowledge gleaned from the research is likely to be more user-friendly for clinicians in practice and knowledge transmission can occur. Additionally, the literature suggests that occupational therapists should also continue to critically analyse theoretical perspectives regarding knowledge uptake from other disciplines, as those ideas may be important when developing occupational therapy specific ideas.

In the meantime, we must use what knowledge we have and selectively use it as a basis for practice. This means bringing diverse ideas together to provide a coherent knowledge base that is flexible and can be used with populations, cultures and individuals. As new knowledge becomes available to us, we need to have an open mind to see if that new knowledge can be layered onto or integrated into old knowledge, or whether previous knowledge should be discarded. If we can do that, then the profession will be able to strengthen and change to the needs of the populations served.

Summary

This literature review identified that there was no information specifically addressing how occupational therapists take up ideas from the international literature. There was little literature identified that looked at knowledge processes with respect to occupational therapy. This literature review was also indicative of current ideas in international occupational therapy, and I have examined each in turn to look at their importance and relevance, and tried to place them into a New Zealand context. The key ideas of occupation and enablement, communication, clinical reasoning, cultural sensitivity, creativity and political aspects were carried forward and linked with the concepts of knowledge gaps, creation, acquisition, translation and transmission to form the basis of the study. This study is needed because there are knowledge gaps in the

literature and it is unclear how ideas and knowledge are currently taken up and used by occupational therapists to inform their practice in Aotearoa/New Zealand.

Chapter Three: Methodology

Introduction

This chapter presents the choice of approach selected for this study and why it is appropriate for the research question. The discussion takes the following format:

- Identification of the philosophical and theoretical underpinnings of a qualitative descriptive approach and linking with my research to show why this was a good choice for this question.
- Identification of any preconceptions I may have had with regard to this investigation using the pre-suppositions interview.
- Presentation of the study design and process by which participants were recruited and selected.
- Examination of ethical and cultural considerations.
- Methods for data collection and analysis
- Strategies to ensure rigor and trustworthiness as the work progressed.

This study seeks to answer the question: "How do occupational therapists take up ideas discussed in the international literature?" When formulating research questions Patton (2002) suggested there are a number of things to consider; first and foremost, a researcher should think about the purpose of the research and what information is required from the participants that will answer the research question. Next is to identify the primary audience for the research and the kind of information they will be interested in. The structure of the questions asked of the participants need to be considered very carefully as they will determine the data gathering which in turn will inform the overall findings in relation to the research question. Finally, it was suggested to consider what resources are required so that the research can happen and what will be used to ensure its validity (Patton, 2002). This chapter addresses all these considerations.

I selected a qualitative descriptive design approach since the study was exploring an area where there had been little or no prior research. A qualitative descriptive study is suitable for this situation, as the study will be a general inquiry where the aim is to describe the phenomenon (DePoy & Gitlin, 2005). Qualitative descriptive research is considered a basic type of research where the emphasis is upon description of a phenomenon. There is less interpretation of data compared with some other forms of qualitative methods such as phenomenology (Sandelowski, 2000), where the emphasis is on discovering "the essence of human experience" (Carpenter & Suto, 2008, p. 128). In qualitative descriptive research, the descriptions must always be true to the original way the participants express and understand a phenomenon, staying "closer to their data and to the surface of words and events" (Sandelowski, 2000, p. 336). This allows easier

agreement on the facts of a study by researchers. I also particularly like the language used in qualitative descriptive research because it fits with my own philosophy; it is straightforward, down-to-earth and has the potential to be easily understood by practitioners, who are my intended audience. It provides an organised way of summarising the resulting data and enables the researcher to describe the phenomena and to recommend ways to go forward (Sandelowski, 2000). It is also field-based, and allows the collection of data directly from the participants in their practice settings (Grbich, 2007).

Using a qualitative design allows for one on one interviewing with open-ended, semi-structured questions as a method of data collection that provides richly descriptive detailed data. I felt that more interpretive qualitative methods, such as phenomenology, would not generate the practical information I needed. Likewise, because of a lack of data in the area, I did not think action-research would be appropriate, as using that methodology the researcher works with participants to actively bring about change in their situation (Grbich, 2007). Rather, I preferred an approach that would describe how the ideas were being taken up that could later be used to inform professional development opportunities for occupational therapists, and in turn improve service provision for clients.

Philosophical underpinnings and research method choice

When conducting research, it is necessary to have consistency of concepts throughout a study (Crotty, 1998). I used Crotty's descriptions as a basis to construct my research approach and to understand the connections required in the research process. Additionally, characteristics of qualitative inquiry affording consistency were described by Patton (2002), who concurred with Crotty, but more specifically suggested that the design strategies of qualitative research were naturalistic inquiry, emergent design, flexibility and purposeful sampling. The naturalistic paradigm suited my intention to explore the thoughts underpinning the practices of the participants, as "…observations take place in real world settings and people are interviewed with open-ended questions in places and under conditions that are comfortable for them" (Patton, 2002, p. 39). This fitted in with the ontological approach of relativism: understanding what is real, making sense of the world; and the epistemological perspective of constructionism: understanding what we know (Crotty, 1998). This in turn, influenced my decision to use a qualitative descriptive methodology that would capture rich description of the participants' perception of their world and also guided my choice of data gathering method, one on one semi-structured interviewing. To make the philosophical underpinnings more clear, I have summarised them in Table 4 below.

Table 4. Chart to summarise the concepts used in this research project

Concept	Description of concept	Research perspective
Purpose of research	The objective underpinning the study	To describe how occupational therapists take up ideas from international literature
Paradigm	Set of beliefs; making sense of the world	**Naturalistic inquiry**: "Realities are multiple, constructed, and holistic; knower and known are inseparable; impossible to distinguish cause from effect; inquiry is value-bound" (Lincoln & Guba, 1985, p. 37)
Ontology	A way of understanding; Study of being; what is real	**Relativism**: "rejects notion of researcher as a detached value-free and objective observer… prefers to examine the ways in which claims to truth and knowledge are produced in the social world including the research process itself," (Griffin & Bengry-Howell, 2008, pp. 21-22)
Epistemology	Understanding what we know; combined gathering and dispersion of meaning	**Constructivism:** "people having to make sense of their encounters with the physical world and other people" (Blaikie, 2010, p. 95)
Methodology (Theoretical perspective)	Theoretical underpinning of research; strategy to gain knowledge; influences choice of method	**Qualitative descriptive**: "straight descriptions of phenomena" (Sandelowski, 2000, p. 339),
Method	Process used to gather and analyse the information	One-on-one semi-structured interviewing; purposeful sampling, thematic analysis

My choice of a qualitative descriptive methodology, semi-structured questions and purposeful sampling meant that I had flexibility to study and obtain rich descriptions of the stories of the participants within a natural, real world, setting. I was able to probe for more detail during the interviews and concurrent analysis of the data enabled tailoring of the questions over time. While this was essentially exploratory, basic research in that it was "generating evidence about some phenomena" (Kielhofner, 2006, p. 31), it was hoped the findings would provide some initial themes with respect to how occupational therapists in Aotearoa/New Zealand have taken up ideas from the international literature and as such recommendations for preliminary educational opportunities and further research could be made.

Pre-supposition interview

I participated in a pre-supposition interview prior to starting interviewing participants so that there was an opportunity to capture any preconceived thoughts that I might have. These interviews are used in research as one way to ensure rigour in a study. A pre-supposition interview aims to reveal both conscious and unconscious ideas and understandings that researchers may have, related to their study area. The reason for doing the pre-supposition interview assumes that the researcher is not able to "bracket" what is already known, in other words, where what is known is put off to one side and the study is approached as a blank slate. In this study, it was assumed that researchers are unable to put their own knowledge, values and beliefs aside, so the interview helps reveal assumptions that might be influencing the data gathering and analysis. If researchers are aware of what they are already thinking, they can then reflect on how to ask a question that goes beyond existing knowledge or assumptions, and how existing knowledge might be influencing this process.

From my point of view, it was about being thoughtful in the process - not to ask what I already thought I knew. I have understood it to be similar to practicing as a clinician and being thoughtful about a patient's case. If there were things that might be already in mind, how could I have seen what might have been influencing what I was doing or thinking, and how could I have opened it up to the possibility of there having been more than I already knew.

The pre-suppositions interview revealed that I personally like to take up ideas from international literature, and assume that other occupational therapists do too. I have particular interests in certain specialist fields of occupational therapy and think that this may be the case with other occupational therapists. I also believe that, like myself, occupational therapists working in Aotearoa/New Zealand are more likely to pick up ideas related to cultural safety due the influence of the Treaty of Waitangi. I believe occupational therapists need to use evidence, models and frameworks to underpin practice, and so I am interested in the link between the theoretical perspectives and ideas that are taken up by occupational therapists, how they use reasoning to apply the ideas to their practice, and how they then articulate the ideas and connections to practice using occupational therapy language. I believe awareness and use of ideas, reasoning and language makes confident occupational therapy practitioners, and as a result, I hoped the participants in this study would express evidence of this process when they talked about the ideas they pick up from international literature.

From the self-awareness promoted by the suppositions interview, I found that I take it for granted that occupational therapists need to be client-centered and culturally safe, responding to the local needs of clients within an occupational focused framework. I believe that assessment and interventions should be "top down", looking at a person's occupations in context and then, where necessary, using the components of those occupations to further inform and understand the occupational capacity of the person. I further believe there is more to occupational therapists than giving out equipment and assume that this is a general belief, held by the majority of the profession. I believe that as a profession, we undoubtedly have ethical challenges, particularly when looking at quality of life versus need only, and I am sure that this can cause conflict within ourselves when making decisions concerning government-funded provision of equipment and housing modifications. Gaining this awareness of the assumptions I make about practice and occupational therapy practitioners provided a basis for reflective critique of my influence over data collection and analysis.

Ethics approval

Participants for the study were to be recruited from a District Health Board (DHB) in a metropolitan city in Aotearoa/New Zealand. Approval was sought from both Auckland University of Technology Ethics Committee (AUTEC) and the District Health Board Learning Centre. The application needed approval from both establishments because Auckland University of Technology (AUT) was the educational institution with oversight for conducting the study, and the DHB was where the participants were to be recruited.

I received ethics approval from both AUTEC and the DHB Learning Centre in early 2011, prior to commencement of the study (Ethics Application Number 11/311). Appendices A and B show approval documentation.

Ethical considerations

The ethical considerations were addressed in the design phase of the study and throughout its execution. Written, informed consent was provided from each participant before the interview commenced (Appendix C). As this study would explore how participants articulated broad philosophical ideas from theory into practice, such as client centeredness, holistic approach and occupation, it was not anticipated that any participant would reveal unethical or unsafe practice. It was unlikely that there would be any discomfort, embarrassment or incapacity resulting from the interview outside normal practice situations, because the subject matter was about ideas from literature, and did not involve any personal issues. Participants would have the option of not answering a question and/or terminating the interview if they wished to do so. If participants felt unsafe as a result of taking part in this study, they were able to access the Employee Assistance Programme (EAP) via their employer.

No risks were anticipated for the researcher.

Do no harm and avoidance of deceit

At the time of conducting this study, I had a leadership position at the District Health Board from which participants were recruited, although my role covered only one area of the service. I discussed this with my Primary Supervisor, it was felt the nature of the information I planned to ask the participants carried minimal risk or conflict of interest. Nevertheless, strategies were put in place to protect therapists working in the same clinical area as myself: The ethics agreement stipulated that I would not approach any occupational therapist from that area regarding participation in the study, and that the invitation to participate in the study would be sent out on my behalf by a clerical assistant not involved in the study. Only once a prospective participant had responded could I contact them and discuss the study. Ultimately, each person made their own decision about whether they felt it was safe to participate and acted accordingly.

To ensure I was clearly not involved in recruiting from my own work area, I arranged for a clerical assistant to send out the recruitment email, participant information sheet and consent form, and also to receive the responses, which she then forwarded to me. In addition, to protect participants and ensure their safety, I did not recruit therapists into this research if I was their professional supervisor. I also did not recruit therapists in the process of completing a Professional Development Review (PDR) that I was involved in. This was to prevent any information gained in the interview from influencing any feedback given by me in the PDR. Some people wanted to participate in the study and had not had their PDR, so I made arrangements to not be part of their next PDR process. These considerations were included in the participant information sheet (Appendix D).

Considerations in relation to the Treaty of Waitangi

The Treaty of Waitangi was signed in 1840, giving certain rights to Maori which are currently interpreted in the New Zealand Health and Disability Act 2000 (Nursing Council of New Zealand, 2011) in relation to health as the three principles of partnership, protection and participation. AUTEC requires that any research approved by the committee follows these three principles. Sporle and Koea (2004) suggested obtaining advice if there is a possibility of working with indigenous people, and so to ensure I understood the importance of the Treaty with respect to research, I consulted with Isla Whittington NZROT, (Ngāti Maniapoto), and of Ngāti Kauwhata descent. We had a conversation regarding how to approach research that may involve Maori participants and how health practice may impact Maori. I also met with a DHB Maori Research Advisor, who suggested I pay particular attention to the coding of information and that I offer to hand write notes during an interview as an alternative to using a tape recorder. I made preparations to conduct my study with their advice in mind. In the event, no Maori occupational therapists volunteered to participate in the study. However, the preparations provided a good grounding for the study and ensured safety for all participants (Sporle & Koea, 2004).

Confidentiality and anonymity

Participants were assured that information they supplied would be protected and used anonymously in the research and written thesis. All participation was voluntary. A participant information sheet detailing the plan of the study and the role of the participants was issued to persons interested in participating, (Appendix D), which reduced the potential for coercion and enabled prospective participants to make their own informed decision whether or not to participate in the study.

All written notes and transcripts of the interviews were put in paper folders and stored in a locked filing cabinet, and the recordings of the interviews were stored on a computer which is password protected. The original recordings on the tape recorder were deleted. Participants were allocated a pseudonym for all transcripts, written data and the research report. Only the researcher, supervisors and transcriber had access to the data. The transcriber signed a confidentiality agreement prior to working on the transcripts (Appendix E). Storage of residual data, including consent forms and transcripts, was within a locked filing cabinet at AUT, where only the supervisors for the thesis would have access. It will be stored for six years, and will then be shredded and disposed of confidentially.

After data analysis, and discussion with the thesis supervisors, there was a concern that some participants might be identifiable, so the way the participant demographics were reported in the research report was changed, so that individual data was not specifically mentioned and the reporting was completed in more general terms. Additionally, although there were males in the study, all pseudonyms were changed to female names.

Application of partnership, protection and participation

I designed a study so that it was safe for both Maori and non-Maori. Preparing for Maori participation involved recognising and responding to cultural beliefs, values and practices and ensuring that all participants felt respected and safe. Prospective participants were informed that a supporter could accompany them in the interview and speak for them. Culturally, some Maori might have felt it boastful to speak of the ideas they implemented or their efforts to stay updated, so the supporter could do this on their behalf. I clearly explained what my research was about and what was expected of the participants. I obtained informed consent and stressed the importance of confidentiality (Sporle & Koea, 2004), and used pseudonyms to protect individuals from being identified. To respect knowledge and information shared with me, I verified that each interview transcript was correct and gave participants the opportunity to remove or withdraw any information with which they were subsequently uncomfortable. At the conclusion of my research, I undertook to provide a copy of my findings to those participants who had indicated they would like to be informed about the findings of the study.

Gift

In the spirit of partnership, small gifts may be given in recognition of a person's participation of the study. It is recommended that this is not made known beforehand because it may be considered an inducement (Sporle & Koea, 2004). I included provision of a gift to each participant on my ethics application and it was approved. The gift took the form of a small monetary token of appreciation, which was given to participants at the end of each interview.

Recruitment

Recruitment happened in two ways. For the wider DHB, I personally sent out an email to occupational therapists containing some general information about the study and requesting interested parties to contact me. I attached the participant information sheet and consent form. When there were respondents, I made contact with them and provided an opportunity for them to request any further information or discuss any concerns. The e-mail message is included in appendix G. For the service in which I worked, a clerical assistant sent out the recruitment email, participant information sheet and consent form. Responses were forwarded to me when received and I then directly contacted the prospective participants.

Participants were to be occupational therapists recruited from all occupational therapy practice areas in the DHB. These included physical practice settings (such as acute services, rehabilitation units, community and primary care); Child, Women and Family (including paediatrics in inpatient and community settings); and mental health services (which included inpatient, community, and forensics).

The inclusion criteria were:

- Registered with the Occupational Therapy Board of New Zealand/Kaihaumanu Turoro o Aotearoa (OTBNZ)
- Holding a current Annual Practice Certificate (APC).

Selection was based on:

- Variety in lengths of practice
- Different practice areas
- A variety of ethnicities and ages.

This is summarised in appendix F: participant data collection form. Participants were asked to complete this form when they responded to the recruitment email request.

There were two exclusion criteria:

- Overseas-trained occupational therapists who had less than six months experience working in Aotearoa/New Zealand. This category of therapist may not yet have had enough time to experience healthcare needs in the country, and would not have had a depth of practice experience to draw on.
- Therapists to whom I provided professional supervision because of possible ethical conflicts.

Participant recruitment

It was anticipated that a sample size of 8-12 participants would provide meaningful results within the parameters of a master's thesis. Participants were selected by purposive sampling, suitable for qualitative descriptive research (Sandelowski, 2000). This aimed to provide in-depth

study of a carefully selected, small number of participants who could provide "information-rich" data that would answer the questions of the study (Patton, 2002). I checked inclusion criteria and collected the demographic information on a form designed specifically for the purpose (Appendix F).

In keeping with the requirements of the ethics agreement, one email was sent to each potential participant, and only ten participants were approached at a time, until the optimum number of participants was reached. In fact every respondent fit the criteria, and was recruited into the study, I did not need to decline anyone, and stopped recruiting when the tenth interview was completed and it became clear that the data was saturated.

Participant demographics

All participants had over six months practicing in Aotearoa/New Zealand. Nine had between one and ten years' experience of working as an occupational therapist, while one was in the range of twenty-one - thirty years' experience. Seven worked in physical health, two in mental health and one in pediatrics. Their age ranges varied; five were 31-40 years old; two were 41-50 years old and three were 21-30 years old. Eight identified themselves as European, while two identified as from overseas cultures, and two were male and eight were female. Participants were given the opportunity to select a pseudonym. Only two chose their own pseudonym and the others gave consent for the pseudonym to be allocated on their behalf. In the interests of protecting all participants, the pseudonyms were all female.

Data collection: Writing the questions; practice interview

To provide consistency in the study and align with qualitative descriptive methodology, data were collected using semi structured, open ended questions, which were selected to provide a loose structure to the interview (Appendix I). Patton (2002) suggested that "open ended questions and probes yield in-depth responses about people's experiences, opinions, feelings, and knowledge" (Patton, 2002, p. 4). The open-ended nature of the questioning allowed participants' considered viewpoint to be raised in each question, but semi structured interviewing allowed probing for deeper insights when I felt the participant had more to say on a particular subject area and allowed that to emerge.

Developing the questions proved to be a long process to ensure the simplest possible wording and clarity. Each question was reconsidered and modified during the development of the research proposal. A practice interview was conducted which allowed for further question

refinement. Prompt questions were also added for the case when the participant was responding to a question, but I felt there could be more detail obtained by following the line of inquiry.

It is imperative that the right questions are asked, as qualitative methods "capture and communicate the participant's stories" (Patton, 2002, p. 10). It is the questions that enable the participants to tell their stories about what they think and believe, and actions that might influence these. The stories are the heart of the data.

Data gathering and transcription

The interviews were planned to be approximately one hour in duration, with the possibility of an extra half hour follow up if required, as well as time for the participants to check the transcripts. The interviews were held in interview rooms within the DHB premises. I arranged to meet participants in an area with an environment suitable for talking privately and quiet enough to be able to record the interview.

I conducted a one-on-one, in-person interview with each participant, which was tape-recorded after checking that each participant was comfortable with this method of gathering data. As an alternative, I was prepared to make written notes instead of making a tape recording. Once each interview was completed, I debriefed the participant and told them what would happen next; explaining that the data collected via the tape recording would be transcribed immediately after the interview by myself or by the transcriptionist who had signed a confidentiality agreement (Appendix E). I occasionally wrote a few field notes after the interview, but my main source of data was the interview itself.

The practice of open-ended interviewing enabled the participant to freely describe their experiences and beliefs to me. I recorded and transcribed the resulting data of the first three interviews myself, but for the remaining seven interviews, the interview recordings were professionally transcribed immediately after each interview, as I realized I was too slow at completing this stage. Upon completion, copies of transcripts were sent to the participants to check for accuracy, and I asked that they would verify that the transcript was accurate and to confirm that it could still be used for the study. I also gave the participants the opportunity to indicate on their consent form whether they wanted a summary of findings to be emailed or posted to them at the end of the study. Most indicated that they would like this information sent to them.

Data analysis

Inductive analysis

I completed initial coding for each interview before commencing cross-analysis, looking for patterns and themes in the data. Inductive analysis, defined as "specific observations that build toward general patterns" (Patton, 2002, p. 56), enabled me to concentrate on each participant's data before comparing it with that of other participants. I was able to continually refer to the original interviews as themes emerged, which allowed me to keep in touch with the original data (Patton, 2002).

To gain familiarity with each interview, and to start to analyze the data, I read the transcripts through while listening to the recording at the same time. This made me remember the emphasis put on the words by the participants, and in some cases gave the transcripts back their original meaning. Through the initial use of inductive analysis, I was able to concentrate on individual segments of data, which slowly emerged as initial themes.

Initial organization of data using inductive analysis

I read through each transcript and made notations along the side of the transcript that indicated the broad first ideas that came to me, then used the idea of positive and negative coding by writing initially in the margins of each transcript what I thought each chunk of data was about and whether it was interesting or useful (Davidson & Tolich, 2003). I subsequently compiled these ideas on a grid, organizing the table so that it could track all the codes from a participant across the page and then adding participants down the page. This enabled me to define initial groups of similar data, and I added newly emerging ideas to the table as I went along. A total of 33 ideas emerged. A section from the 'grid of ideas' is reproduced as table 5 below.

Table 5. Example of a page from my "Grid of ideas" from individual participants transcripts

Initial Ideas:	Assessment	Strategies	Goal setting	Reasoning	Listening	Empowerment
Participant 1	Joint Peabody Sensory profile Hammersmith PAMS	Sensory Safe environment Equipment Personal cares Support for family – discussion Education Home modification Advice Talking with the families	Family Small goals Performance based measurable	What is essential need What is our work – what is not our work? Top 10 mistakes – model and pray – remove the magic hands Appropriate assessments Matching services	What does the family want?	Education Teach skills Get the family to do it Options – what occupational therapy can provide Funding – govt vs private
Participant 2	Fast assessments in ED Talking with the client – what do they want to achieve?	Lifestyle redesign Adapting activities rather than equipment supply Long term management vs quick fix Engagement in the community Individualised rehab programs for in hospital and on return home Support Education Acknowledge when a client does not want occupational therapy Communicating Linking in to multiple services How people live daily lives - routines	Client focused-ask the client what they want to do	Performance solutions through participation rather than equipment; lifestyle redesign Narrative reasoning – we do like to get to know people – what's important; putting it all together with a plan at the end	What does the client want? Do they want occupational therapy? Are they ready to make changes?	Yes – by listening to client goals and problem solving together – own their recovery process Educate – community groups, etc. Inclusion in the decision making - provide the right information to enable them to do this Recognition client wants to change
Participant 3	Leisure and productivity,p. 8; "looking at the big picture, p. 8	Lifestyle redesign p. 2	Client centered – what the client want to achieve-example.5	Linking reasoning with evidence p3 splinting example p. 3 Reasoning example, p.4 and p.5	Yes; p.5 example in transcript Example: p. 8 – talking and listening to elderly person about her leisure interests and loss	Yes: p.5 example in transcript

I then sorted the ideas under six broad codes and began to write paragraphs summarising what I was seeing in the data as depicted in Table 6.

