Treating with Te Tiriti in Mind:

Exploring how Kaiwhakaora Ngangahau Occupational Therapists are working with Tangata Whenua Māori in Practice

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Mihi

Tēnā koutou katoa

Ko Rakaumangamanga te maunga.

Ko Omapere te awa.

Ko Mataatua te waka.

Ko Ngāpuhi te iwi.

Ko Ngāi Tawake ki te Waoku te hapū.

Ko Ngāi Tawake te marae.

Ko Whautere toku whānau.

Ko Charles toku pāpā.

Ko Adriana toku māmā.

Ko Huhana toku ingoa.

Nō reira, tēnā koutou, tēnā koutou, tēnā tātou katoa.

Abstract

Background: Statistics have shown inequity in health outcomes for Māori. Māori are overrepresented with higher rates of hospitalisation and lower life expectancy than non-Māori (Brewer & Andrews, 2016), have higher rates of drug and alcohol abuse (Zambas & Wright, 2016) and psychological distress (Maclennan, Wyeth, Wilson, & Derrett 2014). Māori people are more likely to come from low socio-economic backgrounds leading to inequity in employment, total household income, education, and access to healthcare (Zambas & Wright, 2016). As a profession kaiwhakaora ngangahau occupational therapists are well placed to be catalysts for change, to better the health outcomes for Māori.

Aim: This study aimed to investigate and understand how kaiwhakaora ngangahau occupational therapists are working with Māori post-injury within Aotearoa and share this understanding with others to encourage discussion within the profession to inform practice with Māori.

Methods: A qualitative interpretive description approach (Thorne, 2016) was used, and ethical approval was gained from the Otago Polytechnic ethics committee. Through purposive sampling, a sample was selected from the population of kaiwhakaora ngangahau occupational therapists within a private health and rehabilitation company. Semi-structured interviews were completed with five therapists. Questions explored the thought processes of the participants when working with Māori and how the culture of the client informed the occupational therapy process. The interviews were then analysed using thematic analysis.

Findings: Three main themes were identified with associated subthemes. These were rapport building, therapist experience and reducing barriers. There was evidence of Māori principles being utilised, these were Maanakitanga, Kaitiakitanga, Wairuatanga, Whanaungatanga, Kotahitanga and Rangatiratanga.

Conclusion: This study identified that kaiwhakaora ngangahau occupational therapists are actively adapting their practice when working with Māori. Implications for the funder included needing to reconsider the service and funding model to allow a more culturally responsive practice for providers. Implications for the therapists included ideas for actions to implement in practice such as involving family/whanau.

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Form MO9: Declaration of research Thesis/Project being own work

Otago Polytechnic

Declaration concerning Research Thesis/Project (delete the incorrect) presented for the degree of Master of Occupational Therapy

I, Huhana Whautere

(Full Name)

Of
(Address)

Solemnly and sincerely declare, in relation to the research Thesis/Project entitled:

Treating with Te Tiriti in Mind

a. that the work was done by me personally

and

b. that the material has not previously been accepted in whole, or in part, for any other degree or diploma

Signature:

Date: 28/7/22

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Firstly, to the kaiwhakaora ngangahau occupational therapists who shared their experiences with me, thank you for your willingness to be a part of this research.

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Ethics Approval

Ethics approval was granted by the Otago Polytechnic Ethics Committee on 17th March 2021 for 890 Treating with Te Tiriti in Mind.

Please refer to Appendix A for the Ethics Approval letter.

Glossary

Aotearoa – New Zealand

Awa – Body of water

Hapū – Subtribe

Hauora – Health

Hui – meeting

Ingoa – Name

Iwi - Tribe

Kai moana – food from the ocean

Kaiwhakaora ngangahau – Occupational Therapist

Kanohi ki te kanohi – Face to face

Kapa Haka - Māori cultural performing group

Karakia – prayer

Kaumatua – elder with wisdom, a person with status

Kaupapa Māori - Māori customary practice

Māmā - Mother

Māori – indigenous New Zealander

Marae – where formal greetings and discussions take place.

Maunga – Mountain

Noho – stay

Pāpā - Father

Poi - a light ball on a string of varying length which is swung or twirled rhythmically to the sung accompaniment

Powhiri - welcome ceremony on a marae

Rangatahi – Youth

Rangatira – Chief

Tangata whenua – people of the land

Tapu - be sacred

Te Ao Māori – the world according to Māori

Te reo – Māori language

Te Tiriti o Waitangi – The Treaty of Waitangi, an agreement between the British Crown and Māori chiefs

Tikanga – customs

Tohunga – skilled person or healer

Waiata - Song

Waka – Canoe

Whānau – Family

Chapter One: Introduction

Introduction

In 2018 the census showed that 15% of the population in Aotearoa New Zealand were Māori (Statistics New Zealand, 2018) and in the same year 4.6% of the registered kaiwhakaora ngangahau occupational therapists within Aotearoa identified as Māori (Occupational Therapy Board of New Zealand, 2018). With this discrepancy, there is a greater reliance on non-Māori kaiwhakaora ngangahau occupational therapists to deliver services to Māori. This research will explore how therapists within a private health and rehabilitation company are working with Māori service users. To understand the context and issues that form the basis of this research this chapter will firstly explore Te Tiriti o Waitangi and how the effects of colonisation still affect Māori health today. The chapter then discusses the occupational therapy profession in Aotearoa and the requirements of being a culturally competent therapist. Next, an overview is provided of the Accident Compensation Corporation (ACC) context in which kaiwhakaora ngangahau occupational therapists in private healthcare may work. Finally, there is an explanation of the positioning of the researcher to explain the journey that has brought me to this area of interest and a brief overview of the research.

Te Tiriti o Waitangi

On the 6th of February 1840, an agreement called Te Tiriti o Waitangi was signed by Māori rangatira (chiefs) and the British Crown, it was named Waitangi after the location where the initial signing took place. Te tiriti was an agreement between the crown and tangata whenua, to ensure both had equal rights and access to resources, such as land. What was later found is that the two versions, one written in te reo and the other in English had two very different meanings which meant that the crown had more power and control (Brewer & Andrews, 2016). As more British settlers arrived in Aotearoa, Māori identity was changed, with the introduction of the English language and different ways of life. Māori were introduced to foreign infectious diseases (Zambas & Wright, 2016); laws and practices were implemented that would systematically disadvantage Māori across all important outcomes such as health, socio-economics and justice (Jungersen, 1992). This loss of identity continues to impact Māori in current society.

Statistics help to capture positive or negative trends over time. There are negative statistics that show Māori have: higher rates of hospitalisation and lower life expectancy than non-

Māori (Brewer & Andrews, 2016); higher rates of drug and alcohol abuse (Zambas & Wright, 2016) and psychological distress (Maclennan, Wyeth, Wilson, & Derrett, 2014). Māori people are more likely to come from low socio-economic backgrounds leading to inequity in employment, total household income, education, and access to healthcare (Zambas & Wright, 2016). It is hypothesised that these discrepancies come because of colonisation (Zambas & Wright, 2016). Colonisation can be defined as the process of settling among and establishing control over the indigenous people (Emery-Whittington & Te Maro, 2018). Racism and discrimination are facets of colonisation that impact Māori and are social determinants of health (Emery-Whittington & Te Maro, 2018). As a profession, kaiwhakaora ngangahau occupational therapists are well placed to be catalysts for change, to better the health outcomes for Māori.

There are positive trends in statistics about Māori, more Māori are getting higher level qualifications; in the census in 2006 8.8% of Māori had a bachelor's degree, whereas in the more recent census 2018 that is now 12.9% (Statistics New Zealand, 2018). In the same census, 18% of Māori reported speaking te reo which shows a strength of cultural practices continuing to be used (Statistics New Zealand, 2018). From a health perspective in the 2006 census, 42.2% of Māori were regular smokers which was reduced to 28.3% by the 2018 census (Statistics New Zealand, 2018).

Occupational Therapy

Occupational therapy in Aotearoa was gifted the name whakaora ngangahau by the Māori Language Commission: whakaora meaning to restore health and ngangahau meaning active, spirited, zealous; therefore, whakaora ngangahau is restoring to health one's active self (Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa, n.d.). This name helps to capture the essence of what kaiwhakaora ngangahau occupational therapists do as a profession.

The Occupational Therapy Board of New Zealand (OTBNZ) is the profession's regulatory board whose primary purpose is the safety of people receiving occupational therapy services, they do this by ensuring that kaiwhakaora ngangahau occupational therapists within Aotearoa are competent practitioners. Kaiwhakaora ngangahau occupational therapists are regulated under the Health Practitioners Competence Assurance Act (2003), which requires kaiwhakaora ngangahau occupational therapists to remain engaged in the ongoing development of their competence. In OTBNZ this can be seen by engagement with the e-portfolio. Within the e-portfolio kaiwhakaora ngangahau are required to set goals for their

development, provide evidence and reflect on their experiences in practice. There are five competencies that each practitioner needs to address within their e-portfolio. Competency two is titled Responsiveness to te Tiriti o Waitangi (Occupational Therapy Board of New Zealand, 2022). In 2021 an audit group for the OTBNZ presented a report that showed in a sample of 81 e-portfolios qualitatively analysed, 47 (58%) showed some form of evidence of competent bicultural practice and 34 e-portfolios (42%) had no evidence of competent bicultural practice (Silcock, et al., 2021).

Accident Compensation Corporation

One practice area that kaiwhakaora ngangahau occupational therapists may work within is private health and rehabilitation companies that service ACC contracts. The Accident Compensation Corporation (ACC) was created in 1974 as New Zealand's no-fault scheme for when people are injured in an accident (Accident Compensation Corporation, 2018). ACC helps to provide the necessary access to healthcare and covers the cost of a person's recovery whether this is surgery, rehabilitation or other assistance (Accident Compensation Corporation, 2020). People pay ACC levies through employment and through vehicle ownership, which is how ACC is funded (Accident Compensation Corporation, n.d.). While a person is out of employment due to injury, ACC will pay 80 per cent of their earnings until they have been medically cleared by their treating doctor (Accident Compensation Corporation, n.d.). ACC funds different rehabilitative programmes for individuals who are injured, which are provided by private health and rehabilitative companies. An example of a programme that a person may receive is a Stay at Work (SAW) programme, which focuses on vocational rehabilitation to get a person back to their pre-injury employment (Accident Compensation Corporation, n.d.). Māori make up less than 12% of ACC's entitlement claims (Accident Compensation Corporation, 2018). This research will be conducted within a private health and rehabilitation company that services ACC contracts.

Bicultural Practice

The term bicultural practice will be used throughout this project to describe therapists practising in a way that is conducive to Te Tiriti o Waitangi, where two worldviews are represented - tangata whenua and tangata tiriti - and the use of tikanga and te reo is considered. This is in alignment with what the Occupational Therapy Board of New Zealand refers to under their Responsiveness to te Tiriti o Waitangi competency (Occupational Therapy Board of New Zealand, 2022). Other terms similar to bicultural practice are

culturally sensitive practice, culturally relevant practice, culturally responsive practice and culturally safe practice (Heke, Wilson, & Came, 2019).