Table 6. Initial emerging ideas

Working with people	Sourcing ideas	What we do	Keeping us and clients safe	Local New Zealand influences	Ourselves as occupational therapists
Client-centered	Learning and	Assessment'	Safe practice	Legislation	occupational therapy
Family –centered	education	Strategies	Cultural safety	Government	identity
Listening	Resources for	Modalities		policy	Language/jargon
Empowerment	ideas	Home visiting		Resources	Uniqueness
Goal setting	Theory	Community		Processes to guide	Occupation
Liaison and	Spirituality	Complexity of		workload	Creativity
Communication		cases		Cultural safety	Problem solving
					Reflection
					Supervision
					Reasoning
					MDT/IDT

Process of thematic analysis

Once I had some preliminary categories from use of inductive analysis, I continued on using thematic analysis. "In qualitative research, the coding is ongoing, changeable" (Davidson & Tolich, 2003, p. 169). Thematic analysis allowed the data to again be disassembled and reassembled in the quest to recognise new themes and either support or negate existing initial themes. As analysis was completed alongside interviewing and collection of data, new questions would develop that would probe an area of interest more deeply. The data were sorted into thematic groupings that were connected using linking words and ideas which were then gradually brought together as an emerging theme as new data were added after each interview.

I went back to the transcripts as I began thematic analysis and electronically recoded chunks of data into themes using colour coding. When I had done this, I lifted the chunks of the same colour from each participant onto another word document. Each chunk was labeled with the participant's pseudonym so I could identify the transcript it came from. I modified the initial paragraphs containing my analysis of the data as new insights emerged. Gradually, the data and my original paragraphs were brought together as emerging themes (Davidson & Tolich, 2003). When I had finished, I had the document organized so that there were seven themes under which the data fitted, which were more in line with central occupational therapy themes and more specific to my original question. These are summarized in the following Table 7:

Table 7. Themes from thematic analysis

Themes	Ideas
Sourcing ideas	Where, what and why:
	People peers and colleagues
	Events meetings and getting together
	One-off events
	Self-directed learnings
Occupation	Brevity
	Related to client goals
	Confidence
	Health and Lifestyle redesign
	At home
	Leisure
Enablement, justice and safety	Linking to theory
	Stress reduction
	Working towards client/family goals
	Clarity of role
	Competency and capacity
	Politics
	Risk
	Limitations of role
	Government policy
Theory, tools and strategies	Dominant models and assessments
	Related to relevance to practice area
	Going outside the profession
	Linked to occupation -
	Assessment
	Assessment and Clinical reasoning
	Strategies
	Complexity
	Seeking guidelines / formulas
	Seeking surety
	Evidence-based practice
	Occupational science
	Supervision and reflection
	Occupational science
Engagement	Being client-centered
	Family-centered
	Active listening
	Engaging with colleagues
Culture and Spirituality	Policy
	Education
	Support services
	Family centered
	Assessment
	Strategies
	Spiritual understanding
Occupational therapy identity	Uniqueness
	Holistic
	Language
	Creativity
	Problem solving

Final analysis of data

Once I had reached this stage, I realized there was deeper level of abstraction that could be obtained. The final themes are depicted in Table 8 in chapter six but in summary, they are:

- Sourcing ideas and ideas implicit in occupational therapy

- Providing occupational opportunities
- Providing enablement, justice and safety for clients
- Use and uptake of occupational theory, tools and strategies
- Occupation and medicine: an uneasy alliance
- Engagement with clients and colleagues
- Recognition of culture

The themes illustrate the complexity of occupational therapy knowledge. Multiple ideas over a broad range of areas have been taken up from both within occupational therapy and external to scope of practice, from psychology, medicine and social work. They do not always sit comfortably with the confines of the work environment, but participants worked to find a way to navigate between their occupational ideals, the influence of the biomedical model and the constraints and realities of actual practice.

Overlapping coding and un-coded text

Some data appeared to overlap at first, but with continued refinement of the emerging themes, this appeared to resolve itself. The themes are closely interrelated due to the nature of the components that were identified, as they support each other. There was some text that could not be placed within the themes, which on further review was recognized as unrelated to the research question.

Strategies to ensure rigour and trustworthiness

Qualitative research is associated with methodology and methods aimed "to interpret and explain behavior" (Davidson & Tolich, 2003, p. 122). Data gathered from the participants is subjective and value bound; likewise, because "the researcher is the instrument" (Patton, 2002, p. 14), researchers will inevitably bring their values to the research too. So "the credibility of qualitative methods, therefore, hinges to a great extent on the skill, competence, and rigor of the person doing the fieldwork as well as things going on in a person's life that might prove a distraction" (Patton, 2002, p. 14).

For most researchers, addressing rigour in qualitative research is an important part of designing a study. This is because when there is inclusion of rigour in a study, it will be seen as more credible to those reading it. Therefore, in the context of my research, where I have used a qualitative descriptive approach, it has been necessary to be aware of and implement methods used to ensure that rigour is built into the study.

Giddings and Grant (2009) argued that the means of establishing rigour in a study needs to be chosen carefully so that it complements the research paradigm, methodology and method. Some

forms of rigour that could be used in positivist/post-positivist research for instance, will not be suited to the interpretivist/constructionist paradigm. This is because there is a shift from numerical validation to description in words. Therefore different ways of capturing rigour are needed when rich description is used (Giddings & Grant, 2009).

Barbour (2001) pointed out that purposive sampling, multiple coding, triangulation and respondent validation are some methods used to demonstrate trustworthiness in qualitative research. These methods are said to address bias, original theorizing, and interpretation, but Barbour argued they all have limitations and are only valid if they are part of a larger understanding of qualitative research, rather than a formula to make research acceptable (Barbour, 2001). One well known naturalistic approach to rigor is that of Guba (Shenton, 2004), who used alternative terminology from that of quantitative research to describe the criteria for trustworthiness. These are credibility (internal validity), transferability (external validity), dependability (reliability) and confirmability (objectivity). I have reviewed these criteria and used aspects of each to build rigour into my study.

The credibility of a study requires that measures must be put in place to ensure appropriate data is collected, so that the findings are actually what the researcher is looking for. Some ways to do this include purposive sampling, where participants are selected because they fulfill certain defined criteria needed to obtain the correct data for a study, and triangulation, a way of looking at the whole picture when attempting to come to a conclusion and to corroborate findings. Triangulation can involve using several types of method to gather data (Golfashani, 2003), suitable to methodology being used. There are several forms of triangulation; in qualitative research, one is to collate information from different informants, another is to use different geographical sites to corroborate findings and create diversity. Further methods to ensure credibility include observation, focus groups, individual interviews, iterative questioning (Shenton, 2004), audit and peer debriefing, There should also be a detailed account of the phenomena being studied to assist with understanding of the subject matter and the context. A final, but important method, is having participants read transcripts of their words to confirm that the content contains the essence of their original interview (Lincoln & Guba, 1985).

I addressed credibility by carefully planning the research project and making sure that I had a well thought out research question appropriate for descriptive research. As qualitative descriptive research does not have a distinctive underpinning methodology, I carefully chose the following elements:

- selection of one-on-one interviews as a method of data collection suited to naturalistic inquiry

- acknowledgment of personal values and biases by participating in a pre-suppositions interview prior to the commencement of the study
- use of purposive sampling to select participants
- requesting participants to read the transcript of their individual interview to check that they agreed with the content and that the transcript reflected what they remembered they had said.

I believe this would be valuable in qualitative descriptive research as this type of research is about "straight descriptions of phenomena" (Sandelowski, 2000, p. 339), so what a person actually said is vitally important. To address triangulation, I engaged ten participants of varying ages and sex who were from different practice areas, who were interviewed separately to ensure that findings were more reliable.

Transferability involves the generalization of a study outcome from one situation to another. Transferability would not be expected in a Masters-level study because the small size of study samples. Therefore, although I have collected and referred to research data that is rich and in-depth, and provided details about how I conducted the study, selection and number of participants, data collection methods, findings and conclusions, the study sample is not big enough to allow comparison to occur (Shenton, 2004) and therefore is not transferrable.

Dependability, or the ability to repeat the study exactly and come out with the same results is another challenge to qualitative researchers because of the generally fluid nature of qualitative research subject matter. What might be achieved is to ensure enough detail is described in the study to ensure that it could be repeated, but at the same time acknowledging that results might have altered. Use of an audit trail throughout the study captured detail to enable repetition. Crowe (2005) also stresses the importance for interpretive rigor, which means adequate, clear description and details of the relationships and links between the data and the findings to support the emerging theories (Crowe, 2005). To maximise dependability, I used an audit trail and clearly documented my choices pertaining to theory, method and analysis in my thesis, relating each step to relevant literature.

Confirmability in a qualitative study may be viewed as minimizing researcher bias as much as possible. The process of triangulation, acknowledgement of a researcher's own beliefs and biases and giving participants the opportunity to read and comment on what is written in interview transcripts (where interviews are used), all play a role in achieving this goal. Therefore, an audit trail is essential to show attention has been paid to the potential of researcher bias as well as acknowledgement of any shortcomings in the study. To satisfy the requirement of confirmability in my study, I participated in a pre-suppositions interview, transcribed it and

reflected on the findings. I also gave the participants their interview transcripts to provide feedback for accuracy and to confirm that was written was correct. I sent the transcript to them by email and asked them to read through and correct, make comments or delete as appropriate, and then return to me. My audit trail consisted of a written proposal, ethics application, interview transcripts and post interview notes; keeping tables of data and accounts of emerging themes; documenting my impressions as the data evolved; presuppositions interview transcript and practice interview transcript; using Endnote to keep records of references and keeping drafts of chapters from first writing to finished version. I also used my supervisors to check my interpretations of the data.

Summary

In summary, this chapter has described the methodology, methods and associated processes that were planned and used to carry out the study. The data analysis has been described in detail. It is important to note that my supervisors were involved particularly in the data analysis, as the process turned out to be more complex than I anticipated, and I needed their encouragement, support and experience to continue to delve deeply into what the data seemed to be saying and to identify the final themes. The next two chapters will focus on the analysis and description of the emerging themes.

Chapter Four: Findings Part 1
Sourcing and Taking Up Ideas Implicit in Occupational Therapy Practice

Introduction

This chapter briefly outlines how the participants sourced ideas before discussing how they took up ideas implicit in occupational therapy. Ideas that have been taken up from outside the occupational therapy profession are considered in the following chapter. In this chapter the findings revealed that the participants sourced ideas in a number of ways including peers and colleagues, meetings and through self-directed learning. The ideas implicit to occupational therapy that had been taken up were being occupation focused, enabling occupation, spiritual understanding, use of occupational language and clinical reasoning in practice.

Sourcing ideas

In order to take up ideas presented in the international literature, occupational therapists practicing in Aotearoa/New Zealand must first be aware of new ideas and have a means of accessing them. When reading across the data, I found that the participants had distinct reasons for and many ways of sourcing ideas. Erica summarised the approach of most of the participants when she commented that she was:

> always coming across new ideas… that I want to integrate into my practice.

Like Erica, the other participants signaled that they were open to new ideas and that they were taking up ideas willingly and actively. New ideas coud both be new to the participant as well as new in the literature. Further, as Erica suggests, their uptake of ideas was clearly related to their interests and area of practice. That entailed both an awareness of their current practice knowledge and a strong desire to continually seek new ideas to improve their practice, which would lead to excellent service provision to their clients. The sources of ideas could be loosely grouped into categories: Peers and colleagues, structured events and meetings and self-directed learning.

Peers and colleagues

The majority of participants either stated or implied that they were learning from or consulting with a broad range of people, in various personal interactions or collaborative events and using their local knowledge. One of the particpants, Eleanor, also wanted confirmation that her ideas from training and working abroad were correct for her practice in New Zealand. She picked up ideas

From counterparts; Not only seniors, but also occupational therapists that work with me; Other disciplines. Definitely physiotherapy. ... I do check a lot of it with my supervisors and my seniors, only because this is new for me… So I have to seek assistance and advice all the time, which I do and which I find is very useful.

Callie also actively and intentionally sought ideas amongst her multidisciplinary team (MDT), knowing who had expertise and who would be able to provide answers to her questions

Nurses who are very skilled and experienced - good access to psychologists and psychiatrists and things like that, so there's lots of good access to the MDT.

Jane valued interactions with both new graduates and experienced colleagues because each group had something different she could learn from.

I've gone out with new grads and learned heaps 'coz they've got all the new stuff, and I go out with older therapists, and always it's the most useful form of training, professional development.

In addition to gathering ideas from colleagues through conversation, Laurie emphasized the usefulness of observing her peers engaging in interventions with their clients. She learned different techniques from them that she suggested she would have otherwise not known about.

I think it's just interesting to see how people do things differently. I remember going in to do a kitchen assessment with a peer and there was something she was able to test by just asking her [the client] to do a certain thing. I remember being quite impressed, thinking, 'gee I never would have thought of that.

In addition to putting themselves in situations where they might learn something, some participants targeted those who would be able to provide answers to specific questions, such as Callie who

will ring up and pick the brains of certain community occupational therapists.

However, only one participant mentioned obtaining ideas via emails from an occupational therapist friend who was working in tertiary education, who

flicks me things that she thinks are interesting.
- Sara

Additionally, Sara and her friend met socially and engaged in lengthy occupational therapy related conversations because she wanted to know what were the current ideas at university level and she would ask her friend

where is occupational therapy going? I need to be on the ground floor of where it's going to happen.

Sara was the only one accessing someone who was away from the direct practice setting, which brought her more than knowledge that could be directly taken up in practice; her friend was a source who could inform her about the direction the profession was heading.

It would seem therefore, that the participants were quite selective about how they sourced ideas, valuing both the knowledge built up by people with recognized expertise and also the new

knowledge that those recently graduated were bringing with them. They used opportunities that were open to them locally; from colleagues they trusted and believed would have valid ideas.

Structured events, processes

In addition to these informal strategies to exchange ideas, participants identified sharing ideas at occupational therapy in-services and meetings, such as inter-DHB occupational therapist meetings. These meetings were considered a major way of spreading information relevant to practice. It seemed particularly important for the take up of ideas around new equipment and ways of installing it.

> *We meet fortnightly as occupational therapists and swap ideas. Any time we get a break though, like that and new products come out, we share it between us at the occupational therapist meeting. We just keep informing each other of what's going on and keep picking each other's brains.*
> *- Jane*

A popular event was attending an annual equipment show

> *Show your ability was on in February, which we all went to.*
> *- Jane*

'Show your Ability' is an annual equipment show where new products are showcased and there was an opportunity to try equipment out as well as ideas about how the equipment could be used in practice.

A proportion of participants also found value in attending externally facilitated District Health Board (DHB) workshops, which could be *"quite an inspiration really" (Laurie)*, or engagement in formal post-graduate study such as *"my post grad certificate" (Rosalind)*, as well as DHB Career and Salary Progression (CASP) programmes. These avenues provided a way of accessing ideas that were not usually easily available from the people they worked alongside, and offered opportunities to be exposed to specialists in a field and learn theory, in addition to practical treatment approaches. While a salary increase is attached to satisfactory completion of CASP objectives, it appeared to be valued in its own right as a means of formally participating in projects that would impact and improve practice.

> *I am doing CASP this year with a variety of projects attached to that, which I enjoy very much.*
> *- Sara*

Jane emphasized that regular peer review with colleagues providing feedback was an official organized source of discussing ideas that could be incorporated into practice. It was seen as particularly useful as it was an inter-DHB arrangement so this was a way of networking with colleagues from another DHBs and being exposed to knowledge and ways of working different from that within the usual work environment.

We also have inter-DHB peer review so people are allowed to pick your brains…
you ask what you want to have the peer review about and you look at particular
area of practice.

The participants appeared to demonstrate cooperative efforts to pick up new ideas, again with a focus on direct applicability of information to practice, but additionally linked to personal gains such as enjoyment, being inspired and playing a part in other people's learning. At the same time, they were also paying attention to a wider view of the profession's knowledge base in seeking exposure to theoretical developments via engagement in formal educational opportunities such as university post-graduate study.

Self-directed learning

Some participants described instances of self-directed or found learning opportunities, such as overseas-sourced textbooks, magazines and Internet articles (often UK or USA), books purchased locally out of interest, and literature provided at equipment shows. The reading was often done around specific areas of interest such as

a book on posture management, which is a particular passion of mine.
- Sara

The participants seemed to be looking at a variety of sources. Some sources were well known in the participant's sphere of practice and were aligned with providing interventions with specific categories of client. Some were tightly aligned to the ideals sought by a particular participant and were not necessarily from occupational therapy literature. Erica questioned current mental health practices and looked for alternative ideas and practices around the world to inform her practice. She mentioned the use of 'Google' and U-tube to locate information

I can Google Thomas Szasz…[a psychiatrist]or U-tube Thomas Szasz and then
watch him talk about his own [ideas].

Yet other sources were more diverse, embodying general theories and ideas and broader professional issues. For instance, Laurie identified how she reflects on her practice when reading

I think it's lots of reading. Lots of thinking about what I've done before and
relating current issues to things I've seen in the past ... I also bought a couple of
books by Maori health professionals so I read about those. So, all self-directed
learning really.

Two participants identified they accessed the library service at their place of employment and databases available to them through enrolment at a local university. In taking up new ideas, there was a sense that participants were seeking *"a deeper understanding" (Erica*), and expressing their commitment to professional growth.

The following sections explore how broad frameworks shaped the ideas the participants have taken up related to occupation and how they used the ideas in practice; how ideas influenced

them to be with and connect with people, how the concepts of culture and spirituality influenced them and how all these and other ideas shaped their identity as occupational therapists.

Providing occupational opportunities

Following on from the outline of the ways occupational therapists access knowledge, in the section above, the presentation of findings now turns to the idea of occupation as a core concept, which was prominent in all the interviews and was seen to be

> *about who people are… [and]… provide meaning to people…*
> *- Linda*

This section continues on with the following themes: adaptability - taking on an occupational perspective; occupation in practice; occupation and a holistic perspective; and occupation, creativity and problem-solving.

Adaptability – taking on an occupational perspective

The participants took it as given that to practice occupational therapy it is necessary to have a big picture view of each client's occupations, which includes a person's routines and leisure activities in the community as well as the basic activities of daily living. One participant described how she feels she needs to be flexible and adaptable depending on which occupations a client wants to address. Sarah suggested

> *everything eventually is an occupation.*

This seemed to be a reference to pluralistic practice when she said

> *you can be whatever the patient needs you to be,*

and she gave some examples

> *It's the lovely lady who desperately wanted to knit after her stroke, so we sat and did knitting together. There was a lady who was so low, that could knit, but wouldn't knit by herself so I bought my own knitting – we shut the curtains and knitted side by side together and just talked, You know, it's the woman who really just wanted to see how she could have sex after her stroke - whatever they want me to be. If I am going to be the bad guy who makes them get out of bed - then that's who I will be - so if they say, 'oh, I am going to get cranky at you, dear…' I say, 'you just be cranky – I can handle it – it's fine. …You know, all those things - everything.*
> *- Sarah*

Some participants said they *"focus on the occupations and the difficulties people have in occupations" (Linda)* and *"in-depth detailed information about occupation" (Annie)* of their conversations with their clients and how they included not only self-care activities and basic skills to be able to manage at home, but also a person's leisure and interests

That might be how they were making their breakfast in the mornings. ...the occupations that fill up their day; ...family as well and how they talk about their grandchildren. ...socialising. ...shower and dressing, feeding, and drinking, kitchen assessments.
- Annie

Sarah discussed a common client goal of being able to return home. It was an example of taking an occupational perspective; not just to understand clients, but as an organizing concept that guided their thinking about what to do and what clients would be motivated to engage in. In the specific example cited, for the patient to achieve that goal, it meant that the patient needed to be receptive to nutrition via tube feeding. This was apparently met with resistance from the patient. However, Sarah gave an example of how she keeps focused on the person's goals.

I just went in there and said, 'what do you want to do?' [the patient] said, 'I want to go home...'Ok... you want to go home, what will that look like? What do you want to do?

Sarah indicated that she was able to assist that person with making a decision to accept tube feeding by talking about the occupations she would need to engage in and how nutrition supported that goal to return home. She highlighted,

There is no point if they are not working towards something they want.

Sarah was looking at the steps needed to achieve the long-term goal and explaining this to the client in a way that was understood by them, i.e., you need to do this before you can do that... Linda too, felt there should be more emphasis on encouraging a client.

[It is important to be] setting targets and steps to community occupations and base line community occupations.

Occupations in the community included

shopping, cooking, money management; public transport; volunteer work.
- Linda

Annie felt occupational therapists were unique by emphasizing that occupational therapists were the only profession who looked at how people participated in occupations and the skills needed to carry them out because

you're highlighting concerns and issues that you know no other profession would see and identify.

Jane identified her uniqueness as an Equipment Modification Services (EMS) assessor, with access to funding for equipment and housing modifications

Everybody else can do nearly everything else - only I as an EMS Assessor can access that funding, so I do the work that only I can do and a little bit of the work that everybody can.

It seems that in having taken up occupation as an organizing concept, the participants were looking out from the health context to the opportunities and demands in people's everyday lives in their homes and communities. There is a suggestion that this perspective informed much of their thinking about clients and practice so that they were able to look forward in time and

imagine what a client's occupational future could be if the steps were followed. They were then able to articulate that vision to the client in an understandable way and support the client to move forward, step-by-step to towards the goal.

Occupation in practice

Callie talked about how she believed occupation and engagement were closely connected and how together they impacted on improved health outcomes

> *The other key concept is that occupation and engagement in occupation is an important part of health. ... You're either working towards helping this person do an occupation as your treatment goal or you're using engagement and occupation to work towards a treatment goal, which might be improved mood or a better quality of life, or their ability to manage distress and anxiety, or whatever it is.*

Lifestyle re-design was a topic that two participants brought up as an important idea that they were interested in developing in their practice: Rosalind said it was about

> *somebody not carrying on their current path and it very much fits in with public health,*

and Sarah added

> *kind of life skills…*

Rosalind went on to comment that

> *the tricky thing with lifestyle redesign is that they have to be in a space where they are ready to make that difference.*

She suggested occupational therapists could initiate the process, have those initial conversations about how a person may be able to change their occupations,

> *planting the seed, 'I can change – I don't have to carry on like this'.*

Sarah reflected that often clients do not know how to make that change, so it is by talking with them and discussing ways that this could be achieved that is important. From there, the client begins to understand that by making small changes at a time, there are alternative achievable occupations that will address desires and goals.