Positioning of the Researcher

I describe my upbringing as the 'colliding of two worlds', my father is of Māori descent and was brought up with parents who were both Māori, in a te reo speaking household and my mother came from Dutch New Zealand European background. We were brought up on a farm in the Waikato with the New Zealand European side of my family but always knew that when we went up to the far north, where my Ngāpuhi iwi and marae are, we would follow tikanga Māori. This 'colliding of two worlds' seems to have followed me throughout my life, throughout occupational therapy school and into my career.

When I was sixteen, I started to notice inequalities in the world. One of my best friends in high school who was Māori would often come to school without lunch, she would say that she had forgotten it, me being naïve and thought she was very forgetful until one day when I went to her house for a sleepover. I said to her what are we having for dinner tonight? to which she replied "we don't have dinner" I didn't understand what she meant and thought it was some kind of joke. My naïve sixteen-year-old self was completely unaware that my best friend had two unemployed parents on government benefits and lived in state housing.

During my training as an occupational therapist, I remember feeling conflicted about some of the western viewpoints on health and how they did not align with my own. An example of that is as kaiwhakaora ngangahau occupational therapists we are taught that we need to assist people back to becoming independent, but I remember when my Māori nana had a stroke, culturally the right thing for us to do as a whānau was to care for her, not make her independent. I remember thinking that the occupational therapy kawa model (Teoh & Iwama, 2015) was the closest thing that related to my Māori beliefs and I also remember thinking that the noho marae experience for some students was not necessarily the cultural immersion experience that it is meant to be but more just another thing you have to attend in order to graduate as an occupational therapist. I realised cultural differences to other occupational therapy students when I was on my final placement in a hospital and was mistaken for a healthcare assistant which I can only assume was because of the colour of my skin. One of my patients was in isolation and so everybody who goes into that patient's room had to wear an isolation gown so you can't tell what discipline that person is. I was doing dressing

rehabilitation with my patient and a lady came in and abruptly told me that I wasn't doing my job, the mortified look on her face said it all when we exited the room and de-gowned, revelling my uniform which stated occupational therapy. I reflected on this experience with one of the hospital's cultural advisors and she said to me "take a look around, the only Māori at this hospital are cleaners or health care assistants".

In my working life, there have been many notable events that have led me to this area of interest for my masters. When I started with the current company I work for in 2016 there was nothing about bicultural competence in the induction and I knew there was a knowledge gap with therapists when it came to bicultural practice as they would often come to me for guidance on different cultural matters. I once was given two crayfish from a Māori client as a thank you for the work I had done with him, our company policy is that we don't accept gifts from clients so I had to justify to my manager why I had to accept the kai moana as not doing so would be detrimental to our therapeutic relationship. Responsiveness to Māori within the company started to be addressed in 2019 when there was a cultural advisor employed and the commencement of cultural panels where staff employed at the organisation could discuss cases. In my opinion, there is still more that the company needs to do, but it is a start.

In 2019 I attended a brain injury conference in Wellington and a Māori speaker addressed the room saying "raise your hand if you identify as indigenous" and in a room of hundreds less than 10 hands rose; it was clear that my focus needed to be on Māori health. Around the same time, I started a volunteer role at the local YMCA mentoring Māori rangatahi, this further strengthened my interest in Māori health and wellbeing.

In 2019 I attended the Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa (OTNZ-WNA) Māori kaiwhakaora ngangahau occupational therapists noho, where I felt the greatest sense of belonging as if I was exactly where I was meant to be. It was reassuring to hear the experiences of other Māori kaiwhakaora ngangahau occupational therapists and some of the battles that they have experienced through their careers where previously I thought that I was the only one who felt this way. I am now part of a Māori occupational therapist group that meets monthly, it is a supportive environment for open discussion and to ensure that we are safe in our practice while navigating western structures that make up our workplaces.

In 2020, I applied for a position to be a part of the Occupational Therapy Board of New Zealand audit group looking specifically at Competency Two, at the time this was named

Practising appropriately for bicultural Aotearoa. In our group were Dr Mary Silcock, Dr Margaret Jones, Dr Megan Kenning, Sharon (Shaz) Bryant and Whaea Iris Pahau. This was an unbelievable learning experience and I feel truly privileged to be a part of this work. We audited 81 eportfolios of current registered kaiwhakaora ngangahau occupational therapists to explore and evaluate how they were meeting competency two. What we found was new graduates have a much better understanding of bicultural practice than kaiwhakaora ngangahau occupational therapists who have been practising for many years. I think this is a credit to the occupational therapy schools but I believe there is still so much to be done (Silcock, et al., 2021).

There are only a handful of Māori kaiwhakaora ngangahau occupational therapists that have come before me to conduct research at a masters level. To name a few, these are: Georgina Davis, Isla Emery-Whittington and Jane Hopkirk. Because of the limited research that has been completed, I feel as though we are conducting innovative research, as well as battling the westernised world perspective of research. It makes me realise that more Māori kaiwhakaora ngangahau occupational therapists need to be conducting research in this space and motivates me to complete this qualification so that in future I may be able to mentor or supervise other Māori therapists in their masters.

My desires for the future are to be able to help Māori whether that be by getting more Māori in the occupational therapy profession or better educating occupational therapy students and kaiwhakaora ngangahau occupational therapists about how to better work with Māori. Following my previous experience working with rangatahi, I hope to create a not for profit youth service that helps to teach rangatahi fundamental skills that can set them on the right path in life and hopefully stop the chain/cycle of abuse, poverty, mental illness and drug and alcohol addiction. I will spend my life trying to better the social determinants of health for Māori and I feel as though to do that I need to become a researcher. This brings me to my research question *what factors do kaiwhakaora ngangahau occupational therapists believe influence their practices and decisions in relation to working with tangata whenua (people of the land - Māori) following injury?*". By conducting and then publishing this research, it will hopefully reach many different stakeholders for whom the research will be relevant, such as District Health Boards, ACC, occupational therapy institutions and different allied health professionals.

Research Overview

There needs to be a greater understanding of how kaiwhakaora ngangahau occupational therapists are working with Māori, as the majority of kaiwhakaora ngangahau occupational therapists identify as non-Māori, working with a population that as stated above is 15% Māori. There is an absence of specific data relating to what kaiwhakaora ngangahau occupational therapists are doing when working with Māori (Hopkirk, 2013). There is also a lack of research being published by Māori kaiwhakaora ngangahau occupational therapists and focusing on bicultural practice in Aotearoa, which the literature review in the following chapter will demonstrate. The purpose of this research is to provide insight into how kaiwhakaora ngangahau occupational therapists within Aotearoa are working with Māori following injury.

Interpretive description methodology is an analytical, inductive approach designed to create ways of understanding human health that have consequences for the clinical context (Thorne, 2016). This research will select a sample from the population of kaiwhakaora ngangahau occupational therapists within a private health and rehabilitation company and ACC context. Using a qualitative interpretive description approach semi-structured interviews will be completed with five therapists. Questions will explore the thought processes of the participants when working with Māori and how the culture of the client informed the occupational therapy process. These interviews will then be analysed and key themes identified. The research will influence the development of best practice guidelines for working with Māori.

Organisation of Chapters

Following this introduction, chapter two explores the published literature related to bicultural practice and occupational therapy within Aotearoa. Chapter three looks at the methodology that the research project has followed, a qualitative interpretive description approach and thematic analysis supported by qualitative data analysis software. Finally, it looks the relevance of Kaupapa Māori research to this project and the ethical considerations. Chapter four explores the findings that came from interviews and considers a Te Ao Māori perspective. Chapter five makes links between this research and current published literature and considers the implications of this research for the key stakeholders including giving recommendations to the occupational therapy profession in Aotearoa around what actions could be considered for therapists working with Māori. Then considers the limitations and strengths of this research and provides suggestions for future research.

Chapter Two: Literature Review

Introduction

The focus of this literature review is an analysis and critique of the literature and research findings related to occupational therapy practice in Aotearoa, ACC and Māori health. It will do this by looking at published literature about bicultural practice within occupational therapy, then explores private healthcare's responsiveness to Māori. Finally, it explores Māori literature which discussed cultural competence and Māori health models that were used in practice. The research and literature discussed below were selected from CINAHL and Google Scholar databases using keywords such as 'occupational therapy', 'bicultural', 'New Zealand/Aotearoa' and 'Māori'. The literature found is analytic discussions, opinion pieces and qualitative studies.

Occupational therapy bicultural practice in Aotearoa

The first articles that explored occupational therapy and bicultural practice in Aotearoa appeared in the early 90s, publications have become more prevalent in the last five years. It can be theorised that the increase in articles is due to bicultural awareness becoming a central focus, more Māori kaiwhakaora ngangahau occupational therapists have joined the profession and the number of Māori who have written and published articles has also increased so the voice of Māori kaiwhakaora ngangahau occupational therapists is being heard.

Service frameworks, policies and procedures need to demonstrate a commitment to bicultural practice. Jungersen (1992) was one of the first writers to discuss cultural safety in occupational therapy literature, although this is an old reference, the issues she discussed remain important, and continue to be challenges to the profession today. In 1992, Jungersen spoke about healthcare following westernised frameworks which did not align with Māori values and sadly over twenty five years later in more recent literature western frameworks remain dominant (Emery-Whittington & Te Maro, 2018). Jungersen (2002) believed that changes needed to be made to health funding and government institutions needed to have clear policies of how they incorporated Te Tiriti o Waitangi to redistribute power. Thomas (2009) and Reed (2016) believed that the past needs to be acknowledged in terms of the injustices that Māori have faced throughout history. When a healthcare system expects Māori to engage with western frameworks this can be seen as institutional racism (Emery-Whittington & Te Maro, 2018). Henare (1993) explained that just because the name of the service changes to a Māori name, does not necessarily mean that that changes how the service operates. Jeffery (2005) discussed the 2001 recommendations for best practice guidelines for

Kaupapa Māori mental health services, which included full powhiri, karakia, the involvement of whanau, kaumatua, removing the client's state of tapu with tohunga, and the use of maraes versus psychiatric hospitals. However these guidelines can be difficult to implement because, in some cases, if the client has more than one illness then they may need to access multiple services that do not align with a Māori holistic approach (Jeffery, 2005).

A common theme within the literature or research was that the western model was not congruent with a Māori worldview (Henare, 1992; Jungersen, 1992; Tse et al., 2005), as what is important in a western perspective is very different to what is important in Te Ao Māori (Hollands, Sutton, Wright-St. Clair, & Hall, 2015). Te Ao Māori places importance on kaiwhakaora ngangahau occupational therapists using the natural environment when working with Māori because Māori consider respect for the land (Jungersen, 1992). Henare (1992) supports the importance but adds that the environment is largely ignored in a western framework. There is a call for therapists to incorporate spirituality into practice and look at the person from a holistic perspective (Henare, 1992). Henare (1992) argued that the western worldview has taken over so that: spirituality is replaced with science, the authority of the elder has been challenged by professionals, and the value of family has been demoted in relation to that of the individual. Tse et al. (2005) believed there is limited training on how to address the spiritual needs of the person as it is believed to be outside the scope of the profession and uncertainty around occupational therapy's role in this area. Cone and Wilson (2012) completed a qualitative description study to explore how kaiwhakaora ngangahau occupational therapists in Aotearoa incorporated the recovery approach into their practice. They concluded that the recovery approach was a good fit for bicultural Aotearoa, as it viewed the person holistically and involved the whānau in the person's recovery journey.

The use of whanau needs to be better developed into healthcare services with Māori as another common theme in the articles was an emphasis on the importance of working with the client in collaboration with the whānau or wider community (Hopkirk, & Wilson, 2014). Jungersen (1992) discussed that connectedness to ancestors is of importance to Māori, and closeness to extended whānau. Tse, Llyod, Petchkovsky and Manaia (2005) elaborate on this by explaining not only the unwell person needs to be considered but the wider social supports and communities are equally as important. Silcock, Campbell, Hocking, and Hight (2017) supported this notion, by saying that in Te Ao Māori it is important to involve whānau in the recovery process, and not just treat the individual, Thomas (2009) suggests that this can be

facilitated through therapists building real relationships with people and their communities to understand their world view.

Jungersen (2002) believed that a culturally competent therapist will critically analyse generalisations. For example, not making assumptions that if someone looks Māori and has a Māori name, to not assume that they speak te reo and are familiar with Māori protocols. The therapist will be able to pick up on subtle verbal and non-verbal cues when working with Māori (Jungersen, 2002). For therapists working with Māori clients, the use of te reo can be seen as an important indicator of bicultural practice (Durie, 2001). In reviewing the occupational therapy literature for use of te reo the researcher found the earlier articles in 1992 there were Māori words written and then in brackets the definition of what the Māori words meant, for example Manaakitanga (to show respect or kindness) (Henare, 1992). As time has progressed articles continue to use te reo and the English translations (Davis & Came, 2022).

A way of incorporating Māori culture into occupational therapy practice is using culturally relevant activity in the treatment and intervention phase. Jungersen (1992) discussed therapists incorporating arts and crafts such as weaving, waiata, and poi as a meaningful occupation so that Māori can connect to their culture. This was supported by a qualitative study completed by Hollands et al. (2015) which explored the use of Kapa Haka as a sensory modulation intervention with mental health service users who identified as Māori. They concluded that it helped the participants to gain a sense of connection, identity, physicality, and embodied emotion. A therapist would be able to identify occupations that are relevant to the person through implementing client-centred practice. Client-centred practice can be used to identify a person's cultural needs (Hopkirk, 2013). Hocking (1998) emphasised the Māori person being the expert in their care and the need to change the power imbalance between the health professional and the client, this could be addressed using client-centred practice. Client-centred practice is relevant when working with Māori as the Māori service user is able to play an active role in their rehabilitation and identify occupations that are meaningful to them.

The discussion above demonstrates that bicultural practice needs to be ingrained in the knowledge gained by students in the undergraduate occupational therapy programmes. Henare discussed the occupational therapy profession needing to make a commitment to biculturalism, which should be seen by the training and skills of therapists leaving

occupational therapy training (Henare, 1993). Jeffery (2005) believed the education of occupational therapy students are influenced by a western culture so therefore treatment and assessment reflect this. In two qualitative studies, one completed by Whiteford and Wilcock (2000) and the other by Forwell, Whiteford, and Dyck (2001), students completing an occupational therapy degree programme were interviewed and the results showed that students believed that the programme was very centred around western values that do not align with the bicultural society that kaiwhakaora ngangahau occupational therapists in Aotearoa work within. The second study concluded that students need to recognise their cultural values to appreciate others, know the language and customs of other cultures and gain experience on fieldwork placement with cultures different to their own (Forwell, Whiteford, & Dyck, 2001). Ben Te Maro, a Māori occupational therapist, described his own lived experience of how colonisation impacted him and how the deeper he got into the education system the further from his culture he felt (Emery-Whittington & Te Maro, 2018). Henare (1993) explained that in order to change Māori health there needs to be a drive to recruit Māori into the profession and provision of support for them throughout the programme, a similar conclusion made by Māori occupational therapist Georgina Davis in her masters thesis (Davis & Came, 2022).

The occupational therapy profession within the last decade have shown increased bicultural responsiveness through the association changing from New Zealand Association of Occupational Therapists to now Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa (OTNZ-WNA), and the use of the equal partnership treaty model (Emery-Whittington & Te Maro, 2018). This model is discussed later in this chapter. OTBNZ implemented change in 2015 when they redeveloped competency two: Practising appropriately for bicultural Aotearoa New Zealand (Silcock, Campbell, Hocking, & Hight, 2017) and the need for a Māori occupational therapist annual hui to be held, which shows that the numbers of Māori coming into the profession are increasing.
This review has identified an absence of research that explores specifically how kaiwhakaora ngangahau occupational therapists are meeting their bicultural responsibilities, there are limited qualitative studies that capture the therapists' perspectives on this topic and a need to increase research undertaken by Māori therapists/researchers as well as kaupapa Māori research.

OTNZ-WNA Te Tiriti/Treaty Relationship Governance Model

OTNZ-WNA took steps toward addressing inequities through the implementation of Te Tiriti/Treaty Relationship Governance Model in 2015. OTNZ-WNA is the occupational therapy association in Aotearoa. Its "purpose is to support members in excelling professionally and to promote occupation by providing resources, education and representation" (Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa, n.d.). They were the first allied health body to implement this model in Aotearoa New Zealand and internationally. This model was the association's commitment to te tiriti, to ensure that te tiriti was the foundation for how the association would be structured and to create an authentic equitable partnership with Māori.

The model guaranteed a treaty relationship that resulted in equal representation of tangata tiriti (people of the treaty) and tangata whenua (people of the land - Māori), with two presidents, who represent the two houses and council meetings would be co-chaired (Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa, 2015). This is relevant and important to the occupational therapy profession as it demonstrates that occupational therapy as a profession has already been considering their bicultural responsiveness for several years now. The association has introduced a range of initiatives to strengthen bicultural practice within the profession. Initiatives included: setting an expectation that presenters for clinical workshops and conferences have to consider and demonstrate a Māori perspective when planning their presentation; promoting occupational therapy as a career for Māori; appointing Kaumatua as advisors to support and guide the association on issues of tikanga (Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa, 2015). The association has set up an annual tangata whenua hui for all kaiwhakaora ngangahau who identify as tangata whenua. The purpose of this hui is to provide support to Māori kaiwhakaora ngangahau occupational therapists and ensure cultural safety for these therapists through a Te Ao Māori worldview. OTNZ-WNA was not the only organisation to consider changing its ethos regarding better responsiveness to Māori health, ACC is another striving to improve Māori health statistics.

Accident Compensation Corporation

ACC are committed to Te Tiriti o Waitangi and improving Māori health outcomes through the development of their Whāia Te Tika Māori Strategy. This strategy responds to whānau-centred needs and looks to minimise frequency and impact of injury for whānau, hapū and iwi (Accident Compensation Corporation, 2021). For providers delivering services to ACC

clients, ACC have created a document titled "Guidelines on Māori Cultural Competencies for Providers" (Accident Compensation Corporation, 2018). This document aimed to assist healthcare providers when working with Māori to ensure that services are accessible and culturally appropriate. Within the document these ACC Māori Cultural Competency Standards are referred to as "Hauora Competencies" (Accident Compensation Corporation, 2018). This strategy was an effort to improve services as the ACC statistics indicate Māori have 15% lower medical fees claims in comparison to non-Māori and 10% higher serious injury claims in comparison to non-Māori (Accident Compensation Corporation, 2018). It has been identified that there are barriers to Māori accessing healthcare, which can include, financial constraints, geographical options, limited transportation and availability of services that are culturally appropriate (Accident Compensation Corporation, 2018).

The guidelines on Māori cultural competencies for providers encourage providers to connect with and build relationships with local Māori communities, maraes and iwi. ACC encourages providers to consider workforce development to ensure that their workforce is reflective of the communities they serve, this is supported by Davis and Came (2022). Māori staff are given support and opportunities for growth and the provider should seek to employ more Māori where possible (Accident Compensation Corporation, 2018). The guidelines provide examples for how providers should interact with Māori. Firstly, it is important for the provider to take care when pronouncing the name of the Māori client, because mispronunciation could demonstrate a lack of respect for the person. Kanohi ki te kanohi or face to face interaction is the preferred method for the Māori client. Time needs to be considered to establish a relationship between the healthcare provider and the Māori client. Whānau/family should be involved throughout the healthcare journey, as their involvement could be vital to the person adhering to the prescribed treatment. The recommendations in these guidelines align with perspectives expressed by kaiwhakaora ngangahau occupational therapists and others, Hopkirk and Wilson (2014), Jungersen (1992), Tse, Llyod, Petchkovsky and Manaia (2005), Silcock, Campbell, Hocking, and Hight (2017) and Thomas (2009). Huis or meetings could start with a karakia prayer and, finally, consideration needs to be taken in regard to food being near anything that comes in contact with the body and providers need to ensure that linen for the body is kept separate from linen for the head (Accident Compensation Corporation, 2018).

Māori Health Models and Strategies

He Korowai Oranga is the Māori health strategy which was released in June 2014 to help inform the government and health and disability sector to achieve the best outcomes for Māori (Ministry of Health - Manatū Hauora, 2015). He korowai oranga translates to the 'cloak of wellness'. The strands of the cloak are called whenu or aho and represent the whānau, hapū and iwi, the health professionals, community workers, providers and hospitals who wrap around the Māori tangata and nurture them both physically and spiritually (Ministry of Health - Manatū Hauora, 2015).

The overall aim of the strategy is 'Pae ora', meaning healthy futures for Māori. Pae ora is made up of three elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments (Ministry of Health - Manatū Hauora, 2015). For whānau ora to be successful, the health system must acknowledge the central role that the whanau plays in one's health, and the impact that the environment can have on one's health. Wai ora acknowledges that all people should live in healthy, safe environments where they have access to resources, food and water (Ministry of Health - Manatū Hauora, 2015).

Direction one of the strategy is Māori aspirations and contributions, which recognises that Māori are key contributors in decision making and service delivery. Direction two indicates government aspirations and contributions, which is the government's commitment to making the health system work for all people by reducing disparities between population groups (Ministry of Health - Manatū Hauora, 2015). The document details that one way to strengthen He Korowai Oranga is through knowledge, and indicates there needs to be an investment into building Māori health research capacity across the sector, which will contribute to pae ora (Ministry of Health - Manatū Hauora, 2015). This research project will help to contribute to Māori health research across the sector and therefore contribute to pae ora.

In 2001, Sir Mason Durie presented a paper at the Australian and New Zealand Boards and Council Conference, which discussed cultural competence (Durie, 2001). Durie defined cultural competence as "…the acquisition of skills to achieve a better understanding of members of other cultures" (Durie, 2001, p. 4). He discussed that a culturally competent doctor does not always see treatment as scientifically based but is open-minded to other options such as a traditional healer and views this as an opportunity to collaborate rather than a threat. Durie (2001) explained that for doctors to be culturally competent they are to understand the values within that cultural group, allow time and space to establish a working

relationship, they understand that the cultural group's perception of a diagnosis may differ from that of their own and understand that the effectiveness of treatment can depend on the wider circle of friends and family. He emphasised that cultural competence is a necessary skill, and doctors require ongoing education to support that. His future desires are that the workforce's cultural makeup is reflective of the community profile that they service (Durie, 2001). This aligns with the research completed by Davis and Came (2022).