> *What are you willing to give up? What if you just give up one of those? What could we replace it with and still leave you with some of the things you still like to do?*
> *-Sarah*

There was recognition that home visiting with patients before discharge from hospital was a valuable intervention.

> *and you're doing some cooking with them or whatever…to build their confidence [before they went home].*
> *- Laurie*

Peta talked about training family members who would be caring for her client at home. Occupations could be achieved by the correct and safe use of equipment by the caregivers. This meant that eventually the client was discharged home because daily care occupations could be

completed. Peta suggested that a great part of her role in this case was to communicate with, educate and train family members so that essential occupations could be identified and a plan worked out as to how they might be achieved to attain the patient's and caregivers goal of the client returning home.

There was recognition that engaging people in occupations they enjoyed was a way of providing interventions and Eleanor described how she targeted treatment with activities such as board games and lamenting that there was not always the time to engage clients in leisure activity occupations

> *I got to provide rehabilitation to a patient by using a game ...I got it because it's got all the visual spatial, visual perception components to it. And it sort of did remind me of what I used to do at home. The activity was holistic and stimulating to the patient at the same time, which I feel is a huge role of occupational therapists here but we just don't have the time.*

Linda wanted to see more baking groups within the area she worked and suggested that

> *we get positive feedback about those interventions.*

Laurie, who had previously practiced overseas talked about her interest in palliative care and how occupational therapists in her home country were being employed in hospices, which is rare in New Zealand. She talked about enabling people to go home for

> *them to be comfortable and stay home as long as possible...to die in their own homes… but also for clients and their families to [participate in leisure activities such as] creative writing, music therapy, that can help people explore feelings [in the hospice itself for both the client and the families].*

Linda summed up this theme of occupation when she said

> *occupations are essential. Occupations are who we are; we can make a difference.*

The participants provided a variety of examples where they were taking up occupation-related ideas for their practice. These ideas ranged from use of client occupational history and leisure as a resource to draw on; engaging the client in therapy; building their confidence; recruiting others to support occupational outcomes, and ways to support end-of-life care. They picked up occupation-focused terminology from what they had read and from colleagues who used occupational terminology when talking about their own occupation-focused interventions with clients. Occupation-focused terminology was applied quite broadly to support reasoning about using occupation as a therapeutic mechanism. Overall, the participants were able to bridge from the health issues clients presented and shift to identify the occupational mediums required for the clients to resume valued aspects of their lifestyle.

Occupation and a holistic perspective

The majority of participants felt that they practiced holistically and that it was a characteristic of occupation-focused practice. Laurie suggested that a holistic approach meant understanding the "core aspects" of the person as well as the physical aspects, while Annie felt strongly that holism is connected closely to theory. She indicated that because the occupational therapy models were client-centered, this gave the clinician more access to the client's needs and so felt she was able to

> *look at the full picture of a person's life, their experience, where they've come from, [which] gives you a better understanding of that person.*

Peta concurred,

> *particularly cognitively; ...there aren't many professions that look at everything that we would look at.*

Rosalind also identified that occupational therapists

> *look at the whole person and how people live their daily lives.*

Eleanor, however, suggested that the lack of occupational therapy outpatient departments provided a gap of intervention in the client recovery journey and as such, limited a holistic approach to rehabilitation because clients often needed time to

> *gradually do everything sort of step by step, [as] equipment will not solve all issues. ...Coming in for outpatient occupational therapy would make a difference to their overall holistic function.*

She was indicating that clients were missing out on an important part of their treatment, with respect to occupational therapy. There was little or no follow up by occupational therapists with rehabilitative interventions on discharge home, as the emphasis was on equipment provision.

Occupation, creativity and problem-solving

In general, there was a feeling from participants that they were "creative" and "lateral" thinkers as well as being problem solvers. However, Eleanor felt that creative activities were "under utilized" in the New Zealand setting. Likewise, Sarah talked about the loss of some interventions that were traditionally part of the occupational therapy repertoire

> *[There] were reasons why we did the basket weaving and the crafts, knitting and the bingo and all of those things and I think there is absolutely a place for those things; they are still very valid, if that's what the person likes.*

There was a feeling that it was a mistake to turn our backs on certain occupations used in the past because they might be quite valid in certain circumstances.

Callie suggested "problem solving" and "finding solutions" was a large part of what occupational therapists did because the role entailed finding ways to provide "engagement and participation and inclusion". Peta said that

> *figuring out [what clients] can't do, how that's affecting them,*

and then finding a solution is what she does. Annie suggested that problem solving was necessary because each client required a solution tailored to individual need so

> *we have to be good at problem solving and coming up with the many solutions to the many issues.*

Participants reported engaging in a great deal of problem solving. They talked about referring to overseas literature, sharing ideas with one another, trying to find practical solutions to functional issues that enabled clients to participate in occupations.

Eleanor talked about problem solving with colleagues. She felt this was actually better and was less stressful because

> *problem solving together always works.*

Jane identified many sources for ideas to solve practical problems including

> *reps; equipment providers; colleagues; the web; equipment shows; equipment and housing sourcing.*

Sometimes patients were not eligible for government-funded equipment because they were non-residents. Annie talked about problem solving alternative ways to supply what was needed which included resourcing disused equipment from storage and modifying existing equipment – She said that

> *thinking outside the box*

was required of an occupational therapist.

Providing enablement, justice and safety for clients

This section looks at enablement with an eye on justice: influencing clinical decisions; enabling occupation with regard to safety and risk and provision of occupational enablement and justice within a government policy. In addressing the connection between enablement, justice and safety, participants indicated they needed to consider how the ideas of justice and safety impacted their work and client outcomes. Additionally, the skills and commitments participants brought to their work framed what they communicated to and about their clients.

Enablement

The participants indicated that there were many different facets of enablement. They talked about advocating for their clients: Annie believed

> *you're advocating for the patient because your theories allow you to do that,*

linking theory to practice. Callie liked to be able to advocate for clients because there were

things that are important for that person to be able to do, like what jobs they have and enjoy

and facilitate the ability for them to participate in occupations

so they can do it rather than just take that occupation off them.
- Callie

Jane voiced how some simple yet important interventions can enable occupation and reduce stress around those personal activities of daily living that most people want to do as independently as possible

If it's in the right place at the right time, you have made a difference to that person's life. Yes, sitting on the loo without feeling desperate and feeling that we are going to be stuck the moment we get off ...it is not glamorous, but it is essential.

Clarity of role was important in enablement. Jane reported explaining to clients what she did as a therapist and then asking them what she could support them with. She said that after she had listened to them she was then able to give them a list of possible interventions she could provide support or help with that align with their goals. The clients could then decide which would be the priority to try. She further suggested that occupational therapy, in her opinion, was not necessarily about doing concrete things with clients at first but actually asking them what they wanted, what expertise they needed by listening and talking with the families.

Peta also enabled clients by talking to them and really listening to what their goals were

They are more likely to listen to your professional opinion if they know that you're working towards the same goal as them about getting them home.

Peta also talked about listening to a patient's family. She was able to identify their concerns and support them to be able to become involved in their family member's care.

It wasn't really until we had that discussion with the family and we got them on board that was actually going to be a plausible discharge because before then I didn't necessarily see that happening.

The patient, who was accessing palliative care services, was enabled to return home with the support of the family, to pass away in a place of choice, surrounded by family members.

She was really happy because that's where she wanted to be. That was a good outcome for everyone involved.
- Peta

Participants often saw enablement as providing education to clients and their families so that they had the information available and were empowered to make decisions. It initially included telling clients about what occupational therapists do, so clients could decide whether they wanted to have occupational therapy in the first place.

Some people don't want to be seen by occupational therapists and that is fine as long as people have the information to be able to make that decision; that is okay.
- Rosalind

Peta also made the point that it is often the relatives who take on the responsibility of providing care at home. Therefore, the family/whanau needs support to be enabled to put strategies in place for discharge and Peta said that

my role is education to the family and even sometimes just keeping them in the loop.

Rosalind agreed and stressed the importance of enabling clients to continue to participate in occupations on discharge and

give them the information so they can own that recovery at home,

which was a way of continuing the rehabilitation process.

Strategies to enable occupation

Strategies mentioned by participants were strongly related to enabling occupation. The strategies included being able to:

- Explain to clients their role as clinicians and what they were going to do together
- Provide equipment to enable certain occupations or provide a compensatory function
- Use task analysis to break down large occupations into smaller steps
- Practicing how to carry out occupations by role play, facilitation or prompting
- Educate the client to enable him or her to participate in desired occupations
- Making interventions fun.

The following examples from the participants demonstrated how they enabled occupation in action. Erica was clear that if interventions were fun, they were more accessible to certain clients, but could be educational at the same time

So that's what they want. They want to enjoy themselves doing the programmes. They want to have a laugh and a joke.

Erica also mentioned running healthy living courses and activity-based groups. There was also emphasis on teaching compensatory techniques and equipment issue. Linda talked about setting targets and steps for patients to achieve in their occupations, based on what they needed to do when returning to the community. She used words such as:

facilitating
prompting
repetition
looking for impairments
barriers
finding what needs to be learned; practiced, tailored to the client.

Rosalind and Sarah were interested in application of early intervention neuro-facilitation and associated modalities. They gave examples of the connection between being able to engage in improved occupational performance by neuro-facilitation, which in turn improved quality of life. Early interventions could act as a precursor to engagement in occupation. An example of neuro-facilitation and its link to occupation might be enabling the patient to be able to sit up in a good position to be able to eat a meal and be able to become more aware of surroundings. Other examples would be splinting to encourage correct positioning of a limb or the use of wrapping techniques to provide sensory stimulation to part of the body. Sarah gave an example of such an intervention and linked it to the theories and training she is passionate about. Her client wanted to be able mobilise and use her hand. So using a combination of dynamic systems theory, a task-orientated approach, sensory modulation and sensory integration as her theoretical models, Sarah applied techniques she had learned on a splinting course as well as *"things from previous experience"* which improved the patient's *"gait pattern and the tone in her upper limb"*. The patient was also able to pick up items with her hand that she had not been able to do before. Sarah stated that this was an example of the theory she had read, clinical experience and strategies coming together to enable the patient to prepare to participate in occupations.

> *It was a way of building in all the evidence that I have read, all of my own personal clinical experience and all the courses I had been on had coalesced on my patient – it was amazing!*

There were additional strategies mentioned. Erica provided opportunities for clients to participate in a range of programmes, and used communication strategies to encourage, support and enable participation in programmes and engage in occupations *"like playing pool"* and *"do normal everyday activities…[to] give them a chance to practice their skills in a very supportive way"*. Rosalind focused on occupation and participation with less emphasis on equipment provision, which she felt was a "quick fix solution". She suggested that activity analysis was a useful strategy to break down tasks *"…so people return to what they were doing"*, rather than being reliant on equipment.

Enablement with an eye on justice: Influencing clinical decisions

The participants discussed the decisions occupational therapists had input to, and ensuring the decisions were just. All of the participants in this study had been asked to be involved in assessment of the client's competency and capacity to make decisions. Some participants voiced concerns regarding autonomy versus risk and articulated the need to recognize that if a person was found to have the capacity to make decisions, then it should be acknowledged, so enabling the person to be able to make choices without externally imposed compromise.

> *My view is that if people are still deemed to have the capacity to make decisions for themselves then we need to respect their right to make those decisions and when there are big risks look to work on improving insight and minimising risks*

and strategising rather than coercion. I am quite a strong voice for the other side
of that and I guess that's around occupational justice.
- Callie

Most of the participants were based in settings where they were working with people who were residing in facilities other than their own home, either temporarily or indefinitely, such as hospital, residential care or a mental health facility. Callie described a situation that indicated how enablement resulted in occupational justice. She received a referral from a rest home because there was some question about a resident's competency to make decisions. Callie needed to complete an assessment and make recommendations. She identified the client goals and although it became evident the person could not be managed permanently at home, she did not require a more secure environment either, which was under consideration. Callie was able to make recommendations that were taken up and used by others so that the person could achieve those goals while still being able to live in the rest home

> *What came out of my assessment was [not only] recommendations about changes*
> *to the environment that could be made but also really looking at what this person*
> *was wanting. He ended up staying in that facility. Family who were already taking*
> *him out facilitated him going home and they supported him to help him make a cup*
> *of tea for his wife. ... He wanted to be walking more, ...so he needed opportunities*
> *to do that. ...They sat down with him and identified the kind of activity programme*
> *in the hospital he had been interested in. So most of what I recommended was*
> *implemented and I feel like I had an impact on him staying there.*
> *- Callie*

Erica looked at enablement as a political issue and was concerned that client needs were not always taken into consideration because

> *You get lots of politics and professional boundaries and people start acting in the*
> *best interest of their department rather than what the Whaiora[2] need and want.*

She argued that some groups of clients were markedly disempowered within the health system and not able to access the occupations that they needed. She suggested that it could be seen as a civil rights issue because the system and structures allowed for inequality of power

> *a lot of people get wrapped up with those systems and processes.*

Clients should be able to make decisions regarding what paths they choose in life and in their healthcare choices

> *recovery clearly states the Whaiora[2] is in charge.*

She indicated she wanted occupational justice for her clients but felt that the organizational structure limited this. She said that all the services are set up with completely the opposite idea

> *they can be completely disempowered.*

Thus occupational justice appeared to be constrained by influences outside the participant's control, but Erica had taken up the idea and tried to work with her clients with justice in mind.

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[2] [Tangata] *whaiora*: literally [people] in search of wellness

Enabling occupation with regard to safety and risk

Patient safety was a common concern of six participants. They talked about it in relation to a risk-adverse society, omission by neglect, risk assessment and minimization of risk. Safety appeared to be a complex area of work where clear clinical reasoning was required when making recommendations for clients.

Occupational therapists were involved in risk analysis and management where teams needed to know that clients did not pose a risk to them-selves or other people. Erica displayed concerns about risk-averseness, exemplified by warnings such as

> *can't do this because you might fall down.*
> *- Erica*

The impact on how much risk clients should be exposed to in their daily occupations and whether they were safe in certain environments prompted the use of equipment

> *safety here is of utmost importance…[equipment] does add to the safety of patients*
> *towards independence.*
> *- Eleanor*

Referrals in the acute service were often to assess whether a person was safe to return home. Peta explained,

> *so it's dependent on whether I can do it safely. … it's figuring out the problem,*
> *trying to sort it as best as I can. If it's safe, they go home and if not, then we'll look*
> *at the other options.*

Jane concurred

> *It is often about making the place safe, …walking around the house with them,*
> *…talking them through safety and then making safe play areas with safe areas in*
> *the home.*

Participants reported using patient education to promote awareness of risk and offered suggestions as to what could be done to reduce safety issues in the longer term. Peta used this strategy also, acknowledging that

> *If the patient is competent and aware of all the risks and they are willing to take*
> *that risk then personally I think that's our responsibility to help them get back*
> *there.*

Limited time often meant the use of compensatory techniques to enable occupation and address safety rather than engage in a rehabilitation programme:

> *you put in compensatory strategies just to get them out of hospital or you might get*
> *a caregiver in to help.*
> *- Laurie*

One participant talked about wearing two hats – the hat of risk reduction needed by the DHB and the hat of the occupational therapist, supporting a client's choice to retain independence by participating in occupations that might carry some risk when they are doing them, such as performing self care activities

The hospital's all about safety ... reducing risks. It's about making things as safe as you possibly can, but increasing independence at the same time. But kind of wearing two hats, like the DHB and then occupational therapists you're kind of wearing both of them at the same time.
- Peta

Wearing two hats could cause conflict regarding the beliefs of occupational therapy, limiting the ability to focus on client goals outside the scope of safety.

Erica discussed the concept of risk as enabling clients to be

able to demonstrate to the staff that you can manage your risks in the community.

To some extent, the participants' concern with risk encompassed their own actions. For instance, Sarah was concerned with keeping up to date with her knowledge because she did not want to be in a position of neglecting aspects of her role and not providing an enabling service because she did not have the knowledge and skills

I realize that there is the potential to inadvertently do harm if you are not sure that what you are doing is safe. There's a concept ...called neglect by omission ...it's really important to me that I am practicing in a safe and knowledgeable way.

The participant's awareness of risk seemed to have become an inescapable part of their practice, and they believed that the primary aspects of practice that were impacted were making judgments on how safe a person would be at home, as well as the safety risk to themselves and to others in the community. Risk became an ethical consideration in relation to client outcomes and on occupational justice when a person was considered unsafe to participate in desired occupations or live in a preferred residence. There appeared to be a tension for the participants – the wearing of the two hats. Their beliefs in being client-centered and working towards the achievement of client goals, (particularly living in the community) on the one hand and keeping the client safe on the other. They were often obliged to tread that fine line. Taking up ideas therefore is not always so easy.

Provision of occupational enablement and justice within Government policy
It appeared that enablement and justice could also be tricky in some cases because of the Government and Ministry of Health legislation policies and guidelines. Two participants in particular talked about challenges they faced due to guidelines or legislation. Jane referred to the process for equipment provision.

It is a criteria-based service and is not about not about need, fairness or what is good.

The guidelines may compromise the ideas that occupational therapists might want to explore with their clients. In some services

> *it is about fitting the criteria laid down by a body acting on behalf of the government.*
> *- Jane*

She acknowledged that she understood the need for policy as

> *they have to be rigorous and they have no money.*

Jane also referred to her way of working now as more of a consultant.

> *My service has to be consultative ... I don't have the resources.*

This was because in the current economic climate resources are scarce, and where clinicians have high caseloads, there are limited amounts of time to spend with each client. She had the time only to identify the client/family goals; problem-solve; discuss options, make recommendations and initiate and complete the process identified in the client's goal. She needed to be skilled in her reasoning processes to be able to decide what essential interventions were required. As this work took many hours to complete, there was little or no further time available for additional ongoing interventions over a period of time, such as regular therapy sessions.

On a slightly different note, Erica, a strong believer in the recovery model, acknowledged that political agendas and government policy could make it difficult to center on client goals because of the power difference between client and organization

> *I'm more and more sympathetic to the idea that recovery's actually a civil rights' movement that's about Whairoa claiming their powers back. Their rights are breached on a regular basis. ...It seems an intolerable situation to me*

She also suggested that enablement and justice could be limited due to the organization of the system

> *For the most serious offences, we don't have the final say. It's the Minister of Health for the special patients, the restricted patients. They think that they need to attend the programme. And if they had attended a programme then they've recovered.*

Although Erica felt that there were many issues with the organization and the policies that guided it, she none-the-less, aimed to work with her clients and enable them to express and work on their personal goals

> *With the Whaiora it's a question of ignoring the political aspect of it and just helping them work more on their personal recovery, so with those people it's about inspiring hope and helping them work towards the life that they want to have.*

She was driven to provide opportunities for clients to voice what they wanted to do and then support the clients to achieve those goals by channeling their objectives in a positive, inspirational way within the limits of the facility they resided.

In summary, this section has highlighted the ideas that have been taken up in the area of enablement. It shows that there are additional ideas that can be challenges to enablement in

today's risk adverse society. The participants have indicated an awareness of occupational ideas such as occupational justice, as well as competing ideas like societal risk adversity. They discussed how they took up all these ideas and used complex reasoning to find solutions that were enabling and acceptable to the client, family and multidisciplinary team.

Use and uptake of occupational theory, tools and strategies

In looking at the participants' use and uptake of occupational theory, tools and strategies, this section examines spiritual understanding, language and occupation, and marrying things up with clinical reasoning.

Occupation in tension

Two models of occupational therapy that were named by most of the participants were the Canadian Occupational Performance Model (CMOP) which was considered,

> *the most interesting theme that's come out of the last few years from the students,*
> *- Jane*

and the American Model of Human Occupation (MoHO) that

> *is really relevant to the practice setting I'm in.*
> *- Callie*

There is some indication that the models give a sense of surety; they're "familiar", liked

> *I think it just gives you some more specific tools and guidance.*
> *- Callie*

At times, it felt as though they use these overarching models almost as if they are explaining their allegiance – which camp they're in, what identity they hold

> *Generally, I am a CMOP kind of girl.*
> *- Sara*

The models were described as giving structure to practice and note writing and are so ingrained that

> *all assessments are structured around [the model they use].*
> *- Annie*

While a model gives guidance, at the same time there's a tension

> *I did not like MOHO so much but every now and then it does come out.*
> *- Rosalind*

Both these models have been taught in depth at various times in the New Zealand occupational therapy undergraduate programs (K. Reed, personal communication, March 3, 2013). Therefore, both were well known to occupational therapists in New Zealand. However, Erica suggested these models were perhaps a way of standardizing the practice of occupational therapists and she questioned that because she had taken up other ideas for her practice:

Things I have drawn upon would be theories and models from violence prevention and drug and alcohol. Mainly, I would say a lot of my recent movement has been from the recovery movement.

Erica's comments reflected those of other participants, who used occupation-focused models as frameworks in conjunction with other models and approaches that were specific to where the participant practiced. When looking at how ideas are taken up, it seems that occupation-focused language and thinking are experienced as "opposed to" biomedical / impairment focused language and the thinking that occupation and biomedical understandings are dichotomous.

Spiritual understanding

Spirituality is included in this chapter because it is a component of some occupational therapy models. When asked about how they viewed spirituality in the context of occupational therapy, participants described it in different ways but they appeared to link spirituality to enablement. Sarah described spirituality as the particular things a client loves and that as a therapist you follow the client's path.

It's something that's important to them, so you will go there and you will talk about that with them and I love to talk with them about things that they love.

So, if the client wants to address spirituality or an aspect of occupation that is spiritual to them, then Sarah indicated she would find a way to do that. Callie felt spirituality was very complex. If it was a matter of religious beliefs and the person could express it, she suggested she could incorporate that aspect of spirituality and enable the person to move forward because

you can explore whether there are supports there or whether you know that's something that is going to be useful in framing up an intervention.

Annie used the CMOP, because she felt it

gives you a feel of the person's spirituality.

She did not feel that it needed to "be more explicit". Peta linked spirituality with a person's internal motivations and volition, values and beliefs, suggesting that it was implicit and related to being

Spirituality is around the internal motivations of the person so it is not necessarily what religion they are or anything like that. ...It's more what motivates them; what they're striving for their values, their beliefs...

Laurie agreed that spirituality was

more in a person's being really and what makes that person tick.

While Erica suggested,

spirituality is one of those things that support the people ...I think we can't just ignore that. I'm quite happy to talk about spiritual issues.

Participants acknowledged the concept of spirituality; they appeared to view it as what motivated a person and how this impacted on occupation and therefore their engagement in therapy.

Language and occupation

The participant responses indicated the importance of occupation focused language when looking at identity and communicating occupational perspectives of health. Linda suggested that occupational therapists needed their terminology for both a "framework" and for their own professional strength. Sarah used occupational language associated with CMOP in note writing. She then converted occupational therapy language into something clients and colleagues understood, but kept the essence. She mixed in biomedical model language when communicating to medics practicing in the biomedical model

> *I find CMOP quite easy …I try and use some of the terms in my note writing …so it has an occupational focus… I find we can be occupational focused while still practicing in the biomedical model. I can convert my analysis into something doctors will be happy reading, and it is still actually an occupational therapy thing.*

Annie concurred, indicating her clinical notes were

> *occupational focused and from my occupational therapy point of view.*

Sarah went on to say that she used different language to communicate to clients

> *Just like talking with a patient – I would not go oh, deep proprioceptive input with your light finger flexion of your superficialis, – (but instead say,) You know, your fingers are a bit bendy; let's open those hands.*

Linda was the only participant to acknowledge the impact of occupational science on New Zealand practice as well as being able to name known authors of literature coming from within New Zealand

> *Occupational science stud[ies] the science of occupations and I just think that's a real neat adjunct to occupational therapy practice… it kind of lays a theoretical and practical ground-work.*

She added that occupational science had provided a new language, which has paved the way to examine and enter new practice areas

> *There have been things like the occupational justice approach [and] a big push in occupational deprivation. Those concepts. It's given us a language…*

Erica suggested every-day language was best when communicating with clients because she saw it as an empathetic approach that was empowering for the client. Callie felt that her work

> *would prove to be quite rich with occupational therapy and functional terminology.*

She said that she did tend to

> *Use language around engagement in activity and discuss opportunities for social interaction, community integration …motor skills and functional mobility and flexion and strengthening grips, process skills and then emotional factors and environmental factors.*

Peta reported the emergency department (ED) was

medically focused [where the emphasis was on] medical terminology, medical discussion.

She said that she did not use a great deal of occupational language when working there but would revert to using occupational terms on other wards she covered. It would appear that the participants had a preference for and used occupational language where possible, converting to more medical language where necessary. At the same time, they modified their language, using everyday words when talking to clients for better understanding.

Marrying things up: Clinical reasoning

The participants talked about the use of clinical reasoning processes to ground their work. They were able to both serve their clients and justify their actions and decisions while remaining occupationally focused. Participants believed that the combination of experience, use of the occupational therapy process and reasoning would verify what they were doing

> *So from my previous clinical experience, I know that splinting can increase range of movement done in a certain way with certain patients ... what I am trying to do now ... is to actually take the parts of the literature that are generalizable ...take the limitations ... and marry them up to the reasoning side as well.*
> *- Sarah*

Their reasoning seemed to bring together what they knew and what they found out about clients. They expected to be able to bring all sources of information together and provide sound, tailored, recommendations. They also were clear that all aspects of practice must have a reason behind them. The participants could combine their observations, experiential knowledge and ideas from the literature to identify the client's strengths, learning edges and performance issues. They were then able to make individualised intervention recommendations grounded in theory and practice experience. To be able to formulate an intervention plan in this way required a combination of a sound theoretical basis, knowledge of task analysis, knowing what to look for, knowing when something was not right with the performance, what it was and why. In other words, above all, good clinical reasoning ability was paramount and it seemed to be done effortlessly.

> *It's something I think you do without even realizing. It's automatic really. It's a process you have to go through. It's considering evidence-based practice as well...Whether it's been researched or whether it's just word of mouth from peers or whether it's something you've experienced yourself, and you think well, that might work, I'll try that.*
> *- Laurie*

Annie remarked that in some repetitive practice areas it was easy to forget why something was done. It had become an automatic part of what was done and there was no need to consciously think every time about why it was being done, although there was a valid reason.

> *Everything we do, every recommendation we make, every assessment we complete, there needs to be a clinical reason for doing it. ...on the orthopaedic wards where*

a lot of people just get an over toilet frame and a shower stool - perhaps clinical reasoning goes a little bit out the window as to why you're giving that to them…The clinical reason is because they have to carry out hip precautions [in their ADL].

This was important when considering modalities as well as standardized assessments. Some assessments had been developed for occupational therapists, while others were available to be used by a variety of clinicians. Common assessments used by some participants, but not developed with occupational therapists in mind, included the Mini Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975), and the Cognistat (Kiernan, Mueller, Langston, & Van Dyke, 1987). The participants using this type of assessment needed to use their clinical judgment and reasoning to decide why a component-type assessment was appropriate for the needs of the client, what information was required, and whether it provided information around a person's ability to participate in their favored occupations. Neither of these assessments provided occupational performance interpretations. It was up to the participant to make those connections from the results. Jane explained that there needed to be clear reasoning around why a standardized assessment, the Hammersmith (Dubowitz, 1999), which was not designed specifically for occupational therapists, might or might not be completed on a baby in the Special Care Baby Unit (SBCU)

doing a Hammersmith because you are the occupational therapist who goes to the SCBU, is not a good reason …unless it is going to change the outcome for that child, and frankly there in SCBU, they're monitored. Are you going to find anything else?
- Jane

Callie too, was cautious in her use of the Addenbrookes Cognitive Examination-Revised 2005 assessment (ACE-R) (Mioshi, Dawson, Mitchell, Arnold, & Hodges, 2006). It is a component-type of assessment that she was expected to use in her mental health role. Her clinical reasoning was apparent when she talked about questioning whether this assessment was providing the right information she required.

The ACE-R… that's usually done in the first assessment. I don't trust that the Addenbrookes really identifies what domains of cognition are impacted, so I feel that I need to have a better tool.
- Callie

She was aware of other issues that the ACE-R would not pick up

You need to consider other factors, (such as) their suffering.

She indicated that she had found self-rating scales provided more information about a person

to be aware that it's through the lens of that person - their anxiety about it - that it's that person's perspective.

Annie voiced a desire to learn more about clinical reasoning because

*we need to make sure we've got our clinical reasoning to demonstrate why what
we're doing, and that what we're doing, is important.*

She felt it was an area that she should be knowledgeable about, linking it with risk management
and clear clinical documentation. With regard to reasoning around new ideas, Erica felt that it
was necessary to be responsive to clients and to take up new ideas and change practice if better
strategies were identified. However, she also stressed that therapists should look at themselves
and take stock of what they were currently doing in their practice; to apply their reasoning to
themselves

*They haven't understood why things have failed. They think it's the technique
they've been using. They never once think, "Was I doing it correctly?*

Summary

This chapter has shown how the participants sourced ideas in a number of ways. Of interest,
was that they predominantly sourced information from each other. It was seen to be imperative
for participants to have time to meet together both formally and informally to be able to discuss
and reflect on ideas relevant to their practice. They were strongly committed to occupation-
focused practice and used a number of strategies to enable occupation with their clients. They
recognized the idea of and used an occupational language to communicate with each other and
understood that they had a complex clinical reasoning process that enabled them to creatively
problem-solve to provide occupational opportunities for their clients.

The main ideas identified in the second part of the chapter concerned the concepts implicit in
occupational therapy. The participants articulated how they provided occupational opportunities
in practice, with a holistic perspective. This section also looked at how the participants applied
problem-solving to work towards client goals, using creative media where applicable.
Additionally, how the participants enabled occupation within the context of justice, safety, risk
and policy was considered. Finally, the use and uptake of occupational theory, tools and
strategies, spiritual understanding, language and clinical reasoning was described. The next
chapter continues with further findings, this time within the context of how ideas have been
taken up from sources external to occupational therapy.

Chapter Five: Findings Part 2
Ideas Taken Up by Occupational Therapists from External Sources

Introduction

As well as ideas that are implicit to the core of occupational therapy, there were a number of ideas that the participants had adopted from outside sources. These included an uneasy alliance with and take up of the biomedical model, evidence-based practice, again aligned with the biomedical model and quantitative research, supervision and reflection from social work, client-centeredness from psychology and cultural awareness from nursing.

Occupation and medicine: An uneasy alliance

Conflict: The biomedical model and an occupational perspective

Working in a DHB where there is a strong biomedical model embedded in the structure of service delivery can cause conflict with the preferred models used by the participants. When comparing occupational therapy models with the biomedical model, Annie commented:

> *Working within the biomedical model when our models [are] very left wing, one might say, can be quite difficult…*

Use of the biomedical model by participants was reflected when they talked about gaining specialist knowledge and interventions in specific areas such as working with people with dementia, delirium, stroke, and palliative care, putting an emphasis on the medical condition the person was labeled with. However, they did align this viewpoint with their occupational therapy models and so also looked at the person and the occupations they engaged in, as a whole. In the community setting, where some multidisciplinary team members also used the biomedical model, Jane was adamant that from an occupational therapists' perspective

> *It is not very effective if you work in a biomedical model in the community.*

Annie touched on the difficulty of a lone occupational therapist communicating in teams where the biomedical model was dominant. Therapists needed to be bilingual, so they could translate their occupational language for the doctors in particular

> *To make sure your voice is being heard, especially when you are trying to relay it to people that are doctors and they don't understand your occupational therapy talk. …you need to use impairment-based phrases…" [as opposed to occupation-focused phrases] and you need to know that kind of language in order to get your point across*

Participants needed to be able to communicate their ideas when in a work environment that did not embrace their occupational therapy models. They looked for ways to overcome barriers while still being occupation focused. They were prepared to translate for their colleagues, if this

was the way to be understood, but not compromise their professional ideals. An occupation perspective was valued and preferred as an holistic view rather than a narrow medical view, particularly in the community setting, but it also needed to be translated for those professions who were strongly influenced by the biomedical model.

The biomedical model related to practice area

The participants identified tension between occupational perspectives, biomedically defined practice areas, pressure to discharge, and the profession's history of having adopted mechanistic theories which have tended to linger and influence present practice. Although not all the participants seemed to be too perplexed by the conflict between the two approaches (biomedical model and occupational models), Callie felt there were misconceptions about what occupational therapists do and that the profession itself had a *"scattered"* identity with *"disparity"* about what occupational therapists should be doing

> *What's within our scope; What's old school; What's core skills and things like that.*

The literature supports this dichotomy. Estes and Pierce (2012) reported that "traditional medical culture was generally viewed as impeding occupation-based practice" (Estes & Pierce, 2012, p. 21). Participants seemed to use models to identify with the particular therapeutic context in which they worked. For instance, participants from the physical area of practice favored neurological models*,* such as the "Bobath Model" (Jane), and "task-orientated approach" (Annie). They also worked from other models and approaches, due to pressures placed upon their work environment; for instance, *"we have to do a lot of compensatory techniques, given the pressure to discharge" (Annie).* They brought a fairly eclectic mix of theories to inform their thinking and to enable them to frame things up. The *psychodynamic and the psychoanalytic frameworks (Callie)* as well as using

> *cognitive stuff ....for working out ...how I might approach psycho education or strategies, like whether it's what capacity people have to learn.*
> *- Callie*

They looked for complementary models *that work so well together (Eleanor)* and they wanted to include culturally sensitive models,

> *KAWA model ...it is about life stage ...used as a tool for reminiscence and acceptance of where they are now and goal setting*
> *- Callie*

Erica was concerned that overseas thinking was not influencing or changing legislation in New Zealand fast enough so that more effective responses to certain kinds of healthcare in mental health could be addressed. She suggested that there was

> *a lack of vision and motivation for people who have the power to change the system*

She acknowledged,

> *the recovery movement has been getting small changes, ...but the key structures and process have remained in place.*

This seemed to illustrate her frustration at knowing there were ideas out there that she saw as beneficial, but there were barriers to implementing them.

Use of multiple models relevant for their particular area of work was definitely present. These models provided reassurance and confidence that therapists were doing the right interventions for their clients, although it could also create some tension knowing there were ideas that could not be taken up as fully as the ideal suggested.

Evidence-based practice

Some participants appeared to need a recognized pathway to guide them in their chosen area of practice that again gave them the confidence and authority to practice consistently in a particular way. Practice guidelines were an option. Linda felt guidelines were a good way forward, as they were evidence-based and helped to bring "consistent systems" into practice. She also hinted at the accountability and "great responsibility" she felt in providing treatment "consistent with the guidelines". Annie indicated that

> *seeing what other people are doing overseas and using the 2010 Stroke Guidelines*

were ways to keep updated within her area of practice. Many practice guidelines originated from the United States, the United Kingdom or Australia. Linda gave an example of evidence for dementia care from the United States, a dementia care guideline from the United Kingdom, coupled with research that was being undertaken in New Zealand. She indicated that she could source ideas for the interventions she was interested in and felt that dementia care was

> *an area of untapped potential at the moment. But the evidence base is there*

Linda, Annie and Sarah indicated that they used the American stroke guidelines as a reference in their work. Linda reported attending a workshop that was about evidence-based rehabilitation for people with dementia which

> *really reinforced for me the need for a rehabilitation approach for this client group*

She was looking for ideas that supported her viewpoint

> *the evidence is coming and it really coalesces well with the occupational therapy evidence*

Rosalind was also looking for structure and consistency in a particular practice area, which she indicated, could be achieved by focusing on evidence

> *We need to come from an evidence based focus which also gives us a bit of structure of where we are heading, rather than doing it on anecdotal evidence or flying by the seat of our pants, as it were.*

The participants accessed articles to inform their practice from a wide variety of sources. Literature could be both qualitative and quantitative due to the nature of practice being closely influenced by the medical approach within the DHB.

Reasoning was considered particularly necessary when deciding whether evidence in the literature could be applied to a therapist's own client group. It was another component of a participants skill set. Rosalind indicated that evidence-based research was her preference on which to base her practice, but the evidence needed to be understood in the context of the local practice situation. So she believed that occupational therapists should

> *not just read articles, but (know) how to critique them … how useful is the research and information we are reading? Is it actually transferrable, reliable and valid?*

She talked further about the importance of critically appraising ideas from the literature by the use of appraisal tools, essentially a questionnaire that guides a person's thinking when reading through an article to make a judgment as to whether it is quality research and also to enable a person to decide whether it can be applied to local conditions. Sarah agreed but warned,

> *it is quite dangerous to just dismiss a whole modality on three studies*

Sarah felt that an evidence-based approach needed to go hand in hand with the use of clinical reasoning, and suggested how closely the two are intertwined

> *…it shouldn't be evidence only practice - it should be an integration of the available evidence and your clinical reasoning and your clinical experience…"*

Jane suggested that evidence-based research was reassuring because she then knew that there were other people who supported her belief that intensive intervention was the ideal for her patients. She quoted some examples of literature, emphasising

> *It is research based …a child should be getting …people support 24 /7 with advice going in. We have never been able to really implement it …at least you know there's others out there…"*

Evidence-based practice was promoted in the DHB environment and actively taken up by the participants, despite some of the literature drawing attention to occupational therapy being an "art" (Trenc Smith & Kinsella, 2009, p. 304) and implying that an emphasis on evidence-based practice can be detrimental to the creative art of occupational therapy. However, workshops demonstrate the importance of evidence-based practice, and that it is recognized as a required skill set.

Exploration of ideas: Supervision and reflection

Supervision was considered essential by all the participants and was deemed a place where ideas could be explored:

I think as occupational therapists we always have that reflective component. You are always trying to think of how to do something better. There are always situations that you haven't come across before. So you're always trying to think about: Well, you've done this, and my patient's kind of similar or the situation's kind of similar so what could we do or how can we address this.
-Peta

Peta talked about how discussion in supervision clarifies the occupational therapist role when it gets blurred and Linda said supervision was needed to work through complex cases presented to clinicians as well as

you list what's happening ... a review of where you need to go ... essential for defusing those stresses ... where do I want to go next in my practice?

Laurie used the reflective process in supervision to think through the best way to provide interventions for her clients

I actually take at least one case that needs the supervision. I've got this person and I'm thinking that I should be doing this, but is there anything else I could be doing or would you do it a different way?

Laurie said that supervisee training was useful to know

if you are doing the right thing and on how you can learn a bit more out of your time with your supervisor.

Sometimes the time between supervision meetings meant that the person wanted to reflect on an issue before that. Several participants said they engaged in regular on-going personal reflection. Laurie described reflecting alone on the way home about the events of the day by

thinking about what I did that day and was it successful? Could it have been better if I did it a different way?

Peta suggested that she reflected by herself, "*I have usually thought through a lot of the issues*", or with her immediate occupational therapist colleagues "*there is a lot of dialogue (and) reflective practice that goes on in our office.*" Eleanor concurred that reflection happened "*when we're all together in a group*".

It appeared that participants used colleagues in the office to talk about events and reflected together on what happened and how to handle the issue another time. However, Annie wondered whether formal clinical supervision was always helpful, suggesting that hands-on clinical supervision, in situ, could be a more effective learning tool for some situations

Sometimes it can be very different, sitting down and discussing an issue very far away from the environment that you are working in. It doesn't necessarily teach you those skills that (you need) when you are put into your day-to-day stresses on the ward and so, yeah, I don't know if it necessarily builds your confidence in your work environment.

Eleanor, who was trained abroad extolled the virtues of being able to access formal supervision in New Zealand, as "*there was no supervision system encouraging me (to) look at occupational therapists' specific ways of doing things*" in the country she lived in previously,

So it would seem that the idea of supervision was taken up and considered a valuable tool by the participants to both review practice regularly and provide a level of confidence in their own practice. The idea of reflection was also taken up and used not only in supervision, but also at other times done alone and with colleagues, to think through complex cases and what action needed to be taken for successful outcomes. However, there also seemed to be a need for supervision that was hands-on in the practice setting.

Engagement with clients and colleagues

This section addresses engagement and how it relates to client-centeredness and occupation. The participants discuss how to engage clients through being client-centered as well as engaging with other colleagues, to fulfill patient goals relating to occupation.

Client-centeredness meets an occupation-focus

It would seem the occupational therapy process or Canadian Practice Process Framework (Polatajko et al., 2007, p. 233) has been embedded and is a taken for granted aspect of practice, within which an occupational focus and commitment to client-centeredness are enacted. Individually tailored interventions appeared to pressure the participants towards non-standardised observational assessments. Most participants talked about the importance of "top down" functional (occupational performance) assessments. A top down approach is where a person's occupations as a whole are considered first, before the components of an occupation. These assessments were non-standardized and depended on the interviewing, listening and observation skills of the therapist. Laurie stressed the importance of tailoring assessments to the client

> *It's looking at the person as an individual and not categorizing them. It's forming treatment plans and assessments that will suit the person, not just taking a standardized assessment out of the box. And it's making things more meaningful for that person - not trying to get somebody to make a cup of tea because her wife's always done it. It's finding something to assess that's important to them.*

In this respect, participants needed to know a lot about their clients to

> *give us a clear picture of what's going on, physically and mentally.*
> *- Annie*
> *It was necessary to check with the parent and see what is going on.*
> *- Jane*

Participants stressed the importance of talking and listening to the client and family before deciding what approach and assessment to select. Occupational performance assessments included obtaining client occupational histories, concerns and worries, client insights into their occupational needs, the client goals and their usual daily routines. Additionally, their ability to perform personal cares, and instrumental activities such as making meals were all part of the

assessment. Discussion around their socializing habits and leisure interests, *"pets" (Annie)*, as well as family interactions were also included. Observing clients in their occupations was a common method of gathering information.

Initial assessments were a predominant topic of discussion and it was these assessments that therapists used as a basis for deciding whether further assessment in specific areas, such as kitchen assessments, *(Laurie)*, cognitive assessments *(Linda)*, assessments for equipment *(Jane)*, home visits *(Peta)* etc. were required to obtain a greater understanding of a client's occupational status. Laurie talked about having to *"rely on my own observations"*. Annie commented about how the initial assessment was instrumental to work out what clients wanted; *"do they have any concerns - what are they worried about - anything when they go home?"* In some cases, the assessments were also used as a basis for individual occupational rehab programs for therapy assistants to follow and to *"do the occupation with them every day" (Annie)*. Assessment findings were also used to summarise *"how they have done their daily occupations" (Annie)* in discharge reports regarding occupational ability as well as for making plans for the client to be able to engage in occupations at home. The participants believed they could make recommendations on achieving their patient's occupational goals *(Callie)* and be able to suggest where community support would be needed on discharge, such that

> they might need some extra help in parts of the task or the whole task.
> *- Annie*

Participants described follow up assessments that were either observational, non-standardized occupational performance assessments or specific standardized assessments. During a non-standardized occupational performance assessment, a client was observed participating in an occupation such as a kitchen assessment *(Laurie)*. Examples of standardized assessments named by participants as being used by them were the 'Peabody' (pediatric) *(Jane)*, 'MoCA' *(Peta)* and 'Cognistat' *(Callie)*. A few practice areas required the occupational therapist to contribute information around a patient's capacity to make decisions and whether they would able to do their occupations safely at home *(Callie)*. The standardized assessments were used in conjunction with the observational assessment to substantiate findings and provide further information on components of a person's occupational abilities.

Engaging clients: Commitment to being client/family centered

The participants described a number of ways they engaged clients through being client and family centered. Erica said that client responses to a questionnaire regarding staff qualities indicated they

> wanted people who treat them like adults, who are warm, empathetic, understanding.

Erica used empathetic listening where she

let people talk about stuff and then just reflect back the really positive things they say. ... they might even repeat it. ...The basic idea is you do what you hear yourself say.

She used active listening in groups, encouraging the clients to talk and run the session

I try to talk as little as possible. ...I get one of the Whaiora to chair and call the meeting. They set the agenda. You know, I just chip in with the bits.
-Erica

Jane changed her intervention approach after talking with a special education teacher and from reading literature that advocated teaching caregivers to do ongoing interventions. She started to engage family members

...don't even touch the child, support the family first. ...and then ask them what expertise they want ...show them.

Listening and responding to the client and caregiver, became paramount. Jane felt in the long term it was a more successful approach because the caregiver was then educated and skilled in the particular intervention and could reinforce it daily, whereas Jane could only do so intermittently when visiting the client. This would mean the client had more opportunity to practice the particular strategies aligned with the treatment goals. She noted that this approach was challenging, yet rewarding

It is a hard thing to take sometimes. It's extraordinarily hard, especially when you've got a high level of competence.

She felt this approach produced better occupational outcomes for the children. Several other participants discussed engaging others. This was mainly understood in two ways. The first was similar to Jane's approach, but working directly with adult clients. Participants engaged clients in chosen occupations and provided verbal prompts and education as needed. Secondly, the participants understood that the same method of communicating with all clients would not work. The participants recognized the need to engage with the client to work out the best way to connect with that particular individual. Linda described several approaches she might use

(For) Some people...be a kind of coach. That's a kind of, active problem solving approach. ... where people are a lot quieter ...I adapt my approach to just being a lot more laid back and try not to put it on the table all at once...

In summary, the participants were strongly committed to being client and family centered. From practice experience, they saw it making a positive effect. They understood that it could be challenging, especially in areas where they have high levels of competence in hands-on skills. It also requires commitment when the client or family don't readily engage. There were several client and family centered ideas identified as common methods used by participants to engage clients. These were active and empathetic listening, having the caregiver or client directly participate in the intervention and recognition that communication methods needed to be adapted to suit the client. Linda summarized:

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We're engaging with the family. We're engaging with the patient. We're engaging with our whole process rather than just towards occupational therapy goals.

Ways of being client- and family- centered

Erica felt that

everything the whaiora needs to recover is right there inside of her.