Māori health models are used frequently in healthcare in Aotearoa today to provide structured thinking when working with Māori. Sir Mason Durie introduced the Māori model of health Te Whare Tapa Wha in 1984, as a concept to explain how Māori view health, the four cornerstones of health. The four dimensions were whānau (family), wairua (spiritual), tinana (physical) and hinengaro (psychological) (Durie, 1994), which challenged health professionals to look at the person holistically. Durie explained that if one of the elements was missing then the person would feel 'unbalanced' and therefore unwell. The Meihana model was created as a clinical assessment model to be used from the first interaction with the service user and their whānau. The model took the first four components from Te Whare Tapa Wha and then added two more, these being taiao and iwi katoa (Pitama, Huria, & Lacey, 2014). Taiao ensures that the physical space of the meeting room or the location, welcomes family involvement, in this space written materials are translated into te reo. Taiao also focuses on recruiting Māori clinicians (Pitama, Huria, & Lacey, 2014). Iwi katoa encourages therapists to look at the systemic structures and societal perceptions such as racism and socioeconomic status. Services need to think about how service policies can be adapted to better work with Māori (Pitama, Huria, & Lacey, 2014).

Te Wheke or the octopus was a model developed by Rose Pere in 1991. The head of the octopus represents te whānau, the eyes of the octopus as waiora (total wellbeing for the individual and family) and each of the eight tentacles represents a specific dimension of health. These eight tentacles are Wairuatanga – spirituality, Hinengaro – the mind, Taha tinana – physical wellbeing, Whanaungatanga - extended family, Mauri – the life force in people and objects, Mana ake – the unique identity of individuals and family, Hā a ko ro ma, a kui ma – breath of life from forbearers, and Whatumanawa – the open and healthy expression of emotion (Pere, 1991).

Te Pae Mahutonga or the Southern Cross Star Constellation, another model developed by Sir Mason Durie represents the four key tasks for health promotion. The four central stars are

Mauriora (cultural identity), Waiora (physical environment), Toiora (healthy lifestyles) and Te Oranga (participation in society). The two pointers represent Ngā Manukura (community leadership) and Te Mana Whakahaere (autonomy) (Durie, 1999). All of the above models help to provide a way of understanding Māori worldviews which influence practice.

All of the above models and frameworks He Korowai Oranga, Te Whare Tapa Wha, Meihana, Te Wheke and Te Pae Mahutonga provide a means to better understand and view Māori health with the intent of positively affecting and guiding practitioners in relation to Māori health and wellbeing.

Conclusion

To summarise, occupational therapy as a profession in Aotearoa has been discussing working with Māori for over thirty years within this time there have been positive steps towards the profession becoming more biculturally responsive. The same can be said about the wider healthcare system within Aotearoa. However, there continues to be an ongoing misalignment between western and Māori understandings of health. This research will further explore what kaiwhakaora ngangahau occupational therapists are doing when working with Māori clients within their practice. Bicultural practice is essential to bettering the health outcomes for Māori and kaiwhakaora ngangahau occupational therapists are well placed to facilitate this.

Chapter Three: Methodology

Introduction

This chapter introduces the methodology that this research project followed; consultation is integral to kaupapa Māori research and therefore it started the research process. This ensured a Māori worldview was represented. This research uses a qualitative methodology, interpretive description (Thorne, 2016), this is explored in relation to the research topic and its use of it in occupational therapy research, followed by an explanation of why it is appropriate for use in Māori research. Finally, the thematic analysis process and Māori principles that were utilised to analyse the interview data are discussed.

When selecting the methodology for this research project, I had to consider two different worldviews, these being the values and beliefs that I have as a novice Māori researcher but also navigating the expectations posed of me and western concepts. This was a difficult balancing act at times and was an ongoing learning process. The methodology reflects these two different worldviews.

Consultation

It is important as I navigated through this research journey that I ensured my own cultural safety as a Māori occupational therapist, studying within an institution strongly influenced by western values. As the lead researcher, I identify as Māori and the supervisor for this masters project is of New Zealand European background, therefore the supervision relationship will reflect OTNZ-WNA Te Tiriti/The Treaty relationship governance model, this model reflects a true partnership between tangata whenua and tangata tiriti sharing the leadership and responsibility. This ensured that the research represented a bicultural perspective (Emery-Whittington & Te Maro, 2018).

As the research focussed on the experiences/practices of practitioners working with Māori service users, consultation with different people who could provide guidance of Te Ao Māori, was ongoing throughout the research. The people who were consulted with, represented a wide range of iwi within Aotearoa. I have my own whakapapa links to Ngāpuhi iwi. These people were as follows, firstly, and importantly, my father Charles Whautere (Ngāpuhi iwi), who assisted with translation into te reo and provided thoughts and perspectives from Te Ao Māori. I also consulted with and gained support from the members of two groups, Māori

occupational therapist group, through Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa (OTNZ-WNA) and the Māori therapist group within the private health and rehabilitation company where the research was completed and where I worked, this group met monthly and included the company's cultural advisor.

As a part of the process, consultation occurred with the Otago Polytechnic Kaitohutohu Office. Email contact was made on the 28th of July 2020 introducing myself and the topic. Feedback was received on the 21st of September 2020 that stated as I am a Māori, I am well placed to undertake this research. Suggestions for the research were to consider purposeful selection and best practice would show that it is preferable to consult with mana whenua on research undertaken within the iwi rohe (K. Te Maiharoa, personal communication, September 21, 2020). To address this suggestion the research purposefully selected participants from across the country.

Within the private health and rehabilitation company in which the research was based, the research project was presented to and gained support from the company Chief Executive Officer and National Health and Rehabilitation Manager and access to the company's kaiwhakaora ngangahau occupational therapists was gained.

The consultation process helped to reconfirm the researcher's own ideas and encouraged depth to the research process by bringing in different perspectives. This will be discussed in more detail later, an example of this was the inclusion of an exploration of the Māori principles within the findings and using the hui process to help structure the interviews. They also contributed by hearing and discussing aspects of the analysis of the findings.

Māori researcher

I identify as Māori and have whakapapa links these are to Ngāpuhi iwi. Smith (2000) discusses Kaupapa Māori research as being by Māori, with Māori, for Māori, meaning that the research was completed by someone who is Māori with whakapapa links, with Māori participants and the research being of benefit to the population of Māori. It is acknowledged that at the development stage of this research, there was intent to recruit Māori as participants, to gain a Māori perspective however this did not eventuate therefore to be able to call this kaupapa Māori research one element is missing, that being with Māori participants (Smith, 1999). As stated the research aimed to recruit participants identified as either Māori and/or non-Māori descent, a call for participants resulted in no potential participants who identified as Māori due to a change of staffing since the initial scope for the research and a reduction in

the number of Māori kaiwhakaora ngangahau occupational therapists employed by the company at the time of recruitment. The research aimed to gain a better understanding of how kaiwhakaora ngangahau occupational therapists are working with Māori clients. By gaining a better understanding, it will show what is currently occurring and indicate areas for growth, the findings will be used to better educate kaiwhakaora ngangahau occupational therapists and students who work with Māori, to positively impact the health status of the Māori population throughout Aotearoa. Kaupapa Māori research considers the social and historical structures that impact Māori and challenges western ideas of research (Smith, 1999). Kaupapa Māori research considers the Māori worldview as normative and uses te reo Māori (Brewer, Harwood, McCann, Crengle, & Worrall, 2014). Throughout the research process, I incorporated te reo language and followed what I understand to be the Māori worldview, these ideas were formed from my own whānau and my Māori acquaintances. In Kaupapa Māori research the researcher is actively involved physically, ethically, morally, and spiritually (Brewer, Harwood, McCann, Crengle, & Worrall, 2014), this aligned with interpretive description acknowledging what the researcher can contribute to the research (Thorne, 2016).

Interpretive description

For this research, a qualitative interpretive description methodology was used (Thorne, 2016). Thorne suggested that this methodology is for "researchers curious about some aspect of human experience within its natural context, seeking to expand their disciplines capacity to understand its implications for the world of practice" (Thorne, 2016, p. 14), this is relevant to this research context as the purpose was to gain an understanding of occupational therapist's experiences of working with Māori in everyday practice which helped to expand knowledge of bicultural practice and its application to practice. Interpretive description used the researcher as a tool, whose actions and thinking played a purposeful role in the formulation of the research (Thorne, 2016).

Appropriateness of methodology

Brewer et al. (2014) proposed that interpretive description was an appropriate methodology to be used with kaupapa Māori research because it is focused on applied research that creates clinically relevant findings that aim to create a positive difference in people's lives. As kaupapa Māori research and interpretive description are both nonprescriptive there is flexibility with data collection and analysis. The existing knowledge that the researcher brought with them is acknowledged and can add to the research, and from an epistemological perspective there is understanding that knowledge is created between the researcher and the participants (Brewer, Harwood, McCann, Crengle, & Worrall, 2014). The advantages of a

project developed using this methodology will be that it enabled the research to develop an in-depth understanding of the participants' experiences of working with Māori.

Participant recruitment

This research took advantage of the population that made up the private health and rehabilitation company, that the researcher was employed within. Participants in the research were recruited from a pool of 112 kaiwhakaora ngangahau occupational therapists employed by the company, which has employees throughout New Zealand.

The inclusion criteria for kaiwhakaora ngangahau occupational therapists included in this study included:

- Currently employed by the private health and rehabilitation company,
- New Zealand registered kaiwhakaora ngangahau occupational therapists,
- That have provided occupational therapy services to Māori service users, within the past six months

These participants were identified as key informants in terms of their knowledge and experience in bicultural practice. Thorne (2016) stated that under interpretive description purposive sampling is used to ensure representation and sufficient diversity. The recruitment deliberately aimed to recruit a diverse sample of participants who practiced in a range of places throughout New Zealand, different ethnicities and years of experience. In consultation with the company's cultural advisor through purposive sampling these participants were identified. Purposive sampling is an approach to sampling whereby the participants are selected based on the experience that they can contribute to the research (Thorne, 2016). The characteristics that the cultural advisor considered when nominating potential participants were therapists who regularly attend and contribute to the companies' cultural panel. The cultural panel is a space where therapists can bring case studies for discussion where there may be cultural barriers that need to be addressed. Some therapists present case studies and others provide guidance to those therapists, those therapists who provide guidance were the ones who were targeted. The value of targeting a group of therapists who provide guidance on the cultural panel to other therapists is that they had a depth of insight into not only their own clinical experience but also that of other therapists working in practice.

Once identified potential participants were sent a participant information sheet (see appendix B) and a consent form (see appendix C) by an admin staff member via email (see appendix D), this was to ensure that the participants did not feel pressured in any way to participate.

Participants sent the consent form to the admin staff member if they wished to participate in the research.

Under interpretive description, sample sizes are normally between five and thirty participants (Thorne, 2016). For this research a sample size of five kaiwhakaora ngangahau occupational therapists was selected. The reason for the smaller sample size is that this is a research project rather than a thesis, therefore consideration needed to be taken to keep within the time and size parameters of a research project. The sample of five also allowed diversity in geographical locations across the motu. Qualitative research sample sizes are usually smaller in comparison to quantitative research as it provides a deeper understanding of experiences. Thorne (2016) suggested that if the phenomena that is being studied is common in clinical populations, then it is likely that a smaller sample size will be able to produce findings that are worth documenting. Demographics were collected such as ethnicity, years since graduation, and current location of practice. This was presented in a way that protected anonymity.