Her take on client-centeredness was that the clinician would

just need to help her express it… and use it in really positive ways.

This humanistic belief in people's potential could be seen as the bedrock of the occupational therapy process. It also puts the emphasis firmly on clients to express their needs and goals for their lives and the role of the therapist to enable them to work towards those goals. Peta explained this further when she described skills associated with client and family centered practice. She said it was about

figuring out what their beliefs are and what their values are and what they're working towards

She talked about each client having different goals that went deeper than just the diagnosis they presented with

(If) someone came in with a massive stroke …then what he/she might be working towards might be to be sitting independently at the end of his/her bed, whereas someone with a broken leg might want to get back to work.

She went on to say

You don't want to be working in one direction and the person's thinking something completely different, figuring out what … they want to get out of my input (is) usually a good indicator of where we should be working towards.

Callie added that a further skill included *investigative narrative interviewing* and was a key factor in being client-centered. She said that "*you ask a person a question and then you really listen to their answer and you decide what do*". This, she suggested, was essential to all occupational therapy intervention. The participants, as a whole, reinforced this opinion, by stressing that they needed to get to know the person they were working with. It was felt that occupational therapists in particular, were in a good position to be able to do this because of their perceived holistic approach to the client. This enabled them to ask a breadth of questions and then provide support via tailored interventions to work towards the client's goals. One participant described making "connections" while yet another talked about the importance of making interventions meaningful for the client. Once the 'knowing about the client' was satisfied, then the possibility of a therapist and client working together towards the same goals was deemed viable. This would be achieved by devising a realistic plan approved by the client, encompassing those goals,

> *what's important ... putting it all together and then coming out with a plan at the end.*
> *- Rosalind*

Additionally, treatment plans needed to be designed with *"achievable goals" (Jane)*. Because of the occupational therapist's skills at breaking down the goals into small parts, in other words, using activity/task analysis skills, a therapist can

> *see how close you are getting to that little achievable goal and then set another one.*
> *- Jane*

The larger long-term goals then became more viable. Jane also stressed the need for goals to be primarily useful and meaningful to the person concerned with an example:

> *Jonny will be playing with the ball alongside children without the adults standing there, three times in the morning'...that's a measurable goal.*

Erica maintained that if the goals originated from the client,

> *you can get people thinking really positive thoughts about the future.*

She maintained that the therapist could be viewed as a conduit through which the long-term goals might be supported and realized by getting them to

> *come up with the ideas of their recovery. Help them turn it into a goal and give them reinforcement and support in doing it.*

Jane worked more from a family-centered approach, because her clients were children. She had a deep understanding that specific relationships were key to client/family-centered interventions. She needed to know what the family goals were, for them to feel supported in the care of their child. Although the child was still at the centre of the discussion and goal setting, it was also about

> *knowing where the parents are at, the information they have got.*
> *- Jane*

Once a relationship had been established, Jane said she then discussed in depth what could be offered by the occupational therapy service, an example being

> *giving them a toileting DVD - going through the visual schedule with that, and supporting them for a while about toileting.*

Jane indicated that talking with families was often the best intervention. She said they often don't know how the system worked and so needed someone to take time to explain it to them before they felt comfortable and willing to participate. Other participants, working with hospitalized patients or who had clients in residential facilities, also expressed the importance of including families with the consent of the client. They reported communication with family members, family meetings and family education/training often made the client's journey back home much easier, particularly in cultures that were strongly family centered. Peta described a situation where a person's discharge home was in question because there was difficulty getting in touch with the family. The patient's condition had been identified as palliative:

And I managed to get hold of one of the family members and just explained the situation. ...I realized that they were having as hard enough time about dealing with this ...and that's why they couldn't come. ...We kind of had a plan and we managed to sit down with family and explained actually what we needed to do.

The family was then able to actively engage in the plan to have the client return to their home. One participant insightfully described the clinician/client relationship and process as thinking of the client as part of the team and engaging in collaborative goal setting.

Clearly, occupational therapists being client and family centered have ramifications beyond interventions. It is about engaging with the whole service and optimally bringing in the client as a member of the team. The participants had taken up, believed in and used the ideas of both client and family centered approaches. They saw this as a necessary part of their practice, providing better outcomes if the client and/or family were setting the goals. They saw the role of the therapist as supporting the client to work towards those goals.

Engaging with colleagues: professional practice

There was a strong emphasis amongst the participants to engage in teamwork. Participants said they engaged with their colleagues on the multidisciplinary team because it enabled them to collaborate in treatment and to problem solve client issues. Jane said she brought in her physiotherapy colleagues as early as possible because she knew she would be working with the client for several years and that she engaged in

a lot of joint assessments - occupational therapy/physiotherapy obviously.

Participants made engagement happen in a number of ways. For instance, Rosalind described about how the team worked together to get a client home, and how the role of the occupational therapist was to support team decisions by talking with the client and encouraging her to work toward her goal to return home by making some changes suggested by other members of the team. In this case, the decision was made not to put any equipment in place, but to help the client explore, in Rosalind's words, *"lifestyle and health management"*. Sarah, on the other hand, provided in-services to other professions and she reported how this improved the way they worked together because

now I am actually being asked to come across and help a PT with something, which is an interesting experience.

Erica felt that engaging and collaborating with "*a lot of different people*" enabled her to

get a lot of feedback to ensure that what we're doing is on the right track.

She also used collaboration as a way to encourage staff to think about making changes in the way they worked

> *I kind of jump on it and reinforce ... and say, have you thought about looking at this next?*

This was important because she could then obtain staff buy-in on the programmes being offered to clients. Her belief on drawing on colleague's skills and qualities was that the clients would benefit in the end from hearing the same information being reinforced by other staff, and not only from the programmes. As a benefit to occupational therapists, Callie gave an example of using meetings with colleagues to take up ideas that could be used with clients

> *I will go to the meeting where we present cases and from that meeting come away with ideas [about] treatment planning. Sometimes I'll have those ideas.*

To allow inter-professional practice, Peta suggested that in some work areas the occupational therapist role blurs with other professionals roles. She indicated that this might mean thinking and asking questions that are broader than the usual scope,

> *not trying to do other people's jobs but trying to cover everything and (not) just honing in on the little occupational therapy box that we need to look at.*

Finally, Linda described her love of engaging with colleagues and sharing information, which she felt, provided a quicker, better service to the client and thus positive outcomes

> *The best rehab happens when we are making rehab hypotheses. So if the team is quite close, you can do that quite freely and there's a rehab positive spiral.*

They understood the benefits of working in a multidisciplinary way, sharing ideas with each other, providing feedback and supporting each other's ideas that they believed would benefit their clients, themselves and their colleagues.

Recognition of culture

This section looks at legislation with respect to cultural considerations, as well as services and assessments that address and support cultural awareness in practice.

Cultural policy, legislation and education

Where respect for culture and diversity was highlighted as an aspect of occupational therapy practice internationally, it was particularly evident as a feature of practice in Aotearoa/New Zealand. There was recognition amongst the participants that there are policies and legislation guiding cultural practice, which are unique to Aotearoa/New Zealand. The most influential legislation is the Treaty of Waitangi, and this was acknowledged

> *It's about what's important to the patient and it comes back to the Treaty of Waitangi – participation, partnership, protection.*
> *-Sarah*

Furthermore, with regard to bi-culturalism, Linda talked about the connection between Maori loss of land and health, suggesting that current health outcomes amongst Maori could be connected to this historical event

> *All occupational therapists are trained in the Treaty of Waitangi and what that means. How Maori colonization is depicted; health outcomes; And so, if you are*

aware of that, you know their losses – the losses of the land; the losses of the language; the losses of their home; spirituality; the losses of whanau [extended family] and links. Those are the some of the facts you can draw on in your rehab. You know you can make links to whanau. You can try and engage people with blessings and things like that. We've got a great Kamatua [respected Maori elder] service. You know you can draw people in.

The Treaty of Waitangi was understood by almost all of the participants to be very important for Maori. They understood the Treaty's original function was and is to protect Maori rights. In addition to Maori rights, the emphasis the Treaty places on participation, protection and partnership (the three Ps), appears to have enabled a greater understanding of the importance of cultural awareness to other cultures as well as Maori. Participation, protection and partnership are a philosophy that can be applied to empower all people. In terms of healthcare, understanding and working within this philosophy provides client-centered interventions because it becomes a process that promotes therapist and client working together, close consultation with the client and family, and provision of interventions that are consented and agreed to, thus protecting the client.

Callie suggested that cultural awareness was a particular quality of working in New Zealand because of legislation

The fact that we have an opportunity to work with people of Maori and Pacific origin and that there's policies guiding our practice for that in health and education ...makes it an aspect of practice in New Zealand that's unique.

Laurie who had lived abroad concurred

There's a lot more emphasis placed on culture and being sensitive to the patient's culture whereas I don't think it gets much attention in the (names a country). Certainly didn't feature in my training there anyway.

Sarah commented upon the effect of her own culture on communication

I am very aware that I am young, white, educated…. I am aware that's how people perceive me.

There was a feeling that although it might be difficult to understand the practices of different cultures it was essential to respect all cultures by

including people in decision-making. Including people in rehabilitation processes - then a lot of the time you've going to get it right.
- Linda

Erica was aware of the Maori health model and referred to a "cultural team" being present in the service. She indicated that although the service had a biomedical model influence,

they've tried to combine the two, which is difficult because you've got radically different explanations of the same thing.

Erica regarded this as quite a challenge because there could be instances of conflict in how client symptoms were interpreted in each perspective. Laurie had attended

> *a Maori cultural perspective course and a Maori pronunciation course*

provided by the DHB supporting cultural awareness amongst staff, adding

> *...and there are lots of other ones for different cultures as well*

She also commented that it increased confidence because "knowing, understanding" the customs meant that they could be acknowledged during interventions and made her feel more confident. She felt

> *it helped to tailor my service to be more culturally specific.*

The participants have taken up the idea of cultural awareness by recognizing that there is a unique imperative to have and use cultural knowledge with respect to the Treaty of Waitangi in Aotearoa/New Zealand, and awareness of the history of the indigenous population. It is an aspect of practice where they felt well supported by the DHB. It has posed some challenges but at the same time, attending workshops, together with knowing that they were supported by colleagues from cultural services, has increased their confidence.

Services supporting cultural awareness in practice

Referring on to other appropriate services was a way to address cultural needs identified for the client

> *So whether you are Asian or Maori or Pacific Islander, there are lots of resources*
> *that you can use within the hospital.*
> *- Laurie*

Participants talked about working with support services in and outside the DHB, learning new ways, and incorporating their cultural learning into practice for the benefit of the individual client. Support services helped with language and cultural barriers to help

> *support that person through what I suppose, is a very western system.*
> *- Rosalind*

This was seen as invaluable to both the client and other health workers. Sarah had

> *made friends with a Pacifica support worker and the Maori Health Kaumatua*
> *because I want to be doing the best for my patients.*

Annie added,

> *The chaplains are great as well. And they'll tell you where to go if you don't know.*

Assessment and strategies with respect to culture

There needed to be some critical thinking around the use of assessments and strategies with respect to cultural appropriateness. Laurie was aware that some of the assessments

> *seem to be more conscious of culture. I've seen different cognitive assessments that*
> *have been tailored to different cultures.*

Sarah stressed the importance of asking clients about their culture and what the therapist can do to work within cultural boundaries to make the clients feel safe, requiring an expanded skill set:

I just ask…the patient or the family; sometimes the Pacific Support Workers if I am not sure, but I just ask, ' Is there anything I can do? One mode of care isn't appropriate for everybody.

Erica said that she

made sure that all programmes started with a Karakia; a Waiata, if appropriate.

She felt that it was

a process of accepting the people of different values and customs,

and that she tried to

stand next to them and say, 'how do you want to do this?'

Participants held the predominant attitude that acceptance of different values and customs was paramount and the key was to ask the client how they wanted to do the intervention and to be respectful, identifying the family speaker and communicating through them and also taking time to identify the client's role in and out of the family, thus being able to be active in response

He's got his own business that he works in …he actually fetches the coconuts from the trees, and he does not prepare anything. His wife does all of that.
- Eleanor

Participants mentioned the active use of language when working with clients; for instance, two participants, Erica and Laurie, used Maori words while another had

two cards in my folder in 7 different languages,
- Sarah

which she used to support her in this aspect of practice when she had patients from those cultures. Apparently this was welcomed and generally produced a good response from client and family alike. Peta too, provided an active response in an attempt to bridge the cultural divide. She described how surgery recovery pathways might be in contradiction to cultural beliefs of health and recovery. In these situations, she felt it was necessary to explain carefully to the family and client so they understood

why you're doing it and the processes behind it… as long as you've got the family on board you usually can get the patient a lot more motivated.

There was further recognition of the importance of the family in some cultures and the need to be inclusive of the family in the client's interventions where this was the case. Additionally, the client's roles in the family and in the larger community were felt to be invaluable in establishing rapport and trust between clinician and client. It was also a good fit with other aspects of occupational therapy practice, such as client and family centeredness. Callie noted the emphasis on family-centered care in Aotearoa/New Zealand and wondered if it was associated with the predominance of family-centered cultures to be found here

I feel that the importance of considering family/whanau when working with Maori clients and families actually colours our practice when working with people from other origins because family is important to lots of people.

In summary, the participants were describing active ways to be culturally aware with their clients. They recognised the importance of a culturally sensitive approach to communicating and providing interventions for their clients, which required amassing additional skills and knowledge to do this successfully.

Summary

This chapter identified the ideas taken up by the participants from other professions. Some ideas, such as client-centeredness, supervision, reflection and culturally safe practice, fitted very well with occupational therapy practice. However, not all the aspects discussed came together neatly for participants. There was some conflict with occupational therapy beliefs and the biomedical model, as the two approaches did not always fit comfortably together. Additionally, imbalance of power in the biomedical model made it difficult to stand by occupational ideals, affecting confidence in their beliefs and collective identity. The participants needed to translate their occupational language into medical language on occasions to be understood by medical staff.

This can be balanced by recognition of workplace support, teamwork, supervision and reflective practice, all of which were picked up and discussed by participants as being present in their practice. Cultural awareness was a very strong aspect of the participants' practice and was supported by the DHB with recognition that this was closely affiliated with being client-centered and providing positive outcomes for clients.

Chapter Six: Discussion

Introduction

How have occupational therapists in Aotearoa/New Zealand taken up ideas from the international literature? This was the question I endeavoured to answer during the course of this study. In particular, I wanted to uncover the fundamental concepts that underpinned and influenced the practice of the participants in this research. In the earlier chapters, I discussed why this subject was important to me and also conducted a literature search to position the study in relation to ideas about knowledge up take and to provide information about what concepts were currently under discussion in the international literature. In chapter three, I described the methodology and underlying principles behind my research. Then, in chapters four and five, presented the findings using illustrative quotes from the participants to support my conclusions. In this final chapter, I will consider the implications of the findings and compare them with the evidence from the literature to see where they are aligned and whether there is any apparent difference in focus between international ideas and those taken up by the participants in the study. Initially, I will present a synopsis of the findings. Then I return to the themes and consider their composition more closely. I close the chapter by discussing the limitations of the research, and considering what the implications are for practice and further research.

Reflecting on the findings

When I commenced this study, I was curious to find out whether and to what extent ideas in the international literature influenced occupational therapists' way of working in Aotearoa/New Zealand. I wanted to know what was important to them; how they took up ideas. From my own practice, I had some idea of what might be the common concepts that were taken up, and I expanded that awareness by completing an extensive literature search to identify a broad range of concepts that were purported to be essential to occupational therapy practice around the world, from a Western perspective. I also looked at knowledge concepts and how they fitted in with how occupational therapists take up ideas. There were a number of ideas pertaining to knowledge in the literature, such as knowledge creation; fragmented knowledge; knowledge acquisition, knowledge translation; knowledge transmission; knowledge application; knowledge gap and theory-practice gap. The participants interviewed for this study were all extremely interested in and passionate about their particular area of work. So, as well as common themes, there were some individual pathways they had explored from ideas they had taken up relative to their speciality. Two of the participants had lived and trained overseas, so they brought in a different perspective about the ideas they needed to take up to work in New Zealand.

During the interviews, I collected information about the actual way ideas were accessed by participants, as well as what those ideas were. The five substantive themes looked at the actual ideas the participants described. These themes were "Providing occupational opportunities"; "Providing enablement, justice and safety for clients"; Use of theory, tools and strategies"; "Engagement with clients and colleagues" and "Recognition of culture". The table below summarises the findings:

Table 8: Final themes

Themes	Ideas
Sourcing ideas and ideas implicit in occupational therapy	Where, what and why:
	People peers and colleagues
	Events meetings and getting together
	Self-directed learning
Findings implicit in occupational therapy practice	
Providing occupational opportunities	Adaptability – taking on an occupational perspective
	Occupation in practice
	Occupation and an holistic perspective
	Occupation, creativity and problem-solving
Providing enablement, justice and safety for clients	Enablement
	Strategies to enable occupation
	Enablement with an eye on justice: influencing clinical decisions
	Enabling occupation with regard to safety and risk
	Provision of occupational enablement and justice within government policy
Use and uptake of occupational theory, tools and strategies	Spiritual understanding
	Language and occupation
	Marrying things up: Clinical reasoning
Ideas taken up by occupational therapists from external sources	
Occupation and medicine: an uneasy alliance	The biomedical model and an occupational perspective
	The biomedical model related to practice area
	Evidence-based practice: return to mechanistic approach
	Exploration of ideas: supervision and reflection
Engagement with clients and colleagues	Client-centred meets an occupation focus
	Engaging clients: commitment to being client/family focussed
	Ways of being client/family centered
	Engaging with colleagues: professional practice
Recognition of culture	Cultural policy, legislation and education
	Services supporting cultural awareness in practice
	Assessment and strategies with respect to culture

An occupational focus

Use of theory amongst the participants was largely consistent with their commitment to an occupational perspective. The participants were able to select and collect occupation-focused information and consider the validity of a broad range of assessments, and they preferred a top-down observational approach to assess performance of occupations. Using a mix of knowledge,

experience and reasoning, they provided feedback to the client and suggested interventions to the client. The participants talked about a variety of models and frameworks that underpinned their particular area of practice and they were aware of evolving models. Selectivity in their choice of models being influenced on their area of practice had, in some cases, meant a return to a mechanistic, medical based approach. This was particularly evident in physical settings. This finding is consistent with literature that notes the difficulty of retaining a purely occupational perspective when more powerful colleagues such as physicians, are requesting "biomedical interventions" (Estes & Pierce, 2012, p. 21), creating tension. Professional resilience and identity was also affected (Ashby, Ryan, Gray, & James, 2013) and strategies such as "supervision" and "support networks" were recommended.

The literature recommended use of occupational language to both verbally articulate and write occupational therapy findings (Mattingly, 1991b; Wilding & Whiteford, 2007, 2008). The participants indicated that they adapted their language into medical terms for their colleagues when giving verbal reports in meetings, but tended to write reports in occupational language. They also said they simplified their language, using everyday words when interacting with clients so that they would be better understood. This is reflected in the literature, where there are reports of therapists describing themselves as being "bilingual" (Ashby et al., 2013).

A prominent theme that I felt increased confidence was that participants frequently talked about sharing and engaging – talking about ideas, reflecting on ideas. The participants seemed to be able to support other occupational therapists and colleagues to take up and respond to ideas discussed in the literature and then go out and do their work with their clients within the larger team. Even those working more autonomously seemed to need to be able to seek support and share ideas, such as those working in the community. This phenomenon where occupational therapists needed to come together and support each other to cope with the stresses of the wider MDT has been described in previous research (Wilding, 2008).

The importance of occupation and the link to clients was emphasised in all participant interviews; Linda, for example, stated:

> *Occupations are about who people are. Occupations provide meaning to people.*

Occupation was the absolute core, the bedrock of practice. Participants sought information about the range of client occupations, emphasized the importance of meaningfulness and used occupations in practice. They talked about evaluating and setting goals towards enabling occupations. The literature supported this approach from the occupational therapy basic assumption that occupation is "central to human life" (Kielhofner, 2004, p. 44) through to models such as the Canadian Model of Occupational Performance (CMOP) (Townsend & Polatajko, 2007), occupation focused assessment (Hocking, 2009), use of therapeutic strategies

(Price & Milner, 2007), and looking at all the occupations a client engaged in, even implicit ones (Doble & Santha, 2008).

Occupations needed to be meaningful for the client and targeted to their ultimate goals. One concern was the time limitation often placed on the participants to provide occupation-based solutions. They often needed to rely on compensatory interventions, as it was quicker to supply a piece of equipment and provide education on its use to achieve safe outcomes. This "meaning gap" between the ideal intervention and what was practice reality (Aiken et al., 2011), was challenging to participants, who generally had a preference to provide opportunities for the client to restore their ability to engage in an occupation through a longer term rehabilitative approach.

Within the confines of the expectations of their workplace, participants continually focused on occupation by trying to enable their clients to participate in their desired occupations. There were some ideas from the literature supporting the use of occupational enablement to turn clients into real people instead of "their diagnosis" (C. Robertson & Finlay, 2007, p. 74); the use of clinical reasoning (Mattingly, 1991a), the use of reflection or mindfulness (Price & Milner, 2007; Reid, 2009) as well as client-centeredness. There was the presence of different types of clinical reasoning and reflection by the way the participants described therapeutic situations. Participants also reported that active listening and humor assisted enablement through better communication. Although clinical reasoning seemed implicit in their practice, it was unclear whether all participants saw it as something necessary in their practice or that it was needed primarily to account for practice decisions.

In addition to their occupational focus, participants were taking up ideas from the socio-political context of healthcare. Participants reported that there were political agendas and policies influencing what they did. One participant described herself as wearing two hats, one where she needed to consider safety and risk minimization, required by government policy and the DHB, and the other where she provided opportunities for clients to be independent and participate in occupations of their choosing, which could not always be considered 'safe'. Another participant was concerned about the influence budget restrictions and limited resources had on practice and implied that a lot more could be achieved by occupational therapists if they did not have financial limitations and resource guidelines to work to.

While only three participants used the term occupational justice, the importance of providing opportunities for people to participate in occupations in situations where there were limitations or restrictions to the occupations of choice was broadly recognised. This was particularly difficult if a client had cognitive impairments or their environment limited what occupations

could be undertaken. Although there were frustrations expressed at limitations to some situations, such as the viewpoint of the medical team or limitations of the environment, the participants tried to find as many ways as possible to provide at least some access to chosen occupations within the context of safety and risk minimization. They reported using a client/family centered approach, thinking through and reflecting on what would be a safe way to engage in an activity, and keeping their knowledge up to date.

An important document in relation to providing occupationally focused interventions that was not mentioned was the International Classification of Functioning (ICF). As it can be used to look at outcomes, this might be an area that needs more emphasis and encouragement to explore, relating it to practice and reflecting on effectiveness of interventions in relation to the scope of the ICF. The absence of awareness of this document may reflect the heavily biomedical model focused DHB environment, where the ICF is not necessarily seen and promoted as a useful tool for practice.

Clinical reasoning

Although participants did not describe or name the types of clinical reasoning identified by Mattingly and Heyes Fleming (1994), there appeared to be a global acknowledgement of reasoning when participants described interventions with clients and why they did what they did. The most common indication of reasoning was when the participants described situations where there was evidence of storytelling and often emphasised a strong collaboration between the therapist and client. The participants understood procedures and described assessment and interventions and they talked about "doing with patients" (Mattingly & Heyes Fleming, 1994, p. 178). The participants described coaching and encouraging clients, using interactive words such as *facilitating, engaging, targeting, prompting, practicing (Linda)*. They were able to 'imagine a future for the client' by "having 'future images' of who the patient could be" (Mattingly, 1994), such as imagining what possibilities were available in a residential facility, and making recommendations, thus enriching the client's life. There were other examples of clinical reasoning described by the participants. One participant's ethical reasoning (Chapparo & Ranka, 2008), was apparent when she talked about her belief that if people were deemed competent to make a decision, then their goals should be acknowledged and pursued where possible. What was noticeable was that participants' descriptions of interventions tended to be coloured by the individual practice setting. This is supported by findings in the literature, for example, that of pragmatic reasoning: looking at the client's situation with respect to the participant's own practice setting (Chapparo & Ranka, 2008).

Spirituality is placed at the centre of the Canadian Model of Occupational Performance (CMOP) because, "each individual's spirit is expressed through his or her engagement in everyday life"

(Egan & Delatt, 1994, p. 100). However, other researchers have suggested, "although spirituality is a dimension of the process, it is not central to the process of giving meaning to occupation" (Griffith, Caron, Desrosiers, & Thibeault, 2007, p. 87). Furthermore, studies have identified a "large theory/practice divide" (Barry & Gibbens, 2011, p. 177) and that occupational therapists do not feel confident to address spirituality due to lack of training (Egan & Swedersky, 2003). On prompting, participants acknowledged spirituality to be part of the essence of a person and that it could be acknowledged, although some participants did not feel they could address spirituality sufficiently, and suggested they would refer on to a cultural or spiritual advisor. This finding aligns with Barry and Gibbens (2011), cited above, with respect to lack of knowledge/training. Cultural awareness was a stronger concept for the participants than spirituality appeared to be. All the participants could clearly articulate how they brought cultural awareness into their practice and how it enabled them to connect with their clients for more successful outcomes. In contrast, when talking about spirituality, the majority indicated they would refer on to another service, or touch on spirituality indirectly within the context of an initial assessment. Spirituality did not seem to be central to their practice. This in turn raises the question of whether being aware of the client's culture displaces spirituality as the essence of enabling occupation, in the Aotearoa/New Zealand context, and if they are considered to be the same thing in this context?

Three participants specifically mentioned evidence-based practice, with other participants implying they used research from the literature to inform their practice. It was important to the participants that practice-generated knowledge (Higgs & Titchen, 2001) should be considered alongside the evidence from the literature to derive the best intervention decision for the individual client. There was reference to and recognition of how biomedical evidence influenced their practice, but in most cases, the participants were linking the literature to occupation in practice, almost as another dimension of reassurance and verification of competent practice. Both professional supervision and reflective practice were ideas that were taken up by participants. Both concepts are integral to the requirements of the Occupational Therapy Board of New Zealand (Schlemmer & Henneker, 2004) and DHB policies. Originating from the field of social work, supervision and reflection are considered essential to health practice, both in New Zealand and internationally (Davys & Beddoe, 2010; Hunter & Blair, 1999; van Ooijen, 2003). Participants considered professional supervision as protected time to be able to reflect on their practice. Supervision was also seen as an opportunity to obtain ideas from colleagues. Coaching or supervising colleagues practically was also a way to provide clinical support in the field. Coaching is present in international literature and is becoming recognized as another tool for professionals to utilise for their professional development (Driscoll & Cooper, 2005; Jones & Murphy, 2007). Tacit knowledge (Heyes Fleming, 1994) is stored and retrieved unconsciously, increasing with experience and reflection. As the

participants reported observing the practice of colleagues, problem solving together, sharing ideas, trying ideas out, and then reflecting on outcomes, it seems they might have been building and using tacit knowledge in their practice. The conversations with the participants about their practice experiences and their ability to look at the big picture generated in my mind a global idea of mindfulness, associated with clinical reasoning and reflection.

Engagement with clients and colleagues

The participants described actively engaging both clients and their colleagues in an occupational perspective. Engaging the client was an idea crucial to all of the participants. The participants described the need to be both client-centered and family-centered as an effective way to get to know the person. The client-centered approach was initially developed in psychology and embedded into the Canadian Practice Process Framework (CPPF). Primarily, the participants' objective appeared to be having client involvement in goal setting; they identified strategies such as listening to the client's story and what they wanted, adapting communication styles to suit the individual. Participants reported the use of a number of strategies noted in the literature (Price & Milner, 2007) such as activity analysis, verbal cues, positive reinforcement, story-telling, working with or alongside the person, practicing occupations, providing education, developing achievable goals, and advocating for the client through a client/family-centered approach. In addition, they identified task analysis as a means to simplify occupations so that clients could be engaged at optimum level.

The belief that culture is a crucial part of a person's being was strongly advocated by the participants. It shaped the way the participant engaged and worked with the client. One means of doing this was by respectfully asking the client about their cultural practices, listening and responding appropriately. The participants talked about the importance of family involvement, of encouraging participation and partnership and providing protection. The participants were actively engaging in cultural awareness practices in their work, and the Treaty of Waitangi appeared to be fundamental to this awareness. Cultural awareness was supported through cultural training provided by the DHB as well as access to cultural support services. One participant who came to live in New Zealand from overseas felt that there was more emphasis on cultural safety in New Zealand than her homeland, which had a heavily multicultural component to its population. Therefore, the claim that "Cultural safety is a uniquely New Zealand concept" (Gray & McPherson, 2005, p. 34) may be true.

The participants acknowledged that they engaged their occupational therapy colleagues and other professionals in learning by sharing their expertise and provided occupationally focused training for them. They asked for feedback from colleagues on occupational therapy initiatives. Additionally, participants tried to be aligned with the same client goals as the medical team as a

means of supporting both the client and their colleagues in attaining the goals. However, there were concerns that engagement with both clients and colleagues could be difficult in some instances because describing what occupational therapists did was complex. The literature reports that misunderstanding of their role by others can be stressful for occupational therapy clinicians (C. Robertson & Finlay, 2007). In some practice areas there was a blurring of roles, particularly in mental health and the emergency department, which was confusing when defining what a participant did. In the literature, there is concern about unclear definition of role, and difficulty articulating what an occupational therapist does, with Shiri (2006) calling for occupational therapists to have a clear concept of their role. Additionally, Wilding and Whiteford (2007) recommended the use of occupational language so that occupational therapists could articulate their role in occupational terms.

Situating the findings

Overall, the findings suggest that the participants had an awareness of what was under discussion internationally and were taking up selected ideas in practice. Looking at the findings from a "knowledge" perspective, I found that the participants had a mix of knowledge taken from both their clinical experiences and from the literature. They talked about transmission of knowledge by sharing what they had learned, and the ideas they had taken up, with colleagues and vice versa. They were keen to apply ideas they had taken up from workshops or post-graduate study to clinical situations. This seemed to be because they were constantly focusing on their clients and wanting to provide the best interventions they could to each person. They created new knowledge by taking up ideas and considering how those ideas could be implemented and would try out some of the ideas to see what the outcome was. If the outcome was successful, they felt they could build on the idea. An example of taking up ideas learned from a workshop and building on the initial intervention with a client was when Sarah used her new splinting knowledge with a client and then added in wrapping techniques which had ongoing positive outcome for her client in that his posture and arm control improved so that he was able to pick up an object and mobilise more easily.

Something rather more subtle, but I believe none-the less present, was knowledge translation, a desire among the participants to provide a high quality service, and this was accomplished by them taking up sound ideas from the occupational therapy theoretical base. Prominently, this was the focus on occupation and enablement. Participants also looked for more specific theory from outside of occupational therapy that they deemed relevant and would benefit their clients' outcomes from an occupational therapy perspective. Examples could been seen in take up of the recovery model in mental health, originating from the 12-step programme of Alcoholics Anonymous; the client-centered approach from psychology, and the cultural awareness

approach promoted by New Zealand nursing, all three ideas being used by all participants. However, some participants recognised that knowledge was fragmented, and pointed out that although there was research available in the literature for some practice concerns, this was not the case for everything. Some also felt that research that was available, was often exploratory and not highly detailed, and gave only guidance to assist with practice decisions. Therefore, this created theory-practice gaps. A number of the participants welcomed guidelines, such as stroke and dementia care guidelines as this gave them an evidenced-based platform from which to practice which helped close the theory-practice gap in those areas.

A finding of particular interest and supported by the literature (Wilding, 2008) was that there was an indication that the concept of occupation can exist alongside the biomedical model. It can be challenging, but is do-able. This needs to be recognized, as occupational therapists working in environments where they need to address both occupational and biomedical concerns, can be left to feel inadequate, or that they are doing the wrong thing, when actually there is a skill to working successfully in both models. Using the language of both approaches and translating from one to the other requires a sound knowledge base of both models as well as confidence to use both languages fluently, both verbally and in the written context.

I divided other notable areas into two sections addressed below:
- Knowledge transmission and application from the perspective of clinicians
- How clinical leaders can support and promote knowledge transmission and application for clinicians

Knowledge transmission and application: Reflecting on clinicians

My findings suggest that the participants shared knowledge and ideas they had taken up with their colleagues to amass a sound body of knowledge on which to base their practice. They used literature to inform their practice, to identify best theories and ideas for their area of practice. This implies that time for collaboration with colleagues is important so that ideas can be discussed and reviewed. Additionally, insights into the process associated with clinical reasoning, supported by the use of critical appraisal tools would aid in deeper understanding of and application of ideas. Indeed some of the participants indicated that they were doing this already. Where there is a learning centre in an organization or a higher education institution available, there may be training offered to clinicians so that they learn to confidently engage in critiquing literature.

Another way of considering knowledge transmission and application could be the inclusion in practice of an intervention deemed by the clinician as beneficial to a client's treatment outcome. Therefore, some of the participants recognized the role that creativity can play in the treatment

programmes of clients. They advocated for the use of creative mediums in practice, in spite of the profession's continued perception that creative modalities should be avoided due to the association with the profession's past history. The small amount of literature I found actually suggested that creativity could be beneficial (Dickie, 2004). These participants, however, were particularly comfortable in themselves as occupational therapists, confident in their practice and openly used creative mediums where appropriate, such as when the client identified engagement in a craft as a goal. One example was Sara, who recognised that a patient wanted to participate in knitting, but did not want to do this alone, so Sara sat by her and they knitted together.

Knowledge transmission and application can support clinicians who are coping with change through take up of new ideas that might be more efficient and effective. Participants kept in touch with the literature and took up ideas that provided them with tools to manage changes to local needs, at the same time keeping the occupational beliefs in the forefront of the profession; they attempted to let go of old ideas and take up new knowledge when they felt the idea was appropriate to their client base. An example was Jane, working with children, letting go of her "magic bag of tricks" and taking a "hands off" approach in favour of focusing on the children's family and their goals. Although the participants were worked in different areas, using different models, often taken from outside of occupational therapy, all were connected by their occupational beliefs and theoretical underpinnings. In this way, they were responding to local requirements of their clients and the organization and to their own interests and motivations, by experimenting with new ideas and effectively engaging in lifelong learning.

Knowledge transmission and application: eflections on organisational and clinical leaders
The findings show that peer support, inter-DHB meetings and informal discussions are effective opportunities for clinicians to take up ideas. These must be supported by organisations so that they may continue to be a source of knowledge. They are relatively cost neutral for a DHB.
For clinicians to have the opportunity to engage in knowledge acquisition and be able to thoroughly consider the usefulness of ideas they locate in the literature in relation to their clients and the service in which they work, there needs to be a support structure within the organisation in which they are based, which promotes professional development and lifelong learning. The literature recommended that organisational and clinical leaders should play a role in making sure that opportunities exist to enable clinicians to be able to take up ideas in the quest for knowledge transmission and application. As knowledge transmission and application is about provision of an effective health facility, organisations with a clinical governance structure in place, promoting optimum service delivery, should have learning opportunities built into the framework.

The findings of this study indicate that opportunities for occupational therapists to understand, learn and use the process of critically assessing evidence should be available. This in turn promotes clinical effectiveness, another component of clinical governance. Therefore, organisational and clinical leaders need to ensure that there are budgets and learning opportunities and time made available for clinicians to engage in learning. They should also be proactive in developing policy regarding professional development expectations; support motivated employees by provision of supportive initiatives such as coaching, mentoring and study leave; identify pathways for career progression and promote membership of professional association. There should also be learning opportunities to create insights into clinical reasoning through group activities and in-services and discussions to identify knowledge gaps, and collaboration with clinicians to find ways to fill these. Where knowledge gaps are identified, ways to fill the gaps should be discussed, planned and executed. An example mentioned by Linda, was that she felt new graduates who had not experienced her practice area, as students did not have the knowledge to practice in that area without support. Therefore in this case, a program to support new graduates to become grounded in that area of practice would be vital. This would give new graduates the opportunity to learn and take up ideas to assist them to move on from the novice level of practice and reasoning and to work more effectively with their clients.

From a broader perspective, public health planning, emphasizing the concept of population health and health promotion could again be supported and planned for by an organisational or clinical leader. An example where there could be an opportunity for a leader to intervene and support change in practice within the service, was health promotion through the idea of lifestyle redesign. Two participants suggested that by taking up roles as coaches, providing opportunities to support clients through lifestyle redesign, would assist the client to make the transition to a more healthy lifestyle. This would be a change to traditional occupational therapy roles, but may be an effective and efficient use of time. Finally, organisational or clinical leaders should support the concept of clinicians and researchers collaborating and pooling their perspectives when conducting research projects and enable them to have the time to do so.

Reflections on rigour and limitations of the study

There were a number of strategies put in place to ensure rigour. There was a risk associated with the selection of the participants for two reasons. Firstly, although the recruitment was open to all occupational therapists within the selected DHB, there were strict limitations placed on recruitment by the ethics committees. I was only able to email a person once and ten people at a time. Although this method resulted in responses each time, I would have preferred to have sent out the email to all the occupational therapists in the DHB in one mailing and then selected

participants from the overall response list. I feel I might have had a more balanced participant pool if I had been allowed to proceed in that way. As it was, I had more representation from physical health than other areas of practice because those were the areas emailed first.

The second issue that might have created bias was that the eventual participants were all highly motivated clinicians, who presented themselves as having expertise in their areas of practice. I wondered whether some voices were missing in the data as it is possible that therapists who were not so in touch with their profession and their practice, might have been less inclined to volunteer to participate in the study. A further concern was the absence of Maori participants. In my ethics proposal, I discussed the possibility that some Maori have different ways of communicating and practicing. I believe the conditions placed upon the recruitment method meant that it did not lend itself to considering this possibility. I would have liked to have been able to approach Maori occupational therapists within the recruiting pool and offered to talk with them about the possibility of participating in the research. I believe they might have offered different perspectives because it is possible their take up of ideas might have been influenced by their cultural beliefs. Therefore, they may have presented unique and alternative ways of reasoning, understanding occupation, provision of enablement and engagement of clients and colleagues.

The third consideration was whether my assumptions about what the study might reveal would influence the findings. I participated in a pre-suppositions interview and that brought to light many of my preconceived ideas. During the study, I consulted with my supervisors and they were helpful with keeping me on track and separating out my personal knowledge and the information that was coming from the participant transcripts, by discussion and reflection in our supervision appointments. This enabled me to keep to the actual descriptions and look deeply into the rich detail while detaching myself as much as possible from my own preconceived ideas. Some of the findings surprised me, such as the deep commitment the participants appeared to have when discussing cultural awareness and their dedication and loyalty to occupation as a core belief, even though some of the work settings were highly influenced by the biomedical model. Other topics, such as a strong belief that strategies, such as activity analysis, were an effective part of occupational therapy interventions were not surprising, as it is assumed in the literature that this is so, in spite of a lack of evidence to support the effectiveness of many strategies. Strategies were put in place to ensure that my preconceived ideas did not over duly influence the outcomes of the study.

When considering credibility of this study, I listened to the interview recordings and compared them with the typed transcripts to ensure the transcripts were accurate. I then sent each transcript back to the individual participant for confirmation that the data was correct from their

perspective. I worked with my supervisors when analyzing the data so that I was able to reflect on emerging findings, and receive further verification that my analysis was rigorous and that my findings did indeed describe the original meanings provided by the participants.

Of the ten participants, only two were male. This may reflect the profession as a whole in Aotearoa/New Zealand, since the Occupational Therapy Board of New Zealand Annual Report 2012 states that as of March 31st, 2012, 93% (2092) of those holding annual practice certificates were female, so 7% (172) were male (Occupational Therapy Board of New Zealand, 2012, p. 16). I therefore feel I have adequate representation in the study of male to female ratios. While eight of the ten participants identified as New Zealand European, two identified as from cultures outside New Zealand. The 2012 report indicates that of the 2264 occupational therapists with an annual practicing certificate, 64% identified as NZ European. It would seem that I have slightly more representation from those identified as NZ European, but as I wanted to gather data from a New Zealand perspective, I feel this was an adequate mix. As qualitative study focuses on small numbers of participants due to the methods used in gathering data, it is not reasonable to expect that the findings of this study can be generalised.

Implications

During the course of this research, I have wondered how the findings might be useful. I believe they might have significance in the areas of DHB policy, in practice, in education and as a basis for further research. In general there was recognition that evidence based practice not only required critical review of the literature but application of clinical reasoning and experience to decide what is relevant in specific areas of practice. It is a concern that general standardized assessments such as the Cognistat were in use rather than the occupational therapy specific models and assessments such as the Assessment of Motor and Process Skills (AMPS), the Allen Cognitive Disabilities Model battery and screening tool and the Perceive, Recall, Plan, Perform (PRPP) system of assessment and treatment. It may be due to the fact that these assessments are not freely available and there is high monetary cost and considerable study time attached to the training that is required to become accredited for most of them.

Policy with respect to DHB

Fiscal duty and prudency are words that are often heard in the arena of the District Health Boards with discussion as to how things can be done better, sooner, faster, leaner (Ryall, 2007). This can impact on how ideas are taken up in practice within a DHB environment because funding for professional development and in-service time can be devalued and paired away to save money, while the emphasis is placed on maximum client contact and little time for anything else. Uptake and sharing of ideas happens within the workplace during time allocated

for professional development, such as in-services, meetings, peer review, as well as informally in the office and the tearoom. This study highlights the continuing need to provide sufficient protected time for exchange of knowledge and ideas to be able to occur in the workplace. Clinicians need to be able to share ideas that could progress the development of the service. Additionally, professional development funding and provision of learning opportunities are paramount for informed clinical practice and should be supported and incorporated into DHB organisational planning. It is of value and in the interest of the DHB because ultimately supporting professional development results in a better, more efficient service, with better client outcomes. Accreditation for specifically designed occupational therapy assessment tools such as AMPs and PRPP, can only be gained from attending external courses and so there should be a plan within organisations to address attendance at such courses or alternatively, negotiations as to how the training might be brought in house. Additionally, external learning opportunities where ideas could be taken up and brought back into the workplace to share with colleagues were clearly an important part of the participants' work experiences and highly valued. It enabled them to engage in professional networking, which resulted in the introduction of new practice ideas and increased confidence to practice. Therefore, it is crucial that time and funding is allocated for employees to be able to learn, practice and discuss the take up and application of ideas into the workplace. A further area of development would be the acknowledgement of knowledge gaps with respect to new graduates and staff recruited from other areas of practice. Ability to learn new knowledge and upskill with respect to a new area should be a part of the work environment induction process and recognized that time and support are required to achieve knowledge translation, thus addressing theory practice gaps of new staff.

Practice

 There was the suggestion of prolific use of colleagues to source and discuss ideas both formally in the workplace and informally in their own time. The participants appeared extremely motivated to tap into the current literature and take up the ideas relevant to their practice area. It is imperative that professional development opportunities and ways to access literature continue to be made available to clinicians so they are able to carry on sourcing ideas to develop their practice within an environment which would allow knowledge transmission and translation to occur. With regard to perceived friction between occupational models and the biomedical model, it is anticipated that the processes linked to the biomedical model will remain in place well into the century (Cole & Tufano, 2008). If this is the case, some occupational therapists may well continue to work between both approaches for some time into the future, depending upon the organizational health frameworks promoted by governing bodies. Participants appeared particularly adept at moving from thinking in "occupational language" to use of "medical language" as necessary, when communicating with their colleagues. Competence in this skill appeared to be an implicit and necessary part of their identity. The participants reported they

often needed to adapt their occupational therapy language in this way, so that their co-workers understood them. However, they also changed both the occupational and biomedical model language to every-day language when talking with clients to give them greater understanding. Therefore, it would seem pertinent to recognize that indeed this is a particular skill that helps with communication and the transmission of knowledge. It may be one example of a component of plural practice necessary for working in a DHB situation and as such should openly be respected in practice or occupational therapists could not work in this environment. More importantly, it was very clear that all participants stood strongly by the fundamental belief that occupation was the core of their profession and that they used occupation-based concepts, theory, assessments and interventions with their clients, even though they appeared to engage in multilingual communication.

Analysis of the participant interviews also suggested that clinical reasoning and reflection provided a strong foundation for their confidence and identity. Participants reported that when they thought through their practice experiences, remembering positive out-comes and resolving challenges, they reported their confidence in themselves as practitioners was affirmed. Opportunity for professional supervision, coaching and peer discussion was believed valuable for safe practice, because it challenged practice, creating an opportunity to consider application of ideas and knowledge, which in turn appeared to increase confidence in practice skills.

Education and ongoing professional development (in DHB; learning institutions)

The world of occupational therapy is so diverse that there are challenges as to what is included in the undergraduate student curriculum. New Zealand graduates who have participated in this study have an understanding of the fundamental beliefs of occupational therapy. They practice with occupation, engagement, enablement and cultural safety underpinning their practice. However, some participants identified knowledge gaps, indicating that a deeper understanding and insight into clinical reasoning theory and additionally how to incorporate evidence into practice was needed. Therefore, the implication for education of occupational therapists is that reasoning theory and how reasoning is understood to be utilized and articulated in practice should be a regular feature in both undergraduate programmes as well as available as post graduate study in New Zealand. The occupational therapy higher education institutions, have offered papers in clinical reasoning theory, but these may not be available or practical for all therapists to access. Additionally, the focus of higher education facilities is on the provision of postgraduate papers, not short courses (C. Hocking, personal communication, August 29, 2013). Therefore, other ways to provide low cost training should be investigated by the New Zealand Association of Occupational Therapists (NZAOT) to provide an alternative source and form of delivery such as using an on-line medium for short workshops or podcasts. Alternatively, workshops hosted by DHBs where specialists and researchers could be invited to present their

work and share their knowledge might prove viable and this would be an excellent example of knowledge transmission and application. Finally, integrated research opportunities between higher education institutions, DHB learning centers and clinicians themselves would answer the call from the literature to work together, (Kielhofner, 2005), towards knowledge creation that could be understood by academics and practitioners alike and begin to close the theory-practice gaps.