Data collection plan

Thorne (2016) suggested that because practitioners use interviews in everyday practice, in research interviews become the primary source of information. In occupational therapy undergraduate study in New Zealand, students learn about the use of semi-structured interviews in practice. Thorne (2016) explained that it can be a challenge for health professionals to change their interviewing style from clinical enquiry to a research enquiry. This was something I was conscious of and when reviewing the interview audio, each time I reflected and looked for areas of improvement between each interview. Semi-structured interviews were conducted at a mutually agreed location between the researcher and the participant, either kanohi ki te kanohi (face to face) or via online meeting. Where possible the natural environment was utilised such as a park or beach. Informed consent was gained at the beginning of the interview for them to be recorded via either audio only or visual-audio means and to collect and share demographics.

Hui process

Lacey, Huria, Pitama, Beckert, and Gilles (2011) proposed the Hui Process as a framework to build effective relationships with Māori patients in practice. The interviews conducted within this research project followed the Hui Process (Lacey, Huria, Beckert, Gilles, & Pitama, 2011). Although the Hui Process was developed for the clinical setting, it's structure was relevant for use in this research as the main researcher is Māori and would have naturally

followed a similar process to conduct an interview whether that be clinical, or research based. Step one of the process is Mihi (Lacey, Huria, Beckert, Gilles, & Pitama, 2011), during this stage as the researcher I clearly introduced myself and the purpose of the interview. Step two is Whakawhanaungatanga (Lacey, Huria, Beckert, Gilles, & Pitama, 2011), this helped with the rapport building, where I shared my whakapapa, and gave background to why this was my topic of interest and the relevance to occupational therapy and the wider health system. Where possible I provided kai to create a comfortable, safe space that was inviting to the participant, to enable them to share their case study. As we were both kaiwhakaora ngangahau occupational therapists, we connected through this commonality. Step three is Kaupapa (Lacey, Huria, Beckert, Gilles, & Pitama, 2011), this is where we attended to the main purpose of the interaction. The interviews were conducted in a combination of English language and te reo words and phrases. The participants were asked to come to the interview prepared with a case study to focus the conversation and discussed a scenario when they recently worked with a Māori service user. Questions were open ended and explored the cultural considerations that the therapist took throughout the occupational therapy process. Examples of questions that were included were when you first received the referral and recognised that it was a Māori client did that impact your actions or thinking if so how? and what do you see as important to consider when working with Māori? List of questions are provided in appendix E.

The final step is Poroporoaki (Lacey, Huria, Beckert, Gilles, & Pitama, 2011), at the conclusion of the interaction I summarised what the participant had shared ensuring that I understood and grasped the information provided, then explained the actions from there, these are that the interview audio was to be transcribed, once transcribed the participant was able to review to ensure that the information is correct, then my supervisors and myself went through the process of making sense of the data, then findings and discussion were completed and at the end the participant was entitled to a copy of the report.

Data analysis strategy

This research utilised thematic analysis. Thematic analysis is a tool often used in qualitative research (Zhang & Wildemuth, 2017). Zhang and Wildemuth (2017) suggested that thematic analysis helps researchers to gain depth and understanding of a social experience both subjectively and scientifically. Firstly, the interview recordings were transcribed verbatim and participants had an opportunity to review the transcript to ensure that it truly captured what

was intended through member checking. Then the transcripts were thoroughly read by the researcher and supervisors.

Thematic coding was then completed using Quirkos qualitative data analysis software. This was used in the analysis phase of research to identify the key themes (Thorne, 2016), an inductive approach to analysis was taken. Within Quirkos once the raw data was coded, then the software compiled a report which gave the ability to compare and contrast between interviews and extracted the quotes which were linked to the different themes. Discussion was ongoing throughout the thematic analysis process between researcher, primary and secondary supervisor, to confirm common findings, and discrepancies were discussed. The data was then analysed from a Te Ao Maori perspective and examples of quotes that represented the key Māori principles of Maanakitanga, Kaitikakitanga, Wairuatanga, Whanaungatanga, Kotahitanga and Rangatiratanga were identified.

Ethics

Ethics approval was sought from Otago Polytechnic Ethics Committee, number 890 (see appendix A). Approval for the research to be completed was gained from the company Chief Executive Officer and National Health and Rehabilitation Manager.

When considering ethics Te Ara Tika Guidelines for Māori research ethics: A framework for researchers and ethics committee members was followed (Hudson, Milne, Reynolds, Russell, & Smith, 2010). Although none of the participants identified as Māori, these guidelines are still relevant as the research will benefit the Māori community. The four main objectives of the framework are to explain key ethical concepts for Māori, to support decision-making around Māori ethical issues, to identify ways to address Māori ethical concerns, and to clarify the kaitiaki roles of Māori ethics committee members (Hudson, Milne, Reynolds, Russell, & Smith, 2010). Hudson et al. (2010) emphasised that to ignore cultural difference in research could restrict the validity of the research and the implications for human development, they stressed engagement with local Māori communities throughout the research process. The four concepts within Te Ara Tika are whakapapa, manākitanga, tika and mana (Hudson, Milne, Reynolds, Russell, & Smith, 2010).

Whakapapa was demonstrated within this research, by meaningful relationships being developed between the researcher and the research participants (Hudson, Milne, Reynolds, Russell, & Smith, 2010). At the beginning of the interviews, I shared with the participant my own whakapapa and provided some background information of the project and how it came about, then encouraged them to share their own backgrounds. Aroha (care) and consideration

was taken so that the participants had an awareness of what was involved in the research process, making sure that the information sheet was clear so that the participant could make an informed decision about engaging in the research and what the information they share was used for. The whakapapa concept under Te Ara Tika considered the potential positive benefits that the research may have on Māori and ensured that Māori communities were consulted throughout the process. In this project consultation with Māori was completed through the Māori occupational therapy group through OTNZ-WNA and the company's Māori therapist group. As group members were spread throughout the country, they were representative of different iwi. Whakapapa also emphasised Māori taking a leadership role within the research, as I identify as Māori and am conducting the research this was also addressed.

Manākitanga considered privacy and confidentiality (Hudson, Milne, Reynolds, Russell, & Smith, 2010), within the project manākitanga was shown by the de-identifying of information that could be linked to the participant such as geographical location and names. There was a responsibility of manākitanga towards the private health and rehabilitation company, to ensure that they were not easily identified unless in consultation with the CEO and national health and rehabilitation manager they were happy for their company name to become available to the general public. No decision was made on this. Written consent was explained in the consent form (see appendix C) and required the participants to sign to signify their understanding that interviews were recorded via audio or visual-audio means and how the findings would be shared.

During the recruitment phase of the research, confidentiality agreements were signed by the cultural advisor who helped to identify the potential participants, as well as the admin staff member who sent out the invites to the participants and received the replies.

During the interview phase of the research, participants were offered the opportunity to complete the interview outside of worktime to avoid needing to disclose a reason for meeting with me. Manākitanga was shown in the way the interviews were conducted as they followed the hui process. When discussing the Māori client who they previously worked with, the participant was asked to refer to them by not their real name, nor to give other identifiers such as the name of workplaces. Anonymity was protected by participants choosing a name that their information will be associated with. The environment in which the interview was conducted in, was a private space where conversations cannot be heard by others.

During the analysis of information stage, confidentiality agreements were signed by the transcription typist. Privacy was ensured by removing identifiers of the participants such as names, iwi, or locations.

Tika looked at the responsiveness to Māori and defining the purpose of the project (Hudson, Milne, Reynolds, Russell, & Smith, 2010), this project aimed to assist Māori service users in the future to receive culturally relevant services and feel confident in the quality of services they receive regardless of the therapist's cultural background. The research aimed to identify knowledge gaps and highlighted positive examples of bicultural practice within the company. It is hoped the research will contribute to conversations around current company policy on best practices for working with Māori. It will be shared with other kaiwhakaora ngangahau occupational therapists and occupational therapy students and workplaces, to contribute to conversations Aotearoa wide in relation to occupational therapy and potentially other allied health profession's practice. The plan is to publish this research in an occupational therapy journal or presented at conferences to ensure that it reaches different stakeholders such as Accident Compensation Corporation (ACC) and District Health Boards. The overall desire is to affect change in the physical and mental health of Māori who access occupational therapy services.

Mana considers power sharing (Hudson, Milne, Reynolds, Russell, & Smith, 2010), when conducting the interview mana was shared between myself as researcher and the participant. Mana was shown through coming to a mutual agreement about the time and location of where the interview was conducted, giving the participant a safe place to share their experiences without judgement or prejudice. Mana was addressed in the research by the participants being given a gift card as a koha or as a token of appreciation for their participation.

Data was stored on a password secured computer and was de-identified so that the participants and the organisation are not identified. The data will be destroyed after 5 years.

Trustworthiness/Credibility

Thorne (2016) indicated that caution needs to be considered that a single research study conducted using interpretive description could influence changes in the practice of practitioners, this puts a greater emphasis on ensuring credibility. Four considerations used to strengthen credibility are epistemological integrity, representative credibility, analytic authority and interpretive authority.

Epistemological integrity ensured that the research question was formed from the researcher's epistemological perspectives and these perspectives were suggested throughout the design of the project (Thorne, 2016). The research question "What factors do kaiwhakaora ngangahau occupational therapists believe influence their practices and decisions in relation to working with tangata whenua (people of the land - Māori) following injury?" and the considerations that were taken throughout the project, helped to make implicit my epistemological standpoint. My epistemological perspective being that of a tangata whenua occupational therapist.

Representative credibility can be demonstrated by the researcher looking at the data through multiple lenses (Thorne, 2016). Triangulation was shown using one researcher and two supervisors discussing the thematic analysis in regular meetings throughout the process and the supervisors challenged and asked for justification from the researcher. This provided different perspectives when interpreting the data. The study used a variety of data sources as there is more than one participant and used more than one method to interpret the data, such as qualitative data analysis software and Māori principles. Thorne (2016) explained that trustworthiness and rigour can be strengthened by the use of member checking. Once the interviews were transcribed they were given to the participants to review to ensure that the information captured was reflective of what the participants intended.

Analytic logic helps the reader to understand the reasons behind the decisions that the researcher has made throughout the process (Thorne, 2016). Throughout the written component of this project, I made my reasoning explicit so that another researcher may be able to follow. I kept a reflective research log to document my thought processes at the steps of the research. A brief example of my reflection was following the initial interview I reflected on how difficult it was to change my interviewing style from a clinical context to a research context something that I actively tried to work on in future interviews.

Interpretive authority gives the audience of the research trust in the researcher's interpretations (Thorne, 2016). The use of the Quirkos qualitative data analysis software thematic analysis tool helped to provide a set of clear steps to follow in the thematic process. Confirmability ensures that steps are taken to ensure that the themes produced accurately reflected the experiences of the study population (Shenton, 2004). Confirmability was seen by involving the supervisors in the theme analysis and ongoing supervision throughout the research process. Interpretive description assumes there is bias of the researcher which became an instrument in the research process (Thorne, 2016).

Brewer et al. (2014) emphasised that in Kaupapa Māori research the validity and credibility comes from the researcher. This can be seen within their own personal qualities, whānau connections, iwi, hapu, and the relationships that the researcher has with people involved in the research, whether that be the participants, the consultation group and the supervisors. Within this research project, I actively involved people in consultation who would increase the validity and credibility by bringing in different perspectives from the iwi and hapu they represented throughout the motu.

Conclusion

This chapter has described the step-by-step process that this research will follow. Throughout the process, two worldviews have been represented, although using western methods such as interpretive description and the use of data analysis software, Māori kaupapa was ingrained from start to finish. This was shown through the use of the Hui process, following Te Ara Tika Ethical guidelines and ongoing consultation with Māori through Kaitohutohu, whānau, the company's Māori therapist group and the OTNZ-WNA Māori occupational therapist group. This is important for the safety of myself as a Māori occupational therapist and novice researcher navigating a western research process and for the overall safety and credibility of this project.

Chapter 4: Findings

Introduction

This chapter will explore the themes that emerged from this research. From the analysis, three themes were identified with associated subthemes (see Table 1). The first theme was *rapport building,* which was seen to create a strong foundation for a working relationship between client and therapist. The second *therapist experience* considered the therapist as a vital tool within the therapeutic process and acknowledges that therapists come with skills from their upbringing and past experiences. Finally, *reducing barriers* looked at the steps that the therapist takes to ensure that the Māori client is receiving equal access to healthcare and resources. Following thematic analysis the data was then reconsidered from a Te Ao Māori perspective and quotes were chosen which represent the key Māori principles of *Maanakitanga, Kaitiakitanga, Wairuatanga, Whanaungatanga, Kotahitanga* and *Rangatiratanga.*

The themes and subthemes will now be explored in detail.

Table 1: Themes

Theme	**Subtheme**
Rapport building	- Kanohi ki te kanohi - Environment - Support people - Time - Connection
Therapist experience	- Life experience - Professional experience - Study - Noticing cues - Bicultural growth
Reducing barriers	- Funder limitations - Therapist advocacy - Empowerment

Data Analysis

Theme One: Rapport building

Rapport building had the highest total codes with 68, therefore it was significant. Rapport building is the commencement of a relationship where mutual trust is developed and respect for one another, this builds the foundation for all future interactions (Governder, et al., 2017). In a private healthcare context when working with Māori rapport is built by the clinician firstly creating a comfortable environment, *kanohi ki te kanohi,* where the *environment* of the meeting is considered, whether there are *support people* present such as whānau and a space that is conducive of being supportive for open sharing and that adequate *time* is spent. The participant is open-minded to different ideas such as alternative methods of treatment and the participant shares information about themselves to create *connection* and explains clearly what their role will be in the person's rehabilitation journey. The naming of these subthemes came directly from the language used by the participants.

To build rapport one of the elements that were seen as essential by most of the participants was that the meeting occurred kanohi ki te kanohi, this allowed them to read non-verbal cues such as body language. Participant two explained why they believe it is a necessary part of the process:

"I met with her face to face because I found it quite difficult to communicate with her openly over the phone. I knew that meeting a Māori client face to face, having a bit of an introduction and collaboration with other parties was going to be the best way to get her on board." – participant 2

Participant number one spoke about a time when they were not given permission to see a client kanohi ki te kanohi and how this subsequently impacted the ability to gain rapport:

"...I wasn't given permission to go onto her property and have that discussion face to face, it was done over the phone and it got a bit ugly and so I think that that impacted quite negatively on the relationship and you know, it didn't end particularly well despite the best intention." – participant 1

Participant four discussed that meeting kanohi ki te kanohi with the Māori service user and their employer at the kohanga reo that they worked at was vital when gaining rapport:

"I believe requesting the work site visit was a really significant part of that therapeutic rapport-building component they were very keen for me to be, to come and come and see the work site having had some experience in the past within early childhood settings and kohanga reo, they were really excited for me to come which was really nice" – participant 4

The next subtheme *environment* considers the environment in which the interaction between therapist and client takes place, participant three explained their thought processes when considering the environment:

"Because he was quite short (abrupt), and I just thought it may be not so threatening wise that I see him on his own turf, rather than trying to organise a time. It wasn't as if I felt unsafe at all in terms of making that call, but yeah I just sort of suspected it might just run a little bit better in his own environment rather than try and organise something at the workplace, or our work offices…" – participant 3

There was a common agreeance between all five interviews that including *support people* was of central importance to Māori and therefore needed to be incorporated with all aspects of the rehabilitation journey. Participant two emphasised:

"…a greater approach with whānau. A lot of them bring their partner, parent, sibling to the initial assessment and sometimes the follow-ups, even in the workplace or our office. They are totally in their right to do this, but it can be a facilitator or a barrier" – participant 2

Participant four described a time when they did not offer a support person and how that impacted negatively on the therapeutic relationship:

"Well I think it showed to them that I hadn't been considerate of…a need and therefore I wasn't given half as much potentially half as much information as I…may have been given had there been a support person there for them and therefore I didn't understand the barriers as well and therefore couldn't provide as great of services or intervention" – participant 4

Time was a concept that emerged in all five interviews. Time was required to build a solid foundation for a therapeutic relationship, participant four talked about how they gave that

time initially which helped them to better understand the client's needs which meant actions were taken that enabled a quick recovery:

"...and therefore she was able to give me a lot of information and within that data gathering section of the process we came up with a few other things within that that I think if we hadn't have spent that time initially I may not have been given and it was those additional things that I could then put in place within the intervention that yeah I believe has helped with that speedy recovery." – participant 4

Participant five explained that although they would like to undertake culturally relevant occupations with the client, they don't believe that time would allow it:

"...doing the weaving thing I really liked that idea but when it came down to the practicalities of doing it, it was sort of like timing, the time to do it." - participant 5

Connection was when during the rapport building process the client and the therapist purposively share information about themselves in order to form a connection. The participant understands the different whakapapa links of the person and considers how to incorporate this in the recovery process, participant four explained:

"...use what we've just been through ourselves, our whanaungatanga. Where we are from, who we identify as and with where. so that was…completed it was a conscious decision to make with this lovely lady and it…formed the basis of being able to build on that therapeutic rapport…" - participant 4

Participant three noticed that finding a connection, could break down any barriers and open up the discussion with the client:

"...he was a lot more open at that time than any other subsequent time that we … he didn't perceive me being there as a threat, there as some ACC person trying to force something that he wasn't really wanting to do, but that's really … yeah. That's how I would tend to create that rapport, just finding … sometimes I find if I have a connection, we have a connection, then that's something to sort of build on in terms of a working relationship." – participant 3

The implications of clinicians building rapport with their Māori clients meant that the clients were more willing to engage in rehabilitation.

Theme Two: Therapist experience

Experience can broadly be defined as an event that has occurred which leaves a lasting impression on the person (Governder, et al., 2017). This theme acknowledges that the therapist brings with them skills that contribute to their interactions with Māori clients. This experience could have been gained throughout their early upbringing based on the locality of their upbringing, the people with whom they have been brought up around. This experience could have been gained through undergraduate study and on placement or through professional practice of working with Māori clients. This knowledge gained helps a therapist to determine what are the elements that they need to put in place, what different community groups they can link into, when to engage the company's cultural advisor or when it may or may not be appropriate to start with a karakia. This theme acknowledges that for some therapists this becomes tacit knowledge where they are easily able to identify environmental and non-verbal cues. It considers the therapist being on an ongoing learning journey in cultural knowledge and competence.

Participants identified two types of experience firstly, *life experience,* the experiences from the participant's personal lives either early or later life that contributes to the skills and knowledge of that therapist which may impact on their interactions with Māori clients. Secondly *professional experience* are the experiences from the participant's professional life practising as an occupational therapist that contributes to a therapist's toolbox and impacts their practice. Participant one discussed their upbringing helping to shape their ideas around bicultural practice:

> *"My own whānau probably. So, my parents are Pakeha but my nana on my mum's side was raised in a Māori whānau because her mum just kind of dropped her off and left her, so then my mum grew-up in Otara, so she was the only white girl, ...so we were raised very differently you could say, so then I guess you could say mostly Pakeha."* – participant 1

Participant two believed that their professional practice had formed their knowledge of bicultural practice:

"I've learnt a lot of that in practice through even disengagement from a client, consultation with the cultural panel or the feedback from the client and had to alter my approach." – participant 2

In the subtheme *study*, study has contributed to the participant's ideas of how best to practice with Māori clients. Participant two explained that their learnings of bicultural practice from occupational therapy training were enjoyable however minimal:

"I loved doing the three days learning our mihi's and staying on a marae and being a part of like understanding what food/kai meant but once those three days are done and you carry on with the rest of your studies, unless its further rolled out in the curriculum or if you move into that space post-study, it can just drop-off." – participant 2

And participant one needed to seek out further bicultural education outside of occupational therapy training to upskill in bicultural practice:

"When I went to Polytech we only had one assessment/module on cultural stuff, and it wasn't specific to bicultural practice, it was just culture and I loved it but I realised very quickly like you look at the statistics, which I don't like to go to, but you look at statistics on who our kind of biggest group that needs support is and especially in the public health system and then you look at what we are learning, so that's when I went to Uni.
I went part-time Polytech and part-time Uni and started by BA in Māori studies, so that I could actually get the knowledge that I needed to work bi-culturally, so it kind of formulated from there." – participant 1

Noticing cues subtheme is when participants had gained experience from previous interactions to be able to read the environmental cues and nonverbal cues such as body language, an example of this may be when completing a home visit, noticing at the front door that there are shoes lined up and therefore the therapist should remove their shoes also. Participant three felt as though following years of experience they were able to pick up on environmental or non-verbal cues as to when it was or wasn't appropriate to follow tikanga:

"But when I turn up to someone's house, it doesn't matter if they are Māori or Island families, then I know I have to take my shoes off, that's just a given. I know I need to talk

through some of these things with them, but I need to be respectful. Those are automatic things that sort of come. Now, if they do start … if there's lots of tikanga and things that I might pick up on, then I might go down the track of offering if they want to start off with a karakia or anything of that sort, but I am not going to automatically jump to some things on a referral that says they are Māori, they identify as Māori, I am not going to automatically think oh I'm going to front up to this gentleman's doorway and ah hongi you know that's just, I don't think that's so appropriate." – participant 3

The final subtheme under therapist experience is *bicultural growth,* the participants discussed that bicultural competence is on a continuum of knowledge with an infinite end point, which meant that although experienced in working with Māori, they were conscious of areas for improvement. Participant two could identify areas for growth in their bicultural knowledge:

"I feel that I would like to be able to speak elements of te reo to be able to just roll out your pepeha mihi and not feel like a fraud - it would be really cool - like I would feel a sense of contribution towards treating a Māori person in a really culturally sensitive way but without actively doing it with other people or with meeting clients regularly, it is hard to know if you are doing it right." – participant 2

Therapist experience positively contributed to the interactions between the clinician and the Māori client. It created the foundational knowledge which helped to guide the clinician to the actions they should follow within their bicultural practice.