Further research

This study looked at the ideas occupational therapists took up from the international literature. In the literature review, multiple ideas were identified, but the main ideas centered on theory, culture, occupation, enablement, identity, and pluralistic, client-centered, responsive, reflective practice. The participants echoed these areas in their interviews when they too, talked about occupation, enablement, theory, models and tools, engagement supervision, reflection and cultural awareness. This study has provided some provisional themes. Further research is needed to look at how knowledge is acquired, translated and applied by continuing study in how occupational therapists take up ideas from the literature. This may be achieved by recruiting participants from different practice areas, settings, culture mix and geographical areas.

Conclusion

This study set out to identify the ideas occupational therapists have taken up from the international literature. Along the way, knowledge creation, acquisition, translation, and transmission have been discussed in relation to international literature and the findings of this study. The study itself has revealed six themes: sourcing ideas; occupation; enablement; use of theory, tools and models, occupation and the biomedical model; engagement with clients; recognition of culture. Cultural responsiveness was a particularly strong theme amongst the participants. Considered together, these themes show how complex the practice of occupational therapy is and how each theme supports and compliments the other. My choice of qualitative descriptive research was to explore the views of participants that would inform me of possible professional development opportunities. Two potential knowledge gaps were identified. Firstly, there was no mention of the International Classification of Functioning (ICF) and secondly, no indication of awareness of population health. Why this is so, is unknown, but likely, because the ICF and population health are not yet the focus of the organisation where the participants are employed. Education to fill these knowledge gaps could be provided within an in-service education programme.

The themes demonstrate the multiple ideas the participants have picked up and assimilated into their practice. It shows that this group of occupational therapists uses both the 'big' ideas and

beliefs regularly published in international literature, such as occupation and enablement, as well as ideas more attuned to their particular area of practice and client base. In this respect, the participants can truly be seen as practicing in a pluralistic way and responsive to change in practice, and to client and organisational needs. The research has demonstrated that within the existing level of in-service and study allocation provided by the DHB, the participants have been able to take up current ideas within the international literature. As they have used a variety of mechanisms to take up and share their learning, no single mechanism has been identified as *the* way of obtaining knowledge in this study. So at least there needs to be recognition and protection of the avenues and opportunities currently provided by the DHB, that are used to take up and acquire ideas, share and transmit knowledge and discuss and apply literature. These opportunities should continue to be expressly provided within health organisations to enable this method of uptake of ideas.

It is not known whether other occupational therapists in the same work situation take up ideas in a similar way from their participant colleagues, as they have not been part of this study. However, it would be reasonable to expect, as a service, professional competency and legal requirements, and as part of professional currency (Murray & Lawry, 2011), that all occupational therapists do stay up to date with the literature. Professional currency is a term that encompasses lifelong learning, reflection on practice and involvement in the development of the occupational therapy profession (p. 261). It is important for "a dynamic, engaged and motivated workforce" (p. 268). Murray and Lawry (2011) suggest "professional bodies and employers [are involved] in developing appropriate processes for enhancing professional currency" (p. 268). Therefore, my recommendations stated earlier in this chapter may need to be utilised for those who take different approaches to learning, or when new knowledge gaps are identified, as new knowledge is constantly being created and there may need to be other additional avenues of knowledge acquisition made available. Finally, continued access to in-service and study time would apply equally to other professions as it promotes evidence-based practice, thus providing optimum client health outcomes. A final quote by one of the participants, Linda, sums up the importance of being able to take up and share ideas:

> *It's connecting, isn't it? It's ideas… sometimes you can feel quite isolated because you don't know who else might have those thoughts. It's so reassuring to know those experts in America and UK and China and Japan [are] all saying the same thing. It's so reassuring.*

References

Aiken, F., Fourt, A., Cheng, I., & Polatajko, H. (2011). The meaning gap in occupational therapy: Finding meaning in our own occupation. *Canadian Journal of Occupational Therapy, 78*(5), 294-302. doi:10.2182/cjot.2011.78.5.4

Allen, C. K., Austin, S. L., David, S. K., Earhart, C. A., McCraith, D. B., & Riska-Williams, L. (2007). *Manual for the Allen Cognitive Level Screen-5 (ACLS-5) and Large Allen Cognitive Level Screen-5 (LACLS-5).* Camarillo, CA: ACLS and LACLS Committee.

Applegarth, J., Dwyer, T., Moxham, L., & Happell, B. (2012). Identifying and acquiring the contextual skills and knowledge for nursing practice in assisted reproductive technology: A grounded theory study. *Journal of Clinical Nursing, 22*, 1738-1747. doi:10.1111/j.1365-2702.2012.04275.x

Argote, L., Ingram, P., Levine, J., & Moreland, R. (2000). Knowledge transfer in organsiations: Learning from the experience of others. *Organizational Behavior and Human Decision Processes 82*(1), 1-8. doi:10.1006/obhd.2000.2883,

Ashby, S. E., Ryan, S., Gray, M., & James, C. (2013). Factors that influence the professional resilience of occupational therapists in mental health practice. *Australian Occupational Therapy Journal, 60*, 110-119. doi:10.1111/1440-1630.12012

Asher, I. E. (Ed.). (2007). *Occupational therapy assessment tools: An annotated index* (3rd ed.). Bethesda, MD: AOTA Press.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *British Medical Journal, 322*, 1115-1117.

Barry, E., & Gibbens, R. (2011). Spirituality in practice: Using personal reflection to prepare occupational therapy students. *British Journal of Occupational Therapy, 74*(4), 176-180. doi:10.4276/030802211X13021048723219

Belief. (n.d.). In *Oxford Dictionaries Online*. Retrieved from http://oxforddictionaries.com/definition/english/belief?q=beliefs

Berta, W., Teare, G., Gilbart, E., Ginsburg, L., Lemieux-Charles, L., Davis, D., & Rappolt, S. (2010). Spanning the know-do gap: Understanding knowledge application and capacity in long-term care homes. *Social Science and Medicine, 70*, 1326-1334. doi:10.1016/j.socscimed.2009.11.028

Blaikie, N. (2010). *Designing social research: The logic of anticipation* (2nd ed.). Cambridge: Polity Press.

Carmody, S., Nolan, R., Ni Chonchuir, N., Curry, M., Halligan, C., & Robinson, K. (2007). The guiding nature of the kawa (river) model in Ireland: Creating both opportunities and challenges for occupational therapists. *Occupational Therapy International, 14*, 221-236. doi:10.1002/oti.235

Carpenter, C., & Suto, M. (2008). *Qualitative research for occupational and physical therapists: A practical guide*. Oxford: Blackwell.

Chapparo, C., & Ranka, J. (1996). *The Perceive, Recall, Plan, Perform (PRPP) System of task analysis*. Retrieved 30th June, 2013, from http://203.17.62.122/opma/index.php/au/home/opm_book/the_perceive_recall_plan_perform_prpp_system_of_task_analysis

Chapparo, C., & Ranka, J. (1997). Towards a model of occupational performance: Model development. In C. Chapparo & J. Ranka (Eds.), *Occupational performance model (Australia)* (pp. 24-45). Sydney: Occupational Performance Network.

Retrieved 22/3/13 from http://203.17.62.122/opma/index.php/au/home/origin

Chapparo, C., & Ranka, J. (2008). Clinical reasoning in occupational therapy. In J. Higgs, M. Jones, S. Loftus, & N. Christensen (Eds.), *Clinical reasoning in the health professions* (Vol. 3, pp. 265-277). London: Elsevier.

Clark, D. R. (2004). Bloom's taxonomy of learning domains. Retrieved from http://www.nwlink.com/~donclark/hrd/bloom.html

Clouston, T., & Whitcombe, S. (2008). The professionalisation of occupational therapy: A continuing challenge. *British Journal of Occupational Therapy, 71*(8), 314-320.

Cole, M., & Tufano, R. (2008). *Applied theories in occupational therapy: A practical approach*. Thorofare: Slack Incorporated.

Colquhoun, H., Letts, L., Law, M., MacDermid, J., & Missiuna, C. (2010). A scoping review of the use of theory in studies of knowledge transmission and application. *Canadian Journal of Occupational Therapy, 77*(5), 270-279. doi:10.2182/cjot.2010.77.5.3

Creek, J. (2010). *The core concepts of occupational therapy*. London: Jessica Kingsley Publishers.

Crotty, M. (1998). *The foundations of social research*. London: SAGE Publications.

Crowe, M. (2005). Discourse analysis: Towards an understanding of its place in nursing. *Journal of Advanced Nursing, 51*(1), 55-63. doi:10.1111/j.1365-2648.2005.03461.x

Davidson, C., & Tolich, M. (2003). *Social science research in New Zealand* (2nd ed.). Auckland, New Zealand: Pearson.

Davys, A., & Beddoe, L. (2010). *Best practice in professional supervision*. London: Jessica Kingsley Publishers.

DePoy, E., & Gitlin, L. N. (2005). *Introduction to research : Understanding and applying multiple strategies* (16397662, 3rd ed.). St. Louis, MO: Elsevier/Mosby.

Dickie, V. (2004). From Drunkard's Path to Kansas Cyclones: Discovering creativity inside the blocks. *Journal of Occupational Science, 11*(2), 51-57. doi:10.1080/14427591.2004.9686531

DiMauro, N. (2000). Continuous professional development. *The Journal of Continuing Education in Nursing, 31*(2), 59-62.

Doble, S., & Santha, J. (2008). Occupational well-being: Rethinking occupational therapy outcomes. *Canadian Journal of Occupational Therapy, 75*(3), 184-191. doi:10.1177/000841740807500310

Driscoll, J., & Cooper, R. (2005). Coaching for clinicians. *Nursing Management, 12*(1), 18-23.

Dubowitz, L. M. S. (1999). *The Neurological Assessment of the Preterm and Full-term Newborn Infant*. London: Mac Keith Press.

Egan, M., & Delatt, M. D. (1994). Considering spirituality in occupational therapy. *Canadian Journal of Occupational Therapy, 61*(2), 94-101. doi:10.1177/000841749406100205

Egan, M., & Swedersky, J. (2003). Spirituality as experienced by occupational therapists in practice. *The American Journal of Occupational Therapy, 57*, 525-533. doi:10.5014/ajot.57.5.525

Eliasson, A. (2012). Choosing the right assessment for the right purpose. *Physical and Occupational Therapy in Pediatrics, 32*(1), 22-23. doi:10.3109/01942638.2012.643184

Estes, J., & Pierce, D. E. (2012). Pediatric therapists' perspectives on occupation-based practice. *Scandinavian Journal of Occupational Therapy, 19*, 17-25. doi:10.3109/11038128.2010.547598

Finlayson, M., Shevil, E., Mathiowetz, V., & Matuska, K. (2005). Reflections of occupational therapists working as members of a research team. *Australian Occupational Therapy Journal, 52*, 101-108. doi:10.1111/j.1440-1630.2005.00479.x

Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12*(3), 189-198. doi:10.1016/0022-3956(75)90026-6

Gage, M., & Polatajko, H. (1995). Naming practice: The case for the term client-driven. *Canadian Journal of Occupational Therapy, 62*, 115-118. doi:10.1177/000841749506200301.

Gaziano, C. (1997). Forecast 2000: Widening knowledge gaps. *Journalism & Mass Communication Quarterly, 74*, 237-264. doi:10.1177/107769909707400202

Gerlach, A. (2012). A critical reflection on the concept of cultural safety. *Canadian Journal of Occupational Therapy, 79*(3), 151-158. doi:10.2182/cjot.2012.79.3.4

Giddings, L. S., & Grant, B. M. (2009). From rigour to trustworthiness: Validating mixed methods. In S. Andrew & E. J. Halcomb (Eds.), *Mixed methods research for nursing and the health sciences* (pp. 119-134). Chichester: Wiley-Blackwell.

Golfashani, N. (2003). Understanding reliability and validity in qualitative research. *The qualitative report, 8*(4), 597-607.

Graham, I., & Tetroe, J. (2007). Some theoretical underpinnings of knowledge transmission and application. *Academic Emergency Medicine, 14*, 936-941. doi:10.1197/j.aem.2007.07.004

Gray, M., & McPherson, K. (2005). Cultural safety and professional practice in occupational therapy: A New Zealand perspective. *Australian Occupational Therapy Journal, 52*(1), 34-42. doi:10.1111/j.1440-1630.2004.00433.x

Grbich, C. (2007). *Qualitative research in health*. London: SAGE Publications.

Greber, C. (2011). Pluralism: Signposting a split in occupational therapy? *Australian Occupational Therapy Journal, 58*(6), 455-457. doi:10.1111/j.1440-1630.2011.00959.x

Griffin, C., & Bengry-Howell, A. (2008). Ethnography. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 15-32). Thousand Oaks, CA: Sage Publications.

Griffith, J., Caron, C., Desrosiers, J., & Thibeault, R. (2007). Defining spirituality and giving meaning to occupation: The perspective of community-dwelling older adults with autonomy loss. *Canadian Journal of Occupational Therapy, 74*(2), 78-90. doi:10.2182/cjot.06.0016

Guillemin, M., McDougall, R., & Gillam, L. (2009). Developing ethical "mindfulness" in continuing professional development in healthcare: Use of a personal

narrative approach. *Cambridge Quarterly of Healthcare Ethics, 18*, 197-208. doi:10.1017/S096318010909032X

Hall, A. (2005). Defining nursing knowledge. *Nursing Times, 101*(48), 34-37.

Hammell, K. W. (2009). Sacred texts: A sceptical exploration of the assumptions underpinning theories of occupation. *Canadian Journal of Occupational Therapy, 76*(1), 6-13. doi:10.1177/000841740907600105

Harries, P. (2007). Knowing more than we can say. In J. Creek & A. Lawson-Porter (Eds.), *Contemporary issues in occupational therapy: Reasoning and reflection* (pp. 161-188). Chichester: John Wiley & Sons Ltd.

Harris, E. (2008). The meanings of craft to an occupational therapist. *Australian Occupational Therapy Journal, 55*, 133-142. doi:10.1111/j.1440-1630.2007.00700.x.

Hasselkus, B. R. (2002). *The meaning of everyday occupation*. Thorofare, NJ: Slack.

Haywood, H., Pain, H., Ryan, S., & Adams, J. (2012). Engagement with continuing professional development. *Journal of Allied Health, 41*(2), 83-89.

Health Practitioners Competence Assurance Act, 2003 No 48 C.F.R. (2003).

Herkt, J., & Hocking, C. (2010). Participating in supervision: Strategies and consequences for New Zealand occupational therapists. *New Zealand Journal of Occupational Therapy, 57*(1), 27-34.

Heyes Fleming, M. (1991). The therapist with the three-track mind. *The American Journal of Occupational Therapy, 45*, 1007-1014. doi:10.5014/ajot.45.11.1007

Heyes Fleming, M. (1994). The search for tacit knowledge. In C. Mattingly & M. Heyes Fleming (Eds.), *Clinical Reasoning: Forms of inquiry in a therapeutic practice* (pp. 22-34). Philadelphia, PA: F.A. Davis Company.

Higgs, J., & Titchen, A. (2001). Rethinking the practice-knowledge interface in an uncertain world: A model for practice development. *British Journal of Occupational Therapy, 64*(11), 526-533.

Hocking, C. (2009). Process of assessment and evaluation. In M. Curtin, M. Molineaux, & J. Supyk-Mellson (Eds.), *Occupational therapy and physical dysfunction* (6th ed., pp. 81-93). Oxford: Elsevier Churchill Livingstone.

Hooper, B. (2006). Epistemological transformation in occupational therapy: Educational implications and challenges. *Occupational Therapy Journal of Research, 26*(1), 15-24.

Hunter, E., & Blair, S. (1999). Staff supervision for occupational therapists. *British Journal of Occupational Therapy, 62*(8), 344-350.

Ikiugu, M., Smallfield, S., & Condit, C. (2009). A framework for combining theoretical conceptual practice models in occupational therapy practice. *Canadian Journal of Occupational Therapy, 76*, 162-170. doi:10.1177/000841740907600305

Iwama, M. K. (2006). The Kawa (River) Model: Client centred rehabilitation in cultural context. In S. Davis (Ed.), *Rehabilitation. The use of theories and models in practice* (pp. 147-168). Edinburgh: Elsevier Churchill Livingstone.

Jannings, W., & Armitage, S. (2001). Informal education: A hidden element of clinical nurse consultant practice. *The Journal of Continuing Education in Nursing, 32*(2), 54-59.

Johnson, B., & Webber, P. (2001). *An introduction to theory and reasoning in nursing*. Philadelphia: Lippincott.

Jones, D., & Murphy, P. (2007). The case for coaching. *Mental Health Today* (May), 38-39.

Kelly, G., & McFarlane, H. (2007). Culture or cult? The mythological nature of occupational therapy. *Occupational Therapy International, 14*(4), 188-202. doi:10.1002/oti.237

Kielhofner, G. (2002). *Model of human occupation: Theory and application* (3rd ed.). Baltimore, MD: Lippincott Williams and Wilkins.

Kielhofner, G. (2004). *Conceptual foundations of occupational therapy*. Philadelphia, PA: F. A. Davis.

Kielhofner, G. (2005). Research concepts in clinical scholarship - Scholarship and practice: Bridging the divide. *The American Journal of Occupational Therapy, 59*, 231-239. doi:10.5014/ajot.59.2.231

Kielhofner, G. (2006). *Research in occupational therapy: Methods of inquiry for enhancing practice* (14273501). Philadelphia: F.A. Davis.

Kielhofner, G., & Forsyth, K. (2002). *Thinking with theory: A framework for therapeutic reasoning* (3rd ed.). Baltimore, MA: Lippincott Williams.

Kiernan, R. J., Mueller, J., Langston, J. W., & Van Dyke, C. (1987). The Neurobehavioral Cognitive Status Examination. A brief but differentiated approach to cognitive assessment. *Annals of Internal Medicine, 107*, 481-485.

King, A. (2000). *The New Zealand health strategy*. Wellington: Ministry of Health.

Knowledge. (n.d.). In *Oxford Dictionaries Online*. Retrieved from http://oxforddictionaries.com/definition/english/knowledge?q=knowledge

La Cour, K., Josephsson, S., Tishelman, C., & Nygard, L. (2007). Experiences of engagement in creative activity at a palliative care facility. *Palliative and Supportive Care, 5*, 241-250. doi:10.1017/S1478951507000405

Lang, E., Wyer, P., & Eskin, B. (2007). Executive summary: Knowledge transmission and application in emergency medicine: Establishing a research agenda and guide map for evidence uptake. *The Society for Academic Medicine, 14*(11), 915-918. doi:10.1197/j.aem.2007.07.005

Lauckner, H., Pentland, W., & Paterson, M. (2007). Exploring occupational therapists' perceptions of their role in community development. *Canadian Journal of Occupational Therapy, 74*(4), 314-325. doi:10.2182/cjot.07.005

Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. Newbury Park: SAGE Publications.

Lyons, C., Casey, J., Brown, T., Tseng, M., & McDonald, R. (2010). Research knowledge, attitudes, practices and barriers among paediatric occupational therapists in the United Kingdom. *British Journal of Occupational Therapy, 73*(5), 200-209. doi:10.4276/030802210X12734991664147

Mackey, H. (2007). 'Do not ask me to remain the same': Foucault and the professional identities of occupational therapists. *Australian Occupational Therapy Journal, 54*, 95-102. doi:10.1111/j.1440-1630.2006.00609.x

Maitra, K., & Erway, F. (2006). Perception of client-centered practice in occupational therapists and their clients. *The American Journal of Occupational Therapy, 60*(3), 298-310. doi:10.5014/ajot.60.3.298

Mattingly, C. (1991a). What is clinical reasoning? *The American Journal of Occupational Therapy, 45*, 979-986. doi:10.5014/ajot.45.11.979

Mattingly, C. (1991b). The narrative nature of clinical reasoning. *The American Journal of Occupational Therapy, 45*, 998-1005. doi:10.5014/ajot.45.11.998

Mattingly, C. (1994). The Narrative Nature of Clinical Reasoning. In C. Mattingley & M. Heyes Fleming (Eds.), *Clinical Reasoning: Forms of Inquiry in a Therapeutic Practice*. Philadelphia: F. A. Davis Company.

Mattingly, C., & Heyes Fleming, M. (1994). Interactive Reasoning: Collaborating with the Person. In C. Mattingly & M. Heyes Fleming (Eds.), *Clinical Reasoning: Forms of Inquiry in a Therapeutic Practice*. Philadelphia: F. A. Davis Company.

McCluskey, A. (2008). Occupational therapists report a low level of knowledge, skill and involvement in evidence-based practice. *Australian Occupational Therapy Journal, 50*(1), 3-12. doi:10.1046/j.1440-1630.2003.00303.x

McColl, M., Law, M., Stewart, D., Doubt, L., Pollock, N., & Krupa, T. (2003). *Theoretical Basis of Occupational Therapy*. Thorofare, NJ: Slack, Inc.

Menon, A., Korner-Bitensky, N., Kastner, M., McKibbon, K. A., & Straus, S. (2009). Strategies for rehabilitation professionals to move evidence-based knowledge into practice: A systematic review. *Journal of Rehabilitation Medicine, 41*(13), 1024-1032. doi:10.2340/16501977-0451

Mioshi, E., Dawson, K., Mitchell, J., Arnold, R., & Hodges, J. R. (2006). The Addenbrooke's Cognitive Examination Revised (ACE-R): A brief cognitive test battery for dementia screening. *International Journal of Geriatric Psychiatry, 21*(11), 1078-1085. doi:10.1002/gps.1610

Moats, G. (2006). Discharge decision-making with older people: The influence of the institutional environment. *Australian Occupational Therapy Journal, 53*, 107-116. doi:10.1111/j.1440-1630.2006.00568.x

Moats, G., & Doble, S. (2006). Discharge planning with older adults: Toward a negotiated model of decision making. *Canadian Journal of Occupational Therapy. Revue Canadienne D'ergotherapie, 73*(5), 303-311. doi:10.1177/000841740607300507

Molineaux, M. (Ed.). (2004). *Occupation for occupational therapist*. Oxford: Blackwell Publishing.

Moon, P. (2007). The Treaty of Waitangi: Principles and practice. In *Health in the context of Aotearoa New Zealand.* (pp. 75-93). Auckland: Oxford University Press.

Mortenson, W., & Dyck, I. (2006). Power and client-centered practice: An insider exploration of occupational therapists' experiences. *Canadian Journal of Occupational Therapy, 73*(5), 261-272. doi:10.2182/cjot.06.008

Muñoz, J. P. (2007). Culturally responsive caring in occupational therapy. *Occupational Therapy International, 14*, 256-280.

Murray, C., & Lawry, J. (2011). Maintenance of professional currency: Perceptions of occupational therapists. *Australian Occupational Therapy Journal, 58*, 261-269. doi:10.1111/j.1440-1630.2011.00927.x

National Aboriginal Health Council. (2008). *Cultural competency and safety: A guide for health care administrators, providers and educators*. Ottawa, ON: Author.