Theme three: Reducing barriers

A barrier can be described as an obstacle that is in the way, in this context reducing barriers refers to the systemic and institutional obstacles that can occur within the healthcare journey (Governder, et al., 2017). This theme identifies that within services there are limitations such as funding and allocated time which means the therapist is limited in what they can provide Māori clients. Participants identified a need to advocate for and find different avenues to get the resources the Māori client require, such as providing clear clinical rationale to the funder for why additional funding is required or investigating alternate funding streams e.g., green prescription. The therapist empowers the person to be an active participant in their healthcare journey. The therapist is actively involved in reducing inequalities and increasing accessibility.

Under the *reducing barriers* theme is the subtheme *funder limitations* where the barrier to progressing with the Māori client is decided solely by the funder, the service dictates what can and cannot be done with the Māori client and the participant has to align their practice with that of the service expectations.

Participant three discussed the limitations within the service as not being given enough time to do all the things required within the service:

> *"... we've only been assigned as part of our SAW contract for now, so I'm going to try and squeeze all of these things into the one hour. I might get myself into a little bit of bother around that because I might take a little bit more time, but at least that's the time that I think that you can get a good gauge."* – participant 3

This view was shared by participant four:

"SAW assessments for (company) I'm very restricted by time incredibly restricted however I have always felt restricted by time with any role that I've had so it's about making the most of the time that I have and if it means that I spend an extra 10 or 15 minutes to ensure that I build that rapport ... quickly then I do it and we have a system as you're aware unders and overs..." – participant 4

Participant two spoke of a time when they needed to provide clinical rationale to the funder to increase access to services:

> *"...clinically fighting the rationale to obtain this (via funding or entry to service), in all methods of communication. Typically, we would not need to do that for all clients we work with, so it was a real journey to work with this lady, on how to work around the limitations."* – participant 2

Therapist advocacy subtheme describes participants seeking out the avenues and resources that the client may be able to connect with. Participant one discussed how they try to link clients into different services they can access in the community:

> *"I like to have a lot of conversations around things that we can access in the community but often Māori do have those connections already, it's just sometimes*

about guiding in the right direction." – participant 1

Participant four provided recommendations for the client to access a green prescription:

> *"I mean I've got another quick example the green prescription not that particular client but another one who had some real complex health conditions going on and a lot of barriers to… returning to work full time and I saw that the green prescription would be very… useful so it was about helping them to see the GP their GP for that purpose and not just for the med cert and it was helping them to understand that yes there is a small consultation fee to pay which I didn't get across the line for the ACC to pay for sadly but… they understood… the benefits of engaging in that so that… yeah I was really quite chuffed with that"* – participant 4

Also, under this subtheme therapist advocacy, the participant gains an in-depth understanding of the person's situation from a holistic approach, then by being client-centred the participant puts actions in place to address barriers and tailor rehab to the person. Participant four explained:

> *"…had her family whanau to consider she was the only driver in the family and a large family too I might add. so she in between her… work commitments she was committed to her family to drive them to appointments, do the groceries, any errands that needed to be filled so we had to. I had to consider that within the goals and the intervention absolutely."* – participant 4

Finally, *empowerment* requires the participant to work collaboratively with the Māori client for them to become a self-determined, active participant in their own healthcare journey. Participant one spoke about empowering the client to take action when there was a sense of injustice:

> *"It's just about fighting for it and if we can get the client to do the same and if they have that sense of injustice with ACC which is common, there is always a restorative justice process as well, which we see the great companies doing that work throughout New Zealand. You know there are lots of options."* – participant 1

The implications of reducing barriers meant that the Māori clients could be active participants in their own health and positive well-being outcomes were achieved.

Te Ao Māori Principles

As coding and thematic analysis was occurring, it was apparent that some of what therapists were describing aligned with Te Ao Māori principles. Already as a part of the themes I had identified the use of tikanga, however wondered which principles the therapists had begun to acknowledge in relation to their interactions with Māori. I found throughout the interviews the participants were able to discuss the different actions that they would do when working with the Māori client which related to Māori principles however rarely were the participants able to link or name the principle that it related to, whanaungatanga was the only principle mentioned and only by one participant (four). Definitions of Te Ao Maori principles used below have come from the researcher's whanau's understanding of the principles.

Maanakitanga is a blessing given to someone or someplace, a blessing of love and unity to everyone (C. Whautere, personal communication, June, 2022). Maanakitanga was described by a number of participants and articulated by participant three as they were able to describe the actions they would take to create an environment that was comfortable for the Māori client:

> *"I think I am just going to keep coming with those actions probably speak louder then the words type stuff. It just makes that whole experience ... if you go into someone's um home, then you're respectful enough to remove your shoes. You know you don't sit on tables. You know you don't touch people's heads. It's all of those sorts of things that we might know or understand that you just don't do those sort of things, whereas perhaps others won't."* – participant 3

Kaitiakitanga is someone who looks after land, or place like a custodian (C. Whautere, personal communication, June, 2022). Kaitiakitanga was described by participant two, when they would incorporate the natural environment into the rehabilitation with the Māori client:

> *"Yes, so what I did with the goals were cardiovascular I included activity related to her spiritual and mental wellbeing like going for a walk in the bush, looking for herbal leaves for treatment."* – participant 2

Wairuatanga is the spirituality of a person (C. Whautere, personal communication, June, 2022). Wairuatanga was described by participant two, when they spoke about the alternate methods of treatment used to increase the person's wairua:

"I was aware she did not like prescribed analgesia and preferred herbal treatment, mirimiri or a kawakawa headwrap." – participant 2

Wairuatanga was also seen through the actions of other participants when they would offer karakia.

Whanaungatanga is keeping whanau closer together, binding their relationships (C. Whautere, personal communication, June, 2022). Whanaungatanga was described by participant one, when they ensured that family would be present as support during assessments:

"I always invite whānau to come along or just whoever they want, I make a point of that and along the healthcare journey that is always really important to continuously, I always try and make a point, that that is really easy and able to accommodate." – participant 1

Kotahitanga is unity amongst each other, supporting each other especially close family relationships (C. Whautere, personal communication, June, 2022). Kotahitanga was described by participant five, by linking into other community groups, local Marae and health professionals to wrap around the Māori client.

"...immersed in his Māori culture like his kids went to kohanga reo and he was involved in a Marae that were really very supportive and so yeah so those links and contact were used to assist him with some of the goals that we had with the back to work which to get some courses done and he had... a mentor through the marae through one of the trusts that we were supporting him to like get his drivers licence like to help him with he was wanting to just set up his own business repairing Marae..." – participant 5

Rangatira is the highest order of Māori, chief, Māori king or queen, leader, matua or whaea, therefore *rangatiratanga* relates to leadership, autonomy and self-determination (C.

Whautere, personal communication, June, 2022). Rangatiratanga was described by participant four when they provided the client with the suggestion of a resource they could access, and then it was up to the client to choose whether to follow the recommendation or not:

"I've seen a real increase in awareness and opportunities for engagement with Māori which I think is just brilliant and there's more opportunity for Māori to engage in health and their health decisions and their care and I think that's just been remarkable. yeah there's been a huge shift and I think it's for us as OTs it's understanding what is out there and that we can provide for our clients and encourage for them to engage in…" – participant 4

Overall, the therapists were actively incorporating these principles into their practice because they could understand that these concepts were of importance to Māori such as family, the natural environment and spirituality. Some therapists demonstrated an emergent level whereas others were more consistent in their use of the principles.

Conclusion

Through thematic analysis three main themes and thirteen subthemes which represented the overall data set were identified. The participants seemed most comfortable with discussing and utilising the different elements relating to *rapport building*. Participants found actions were simple to accommodate however could have a major impact on the overall outcome of the interaction and could determine whether rapport was built or not, for example inviting or allowing a support person to join or making sure that the meeting is completed kanohi ki te kanohi.

The theme *therapist experience* considered the participant as having bicultural knowledge which was formed from professional and personal life events. One of the participants discussed the need for cultural elements to be ingrained throughout undergraduate study and led another participant to seek out further learning in Māori studies. Participants acknowledged that they were not experts in bicultural practice but on a continuum of learning and could identify areas for improvement.

Finally, the theme *reducing barriers* showed that participants were looking beyond what the service and the funder allowed them, then either fighting for what they believed the client should have access to or empowering the person and guiding them to take control over their own health.

From a Te Ao Māori perspective the participants were able to describe how they were practising with a bicultural lens however did not, apart for one occurrence, articulate the principle in te reo it related to. There were associated words within the data that assisted the researcher with identifying which principle it fit under for example, one therapist discussed self-determination which can relate to the principle rangatiratanga. These themes and principles will be further discussed in the next chapter and further strengthened by linking to current, relevant literature.

Chapter 5: Discussion

Introduction

The experiences that the therapists shared demonstrated that therapists in practice are taking steps towards adapting their practice when working with Māori, in an effort to meet their responsibilities to Te Tiriti o Waitangi. This is not something that is regularly shared with the wider occupational therapy community. The therapists were more confident and comfortable when discussing the components of rapport building. It is evident that bicultural competence is an ongoing area for development for all kaiwhakaora ngangahau occupational therapists and future learnings need to be sought out whether that be through formal courses or informal on the job. The literature found seems to align with the findings of this research and potentially further expands on what is already written.

This chapter will provide a summary of the key findings, and then make links to the relevant literature. Implications for occupational therapy practice, funders of private health and rehabilitation, private health and rehabilitation companies and educators of kaiwhakaora ngangahau occupational therapists in Aotearoa are provided. Following this is an exploration of some of the strengths
and limitations of this research and finally, there are recommendations for future research.

Summary of Key Findings

The three findings that emerged from this research helped to provide an explanation as to what factors kaiwhakaora ngangahau are considering when working with Māori post injury. Therapists do this by building rapport with the person, drawing on their past experiences, and taking steps towards reducing barriers. These were conscious decisions that were made to ensure the best service was provided to the Māori person and their whanau.

The first theme *rapport building* related to the importance of therapists building rapport with the Māori client. When planning interactions, consideration was taken to ensure they are kanohi ki te kanohi, support people were present, the environment was appropriate, adequate time was spent and a connection was made to find common ground. The basis of rapport building is a topic which is often discussed in undergraduate study, however the different subthemes that make up the theme rapport building in this research, provides a deeper understanding of purposeful actions that can contribute to rapport building with Māori such as meeting a person within their home environment.

The next theme *therapist experience* highlighted the experience that the therapist had from earlier in life, their professional experience that they may have gained in practice or study either undergraduate or postgraduate. The therapist was an active participant in the Māori client's rehabilitation journey and was able to read environmental and nonverbal cues to tell how to approach the situation. Therapists understood that he or she is not an expert in bicultural practice and could identify areas for growth and actively seeks this out. For new graduates as they enter the workforce some may not have been in clinical placement settings where they have had the opportunity to work with Māori. This means that for those graduates they will rely heavily on the learnings from undergraduate study. They will need to be proactive and discover learnings and experiences to enable them to achieve the Occupational Therapy Board's competency two. This theme challenges current practising kaiwhakaora ngangahau occupational therapists to pursue bicultural learnings to contribute to their development and influence their practice.

The final theme *reducing barriers* considered limitations within the service and from the funder which meant that the therapist needed to be an active participant in advocating for and empowering the Māori client ensuring they are receiving equal access to healthcare and resources. In order to reduce the barriers, therapists need to have an understanding of the disconnect that Māori have to their culture due to colonisation, the past injustices experienced, what the identified barriers are and what are the resources available to them.