Nursing Council of New Zealand, &. (2011). *Guidelines for cultural safety: The Treaty of Waitangi and Maori health in nursing education and practice* Wellington: Author.

Occupational Therapy Board of New Zealand. (2012). *Annual Report 2012*. Wellington: Author.

Papps, E. (2005). Cultural Safety: Daring to be different. In D. Wepa (Ed.), *Cultural Safety in Aotearoa NewZealand*. Auckland: Pearson Prentice Hall Health.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (12508725, 3 ed.). Thousand Oaks, CA: Sage Publications.

Pentland, W. (2012). Conversations for enablement: Using coaching skills in occupational therapy. *Occupational Therapy Now, 14*(2), 14-16.

Polatajko, H. J., Craik, J., Davis, J., & Townsend, E. A. (2007). Canadian Practice Process Framework. In E. A. Townsend & H. J. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation* (pp. 229-246). Ottawa, ON: CAOT.

Politics. (n.d.). In *Oxford Dictionaries Online*. Retrieved from http://oxforddictionaries.com/definition/english/politics

Pope, M. (1982). Personal construction of formal knowledge. *Interchange, 13*(4), 3-14. doi:10.1007/BF01191417.

Price, P., & Miner, S. (2007). Occupation emerges in the process of therapy. *The American Journal of Occupational Therapy, 61*, 441-450. doi:10.5014/ajot.61.4.441

Reid, D. (2009). Capturing presence moments: The art of mindful practice in occupational therapy. *Canadian Journal of Occupational Therapy, 76*, 180-188. doi:10.1177/000841740907600307

Robertson, C., & Finlay, L. (2007). Making a difference, teamwork and coping: The meaning of practice in acute physical settings. *British Journal of Occupational Therapy, 70*(2), 73-80.

Robertson, L., & Griffiths, S. (2009). Graduates' reflections on their preparation for practice. *British Journal of Occupational Therapy, 72*(3), 125-132.

Rudman, D. L., & Dennhardt, S. (2008). Shaping knowledge regarding occupation: Examining the cultural underpinnings of the evolving concept of occupational identity. *Australian Occupational Therapy Journal, 55*, 153-162. doi:10.1111/j.1440-1630.2007.00715.x

Ryall, T. (2007). *Better Sooner More Convenient: Health Discussion Paper*. Wellington: The Office of the Leader of the Opposition.

Ryu, C., Kim, Y., Chaudhury, A., & Rao, H. (2005). Knowledge aquisition via three learning processes in Enterprise Information Portals: Learning-by-investment, learning-by-doing and learning-from-others. *MIS Quarterly, 29*(2), 245-278.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23*, 334-340. doi:10.1002/1098-240X(200008)23:4

Schlemmer, J., & Henneker, K. (2004). Supervision for occupational therapists in the context of the health practitioners competence assurance act 2003 (HPCCA).

Schmid, T. (2004). Meanings of creativity within occupational therapy practice. *Australian Occupational Therapy Journal, 51*, 80-88. doi:10.1111/j.1440-1630.2004.00434.x

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information, 22*, 63-75.

Sherratt, C. (2005). The Journal Club: A method for occupational therapists to bridge the theory-practice gap. *British Journal of Occupational Therapy, 68*(7), 301-305.

Shiri, S. (2006). Job satisfaction, physical acute care and occupational therapists. *New Zealand Journal of Occupational Therapy, 53*(2), 5-11.

Sinclair, K. (2007). Exploring the facets of clinical reasoning. In J. Creek & A. Lawson-Porter (Eds.), *Contemporary issues in occupational therapy: Reasoning and reflection* (pp. 143-160). Chichester: Wiley & Sons Ltd.

Sporle, A., & Koea, J. (2004). Maori responsiveness in health and medical research: Key issues for researchers (Part 1). *New Zealand Medical Journal 117*(1199).

Stewart, D. (2002). The new International Classification of Functioning, Disability and Health. Concepts and implementation issues for occupational therapists. *Occupational Therapy Now*(July/August), 17-21.

Straus, S., Tetroe, J., & Graham, I. (2011). Knowledge transmission and application is the use of knowledge in health care decision making. *Journal of Clinical Epidemiology, 64*, 6-10. doi:10.1016/j.clinepi.2009.08.016

Stav, W. B., Hallenen, T., Lane, J., & Arbesman, M. (2012). Systematic review of occupational engagement and health outcomes among community-dwelling older adults. *The American Journal of Occupational Therapy, 66*(3), 301-310. doi:10.5014/ajot.2012.003707

Suarez-Balcazar, Y., Rodawoski, J., Balcazar, F., Taylor-Ritzler, T., Portillo, N., Barwacz, D., & Willis, C. (2009). Perceived levels of cultural competence

among occupational therapists. *The American Journal of Occupational Therapy, 63*(4), 498-505. doi:10.5014/ajot.63.4.498

Take-up. (n.d.). In *Merriam-Webster's online dictionary*. Retrieved from http://www.merriam-webster.com/dictionary/take-up

Taylor, S., & Field, D. (2003). Approaches to health and health care. In S. Taylor & D. Field (Eds.), *Sociology of health and health care*. Oxford: Blackwell.

Te Rau Matatini. (2009). *Te Umanga Whakaora*. Wellington: New Zealand Association of Occupational Therapists.

Tetroe, J. (2007). Knowledge transmission and application at the Canadian Institute of Health Research: A primer. *Focus: A publication of the National Center for the Dessemination of Disability Research, Technical Brief No. 18*.

Thomas, Y. (2009). Inspiration: Moving forward when you do not see the steps. *New Zealand Journal of Occupational Therapy, 56*(1), 12-18.

Thorley, M., & Lim, S. (2011). Considerations for occupational therapy assessment for indigenous children in Australia. *Australian Occupational Therapy Journal, 58*(1), 3-10. doi:10.1111/j.1440-1630.2010.00852.x.

Townsend, E. A., & Polatajko, H. J. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation*. Ottawa, ON: CAOT.

Trenc Smith, K., & Kinsella, E. A. (2009). Paediatric occupational therapists' reflections on meaning in professional practice: A phenomenonlogical study. *Canadian Journal of Occupational Therapy, 76*(4), 299-308. doi:10.1177/000841740907600409

Turpin, M., & Iwama, M. K. (2011). *Using occupational therapy models in practice: A field guide*. London: Churchill Livingstone Elsevier.

Upton, D., & Upton, P. (2006). Knowledge and use of evidence-based practice by allied health and health science professionals in the United Kingdom. *Journal of Allied Health, 35*(3), 127-133.

van Ooijen, E. (2003). *Clinical supervision made easy*. London: Elsevier Limited.

Watson, R. M. (2006). Being before doing: The cultural identity (essence) of occupational therapy. *Australian Occupational Therapy Journal, 53*, 151-158. doi:10.1111/j.1440-1630.2006.00598.x

Welch, A., & Dawson, P. (2006). Closing the gap: Collaborative learning as a strategy to embed evidence within occupational therapy practice. *Journal of Evaluation in Clinical Practice, 12(2)*(April), 227-238.

Wilcock, A., & Hocking, C. (2004). Occupation, population health and policy development. In M. Molineaux (Ed.), *Occupation for occupational therapists* (pp. 219-230). Carlton, VA: Blackwell Publishing.

Wilding, C. (2008). *Identifying, articulating, and transforming occupational therapy practice in an acute setting: A collaborative action research study*. Unpublished doctoral dissertation. Charles Sturt University. Mitchell, Australia.

Wilding, C., & Whiteford, G. (2007). Occupation and occupational therapy: Knowledge paradigms and everyday practice. *Australian Occupational Therapy Journal, 54*, 185-193. doi:10.1111/j.1440-1630.2006.00621.x

Wilding, C., & Whiteford, G. (2008). Language, identity and representation: Occupation and occupational therapy in acute settings. *Australian Occupational Therapy Journal, 55*, 180-187. doi:10.1111/j.1440-1630.2007.00678.x

Wood, W. (2004). The heart mind and soul of professionalism in occupational therapy. *The American Journal of Occupational Therapy, 58*, 249-257. doi:10.5014/ajot.58.3.249

World Health Organization. (1980). *ICIDH: International Classification of Impairments, Disabilities, and Handicaps* [A manual of classification relating to the consequences of disease]. Geneva: Author.

World Health Organization. (2001). *International classification of functioning, disability and health: ICF* (9241545429). Geneva: Author.

Wright, C., & Rowe, N. (2005). Protecting professional identities: Service user involvement and occupational therapy. *British Journal of Occupational Therapy, 68*(1), 45-47.

Appendix A: AUTEC Ethics Approval 11/311

MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To:	Clare Hocking
From:	**Dr Rosemary Godbold** Executive Secretary, AUTEC
Date:	13 February 2012
Subject:	Ethics Application Number 11/311 **How have occupational therapists in New Zealand taken up ideas promoted in the international occupational therapy literature?**

Dear Clare

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 28 November 2011 and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 12 March 2012.

Your ethics application is approved for a period of three years until 13 February 2015.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 13 February 2015;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 13 February 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You

are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at http://www.aut.ac.nz/research/research-ethics/ethics).

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Yasmin Orton (email address)

Appendix B: Knowledge Centre Ethics approval
Registration #: RM 0980712051

Approval from Knowledge Centre to Commence study Feb 2012

From: Knowledge Centre **Sent:** Tuesday, 28 February 2012 14:25 **To:** Yasmin Orton (DHB); **Subject:** DHB Approval to Commence

Dear Yasmin

 Knowledge Centre has now received the relevant approvals for your study:

Title: How have occupational therapists in New Zealand taken up ideas promoted in the international occupational therapy literature
Registration #: RM 0980712051

Please continue to forward to us copies of all correspondence regarding ongoing ethics approval for this study (if any). The Research & Knowledge Centre Staffnet site contains further information which may be of use to DHB researchers, such has how to access statistical advice.

Good luck with your study.

Regards

 Knowledge Centre
(Phone)
(Email)

Appendix C: Participant consent form

Participant Consent Form

Project title: How have occupational therapists in New Zealand taken up ideas promoted in the international occupational therapy literature?

Project Supervisor: **Clare Hocking**

Researcher: **Yasmin Orton**

○   I have read and understood the information provided about this research project in the Information Sheet dated (add date).

○   I have had an opportunity to ask questions and to have them answered.

○   I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○   I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○   If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○   I agree to take part in this research.

○   I wish to receive a copy of the report from the research (please tick one): Yes○   No○

Participant's signature

…………………………………..………………………………………………

Participant's name

………………………………………………………………………………..

Participant's Contact Details (if appropriate):

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………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on 13/2/12. AUTEC Reference number 11/311

Note: The Participant should retain a copy of this form.

Appendix D: Information Sheet

Participant

Information Sheet

Date Information Sheet Produced: 24th June 2011

Project Title
How occupational therapists in New Zealand have taken up ideas promoted in the international occupational therapy literature

An Invitation
Hello – My name is Yasmin Orton and I am an occupational therapist. I am working as an occupational therapy clinical service leader within the Allied Health Service at (xx) District Health Board and am currently studying for a Master of Health Science degree at AUT University. As part of this course, I am engaging in research for my thesis. I would like you to consider participating in my research. I am interested in how occupational therapists articulate how they have taken up and used ideas informing the profession internationally. Participation is entirely voluntary and you have the right to withdraw from the study at any time prior to the completion of data collection.

What is the purpose of this research?
There are a lot of claims in the literature about what occupational therapists do and what we should do, the things the profession is committed to. The purpose of this study is to gather information from occupational therapists in New Zealand about the important ideas that underpin practice, including ideas that make occupational therapy unique and ideas and ideals that other also professions ascribe to. I will be comparing this with accounts in the professional literature. I hope the outcome of the research will add to the body of knowledge giving insight into our role and our place as allied health professionals.

On successful completion of this project, I will have fulfilled the requirements for a Master of Health Science degree. When I have finished the degree, I will offer to present at a District Health Board in-service.

How was I identified and why am I being invited to participate in this research?
You were identified as a potential participant from your response to a recent email asking for volunteers for this research or because you heard about the study by word of mouth and you contacted me. The reason you have been invited to participate in this study is because you work for the DHB as a registered occupational therapist and you are based in the Auckland area so that a face-to-face interview can take place. My exclusion criteria are occupational therapists not employed in the DHB catchment area and those registered therapists who are working with a different title and job description, such as NASC. I am also not recruiting from those therapists for whom I am their professional supervisor or those who have started a Professional Development Review (PDR) with my involvement at the time of the interview period. PDRs that include me need to have been completed beforehand or allocated to a different member of staff. I am looking for participants who have over six months experience working in New Zealand. I am hoping to include a diverse range of participants and so will consider the age, ethnicity, length of practice and work area of all prospective participants. Any personal information gathered at this stage that does not progress to participation in an interview, will be shredded.

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What will happen in this research?

If you decide to participate, you will be part of a group of 8-12 occupational therapists who have agreed to meet with me for an individual face-to-face interview that will be tape-recorded or I will take written notes if you prefer. I will be asking questions aimed at enabling you to talk about how you select literature and ideas to inform your practice, and to talk about what current theories and approaches you are finding useful. The interview will take approximately 60-90 minutes. It will be held in one of the interview rooms at the hospital or at AUT if you prefer. I will book the room under my name. I am hoping to conduct the interviews after work finishes or during the day if I am given permission. You may bring a supporter to the interview if you wish.

The interview will be transcribed and I will contact you again to read through the transcription to verify the content is accurate and give you the opportunity to remove anything from it. Once this has been done, I will begin to analyse the data from your interview prior to interviewing the next participant. This will give me the opportunity to adjust my interview questions according to what participants are saying. At the end of the study I will send you a summary of the results, if you have requested them.

What are the discomforts and risks?

I do not anticipate any risks or discomfort to you from your participation in this study.
How will these discomforts and risks be alleviated?

If you do find the interview upsetting for some reason, you can access DHB employee assistance program (EAP), free of charge for 3 visits

What are the benefits?

This study aims to look at how occupational therapists have taken up ideas in the international literature. The benefit of this study to occupational therapy is that there is little research in this area in New Zealand and I hope that themes arising from the research will identify what occupational therapists are taking up in the unique context of New Zealand. I hope findings will help promote a sense of identity and clarity around the occupational therapy role. I hope it will benefit participants by knowing you have contributed to a project that will show how you have articulated what theoretical underpinnings we currently use as occupational therapists and provide indications of where we could go from here to further develop our profession. For me as the researcher, it will benefit my personal and professional development by enabling me to look further into a profession that is my passion and that I want to see thrive in as many settings as possible in the future.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation (ACC), providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

All information gathered from you will remain confidential and will be either stored in a locked cabinet or in a password protected file on my personal computer. I will be the only person to have access to these storage systems and any personal information you have given me. Your identity will be protected in the research by removal of your name and personal details. A pseudonym will be used with your consent, otherwise I will use a numerical code if you prefer. If I employ a transcriptionist to type up the interview, she will need to sign a confidentiality agreement prior to commencing work. Any information you share will be used only for the purpose of this research project. I will not reveal the identity of participants in the study. However, if a participant discloses an issue of patient safety or lack of competence, the usual DHB reporting procedure will apply.

What are the costs of participating in this research?
There will be no monetary cost to participating in this study. In terms of time needed to complete the interview and read / discuss the transcript, I would suggest you would be required to spend a maximum of two hours on the project.

What opportunity do I have to consider this invitation?
You will have at least two weeks from receipt of this information sheet to decide whether you want to participate in my research. Remember, participation is completely voluntary and you can withdraw from the study at any time prior to the completion of data collection. In two weeks time, I will phone you to discuss any concerns you might have or provide further information if you need it on the study. I will also ask about your decision to participate at that time. If you freely want to participate, I will arrange a time and place to do the interview with you. If you do not want to take part, that is fine too, there are no adverse results from not participating. On the day of the interview, before we begin, I will ask you to sign a consent form to conduct the interview. If, after the interview and/or review of the transcript, you want to withdraw, you still can, without adverse consequences. To do this, please contact me by e-mail or phone (see below). Alternatively, you can contact my supervisor, Clare Hocking (see below).

How do I agree to participate in this research?
You will have a copy of the consent form attached to this information sheet. I will follow up in two weeks by phone to see what your decision is. If you agree to participate, on the day of the interview, before we commence, I will ask you to sign the consent form.

Will I receive feedback on the results of this research?
Yes, on your request, I will send you a summary of results on completion of the project.
What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor: Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz*, 921 9999 ext. 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Yasmin Orton: XXXX

Project Supervisor Contact Details:

Clare Hocking: *email address:XXXX work phone number*: XXXX

Approved by the Auckland University of Technology Ethics Committee on 13/2/12. AUTEC Reference number 11/311**.**

Appendix E: Confidentiality Agreement

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title: How have occupational therapists in New Zealand taken up ideas promoted in the international occupational therapy literature?

Project Supervisor: Clare Hocking

Researcher: Yasmin Orton

○ I understand that all the material I will be asked to transcribe is confidential.

○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.

○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

 Transcriber's Contact Details (if appropriate):

……………………………………………………………………………………..

……………………………………………………………………………………..

……………………………………………………………………………………..

Date:

Project Supervisor's Contact Details (if appropriate):

Clare Hocking

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***Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number*: 11/311.**

Note: The Transcriber should retain a copy of this form.

Appendix F: Participant data collection form

Participant data collection form

Name:

Please tick all relevant boxes below.

This will help me select participants who have different experiences, work and cultural backgrounds so that I can access as wide a range of potential data as possible about the ideas occupational therapists take up from the literature

How long have you worked in New Zealand?

a. Under six months	b. Six months and over

How long have you practiced in New Zealand?

a. Under one year	b. 1 – 10 years
c. 11 – 20 years	d. 21- 30 years
e. Over 31 years	f. Other: Please specify……………

What is your current practice area?

a. Children	b. Adolescents
c. Adults - Under 65's	d. Older adults
e. Child, Women and Family Service	f. Mental Health Service
g. Allied Health Service	h. Community
i. Inpatients	j. Primary Healthcare Service
k. Other: Please specify……….	

Age:

a. 21 – 30 years	b. 31 – 40 years
c. 41 – 50 years	d. 51 – 60 years
e. 61 – 70 years	f. Over 71 years

Ethnicity:

a. Maori	b. New Zealand European
c. New Zealand Pacific Island	d. Pacific Islander
e. Asian	f. Other: Please state………….

Appendix G: Email Letter and Summary for Participants

<u>Draft of e-mail to send out to occupational therapists working at (named facility) – CWF and Mental Health</u>

Hello -

There are a lot of claims in the international literature about what occupational therapists do and what we should do, the things the profession is committed to.

Rather than taking that for granted, I'd like to ask New Zealand occupational therapists about the ideas they're committed to, that underpin our practice.

Many of you will know me already.

For those who don't, my name is Yasmin Orton and I work at (facility name) as a clinical service leader, occupational therapy, for the Allied Health Service

My study is part of my MHSC and I am interested in interviewing occupational therapists working in the DHB catchment area for this study.

I would expect interviews to be about one hour long and they can take place at work or away from work, depending upon what you prefer.

If you are interested and would like some more information, please contact me at:

Yasmin.orton (email address)

Thank you.
Kind regards,
Yasmin Orton

Draft of e-mail to send out to occupational therapists working at DHB – Allied Health

(To be sent out by clerical worker on behalf of Yasmin)
Subject: occupational therapy participants required for study

Hello -

This email has been sent out on behalf of Yasmin Orton
There are a lot of claims in the international literature about what occupational therapists do and what we should do, the things the profession is committed to.
Rather than taking that for granted, Yasmin would like to ask New Zealand occupational therapists about the ideas they're committed to, that underpin our practice.
Many of you will know Yasmin already.
Her study is part of her MHSC and she is interested in interviewing occupational therapists working in the DHB catchment area for this study.

She expects interviews to be about one hour long and they can take place at work or away from work, depending upon what you prefer.

If you are interested and not receiving supervision from Yasmin, please contact (Name) ……., who will forward your name to Yasmin.

(Email address)
Thank you.
Kind regards,
(Name)
Clerical Worker
Allied Health

Draft of e-mail to send out to occupational therapists working at DHB – Allied Health

Appendix H: Interview Question Format

The questions I want to ask will be open-ended and based on the following:

(Warm up question)

What is your specialist area of occupational therapy? Tell me about it.

- How do you make sure that everything is done the right way, that high quality occupational therapy is delivered?
- Can you tell me what's important to you
- What are some of the things that make occupational therapy different from the other professions?
- What are the things others just don't "get" about occupational therapy - can you talk about that?
- Are there any shared ideas amongst your colleagues, things the whole group are committed to?
- If you were comparing yourself to other occupational therapists, is there something you would say you are more or less committed to than others occupational therapists?

Are there any models that you like to you use to inform your practice?

- They can be from occupational therapy or any other general model that you find useful
- What do specifically like about it?
- Anything you don't like?
- Are those concepts easy to apply in New Zealand?
- Are there concepts you leave out or gloss over?
- Can you tell me more?

Are there any frameworks you particularly like?

- Why?
- How do you use them?
- Is there anything you don't like?
- Can you tell me more?
- Do you use "top down" and "bottom up' approaches?

Is there any particular terminology you use?

- When writing about occupational therapy interventions?
- When you are talking to occupational therapists?
- Are there any things you think of as occupational therapy jargon?
- Is there terminology you don't like?

- Do you think your colleagues understand what occupational therapists say?
- Can you tell me more?

What do you think are the enduring concepts and beliefs of occupational therapy?
- Tell me more…
- What beliefs are particularly important to you?
- Are these useful in New Zealand – why and how?

Are you aware of new ideas that have come into practice since you graduated?
- Can you tell me about those?
- Have you tried them out?
- Have they been useful?
- Anything you did not like?

Are there things that occupational therapists used to do, but that have slipped away?
- What are they?
- How do you feel about that?
- Tell me more?
- Would they be useful today?

Are there, in your opinion, any "big" ideas in occupational therapy?
- Things all occupational therapists are committed to, what would you say?
- Tell me more?
- Any examples how these ideas are used?

What do you believe is the core or essence of being an occupational therapist?
- Would you describe that?
- Tell me about the things you wouldn't compromise on
- Tell me about the things you aspire to be.

Describe a time when you felt you really were an occupational therapist or felt proud to be an occupational therapist;
- Can you tell me about that?
- Tell me more about that.
- How does it meet your expectations of what occupational therapy is, or should be?

Are there any new ideas that you are currently interested in, coming from the literature or discussions you hear?

- Can you tell me about those?
- Have you tried them out?
- Have they been useful?
- Anything you did not like?

Are there any things you think is unique or special about occupational therapy in New Zealand?
- Can you tell me about those?
- Have you tried them out?
- Have they been useful?
- Anything you did not like?

Have you needed to explore cultural and spiritual components of occupational therapy?
- Can you tell me about that?
- Any examples?

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Thesis Title	How have occupational therapists in New Zealand taken up ideas promoted in the international occupational therapy literature?		

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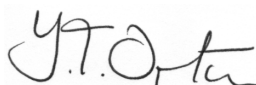
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