It was clear that the different concepts that the participants were describing were in alignment with Te Ao Māori principles. That is when consideration was made for incorporating these Māori principles into the research. For example, talking about including the use of karakia and spirituality into their practice was a direct example of the Māori principle wairuatanga. It is important that in future practice therapists are able to identify the Māori principles that they are incorporating into their practice. These findings link with the existing literature, as elaborated further below.

Links to Literature

The "Guidelines on Māori Cultural Competencies for Providers" developed by ACC emphasised that interactions with Māori clients should be kanohi ki te kanohi (Accident Compensation Corporation, 2018). Similarly in this research, in the subtheme rapport building

majority of the participants agreed that kanohi ki te kanohi contact was seen as important when building rapport with a Māori client. Being kanohi ki te kanohi with the client meant that communication was effective and the therapist had the opportunity to read environmental or nonverbal cues such as body language. One of the participants spoke of incorporating the natural environment into practice with their Māori client, such as going for a walk through the bush to collect leaves for treatment, supporting Jungersen (1992) who encouraged the use of the natural environment when working with Māori because Māori consider respect for the land. Most of the participants discussed encouraging a support person to be present at assessments and incorporating them in planning and rehabilitation, this is supported by Hopkirk and Wilson (2014), Tse et al. (2005), Thomas (2009) and Jungersen (1992).

Time was a subtheme that all of the participants agreed could be a facilitator or a barrier to the therapeutic relationship. When adequate time was spent with a Māori client then rapport was built, if the interaction was rushed or the service didn't allow time then it was seen as a barrier. This was a notion aligned with Durie (2001) who explained that a competent doctor will allow time and space to establish a working relationship. Within the ACC competencies for providers document they emphasise time needs to be considered to establish a relationship between the healthcare provider and the Māori client (Accident Compensation Corporation, 2018). Time was also an aspect found in the reducing barriers theme under the subtheme funder limitations.

Also, in the ACC guidelines for providers (Accident Compensation Corporation, 2018), Came and Davis (2022) and Durie (2001) desires for the future were expressed being that the workforce's cultural makeup is reflective of the community profile that they service. The participants in this research spoke of being identified as competent when working with Māori which would often mean that they are given repeat referrals or asked for guidance by other therapists which could lead to staff burnout. None of the participants in this research identified as Māori, implications for the company are discussed later in this chapter. The participant who had been out of occupational therapy school and practising the longest, discussed their undergraduate study as not mentioning Te Tiriti o Waitangi or bicultural practice. The participant who was 1-2 years out of Occupational Therapy School spoke confidently of working with Māori which aligns with the recent OTBNZ audit on competency two, new graduate therapists were deemed more competent in competency two than other

therapists (Silcock, et al., 2021). Henare (1993) emphasised that bicultural practice needs to be ingrained throughout undergraduate study which was expressed by some of the participants also. Jungersen (2002) believes that a culturally competent therapist will be able to pick up on subtle verbal and non-verbal cues when working with Māori, which is a perspective shared by one of the participants who explained they would go into an assessment and not assume that because someone is Māori that you go in for a hongi, start using tikanga and start with a karakia. Durie (2001) explained that for therapists working with Māori clients, the use of te reo can be seen as an important indicator of bicultural practice. One of the participants discussed their desire to be able to speak elements of te reo and saw this as being an area of development for them.

Jungersen (2002) believed that changes needed to be made to health funding and government institutions needed to have clear policies of how they would incorporate te Tiriti o Waitangi to redistribute power, even twenty years on this continues to be an issue. All five of the participants were in agreeance that the limitations from the funder meant that they did not have the time to build rapport or if they did spend that time then they were somehow short-changing themselves. One participant believed that what was written in the ACC contract is tokenistic and the realities of that in practice is far from what is documented whereas another participant said that the funder is normally open to a request for further funding if clear clinical rationale is provided.

Hopkirk (2013) emphasised client-centred practice as a way to identify a person's cultural needs and Durie (1994) challenged health professionals to look at the Māori person holistically. This was demonstrated within the reducing barriers theme as one of the participants spoke about having to adapt the return to work plan to accommodate the Māori person's roles within their family and not only considering their physical injury but also the other aspects of health that might impact their recovery. Under the subtheme therapist advocacy another participant described working alongside the Māori client and guiding them in the right direction, having conversations around the things that they are able to access in the community. This is similar to what Hocking (1998) emphasised, the Māori person being the expert in their care and the need to change the power imbalance between the health professional and the client.

One of the participants spoke about incorporating culturally relevant activity into treatment, such as helping to repair marae as a part of a vocational rehab service. A perspective shared by Jungersen (1992) about therapists incorporating meaningful occupation so that Māori can connect to their culture. Henare (1992) discussed the need for therapists to incorporate spirituality into practice, illustrated in the current study by one of the participants offering a karakia with Māori clients if it seemed like the appropriate thing to do, at that particular time and place. Spirituality continues to be a bit of a mystery in the occupational therapy profession about how to integrate it into practice or uncertainty of whether that is an area addressed by the profession. If it is identified that spirituality is something of importance for the Māori person, then kaiwhakaora ngangahau occupational therapists need to find a way of including that in rehabilitation.

Implications

For Occupational Therapy Practice

There are many tools already available for kaiwhakaora ngangahau occupational therapists to use in their practice that this research has either used or the participants discussed such as the Hui Process (Lacey, Huria, Beckert, Gilles, & Pitama, 2011), the Meihana Model (Pitama, Huria, & Lacey, 2014) and Te Whare Tapa Wha (Durie, 1994). Some of the participants were practising through a bicultural lens, however, as it was tacit knowledge they found it difficult to identify what they were doing that was specific to working with Māori. Others found that linking their practice into one of the above models, helped to frame their thinking in relation to their practice.

This research found many ideas that therapists can consider for use in their own practice such as ensuring that contact is kanohi ki te kanohi (Accident Compensation Corporation, 2018), working in collaboration with whanau (Hopkirk & Wilson, 2014), spending adequate time (Durie, 2001), considering the environment that the meeting takes place, including te reo language (Durie, 2001) and finding a connection to build a strong and trusting therapeutic relationship. Other things that a culturally competent therapist may do are not making assumptions that just because someone is Māori, doesn't necessarily mean that they follow tikanga (Jungersen, 2002) and changing the power imbalance between therapist and client (Hocking, 1998). The therapist will be client-centred (Hopkirk, 2013) to identify culturally relevant occupations (Jungersen, 1992), incorporating spirituality (Henare, 1992), and having a holistic approach when working with the Māori person (Durie, 1994).

There seems to be a gap in the learning that is acquired from cultural courses and how to then transfer that into practice. One way of bridging that gap could be peer review by a colleague specifically in relation to a therapist's work with a Māori client or in a peer group type setting where cases can be discussed.

For Private Health and Rehabilitation Funders

All five of the participants discussed the limitations that the funder ACC posed to their interactions with Māori clients. These were the funding allocated that meant time is often compromised to build strong therapeutic relationships and the services offered are specific to the injury, therefore, do not enable the therapist to take a holistic approach with the Māori person. This means that participants are either having to advocate for the client to seek further funding or are working essentially for free. This shows that ACC needs to reconsider the service and funding model to allow a more culturally responsive practice for providers. These questions have arisen from the research, are kaiwhakaora ngangahau occupational therapists aware of the different resources available to them? can ACC better advertise or promote these resources? Are case managers aware of these resources also? One of the participants who was involved in facilitating the company's cultural panel, explained that a lot of what they were educating other therapists was around the resources that they might be able to access for their Māori clients.

For Educators of Kaiwhakaora Ngangahau Occupational Therapists

More cultural training has been on offer through the occupational therapy schools more recently, there is room to go further, by making sure that bicultural practice is ingrained throughout study from orientation through to graduation rather than one bicultural module to complete. In undergraduate study, students should be exposed to a variety of clinical contexts in fieldwork which involve working with Māori or being in a Kaupapa Māori service. This is supported by literature from Henare (1993), Jeffery (2005), Whiteford and Wilcock (2000) and Forwell, Whiteford, and Dyck (2001).

For Private Health and Rehabilitation Companies

Finally, a few of the participants spoke about the lack of Māori staff within the company which means that often non-Māori are stepping into roles which are meant for Māori, such as facilitating the cultural panel, and if deemed competent when working with Māori will often receive repeat referrals which can lead to staff burnout. The company needs to consider the recruitment and retention of Māori kaiwhakaora ngangahau occupational therapists, to better

reflect the population that they serve. A similar perspective to that of Māori occupational therapist Georgina Davis in her masters thesis (Davis & Came, 2022).

Strengths

A strength of this research is that the participants varied in years of experience from 1-2 years out of occupational therapy school to over 40 years. This was a strength as each of the participants brought with them a variety of life and professional experience that they were able to draw from in the interviews, which could have not only provided a range of perspectives but also could be relevant to a variety of kaiwhakaora ngangahau occupational therapists in Aotearoa.

Based on the literature review there is limited research that has explored how kaiwhakaora ngangahau occupational therapists are meeting their bicultural responsibilities, there is limited research in qualitative studies that capture the therapists' perspectives on working with Māori and limited research completed by Māori therapists/researchers as well as kaupapa Māori research. This research addresses all of the above gaps in research.

Limitations

For this research five participants were recruited which is a small sample size, this was partly due to this being completed as a masters research project rather than a masters thesis. A larger sample size may have yielded different results, potentially richer data and more accurately represented the wider population of the health and rehabilitation company and kaiwhakaora ngangahau occupational therapists throughout Aotearoa.

One limitation of the research is that there were no Māori occupational therapist participants. At the time of recruitment there were two kaiwhakaora ngangahau occupational therapists who identified as Māori that were employed by the company, one being the researcher and one other, who did not choose to participate in the research. The population of Māori within Aotearoa is 15% and the population of Māori kaiwhakaora ngangahau occupational therapists is 3% (Occupational Therapy Board of New Zealand, 2018), therefore the sample is not representative of the general population.

The participants came from throughout Aotearoa, however there were areas that have a high population of Māori such as Northland or East Coast (Statistics New Zealand, 2018) where no participants were based.

There was no data captured around how often the therapists worked with Māori or how many Māori clients they have worked with throughout their careers, so it is difficult to know whether the data generated is reflective of working with Māori over a period of time or frequent interactions and with many Māori or few. The only relevant recruitment criteria were that the therapists needed to have worked with Māori clients within the last 6 months. There could have also been an element of recall bias, where the participants could have presented their actions as desirable which means that the reported actions may not necessarily be aligned with actual actions.

As the researcher is a novice researcher, there is areas for growth such as the way in which the questions were framed could be reconsidered to yield more in-depth answers.

Recommendations for Future Research

Therefore, based on the limitations future research could consider a larger sample size, from different geographical locations and recruit Māori kaiwhakaora ngangahau occupational therapists. Data could be captured about frequency, intensity and duration of working with Māori. Exploring the perspective of the Māori client receiving occupational therapy services. More kaupapa Māori research needs to be completed by Māori kaiwhakaora ngangahau occupational therapists.

Conclusion

Bicultural practice is essential to ensuring that all kaiwhakaora ngangahau occupational therapists are meeting their responsibilities to Te Tiriti o Waitangi and to meet their competencies with the Occupational Therapy Board of New Zealand. There is little research previously completed which explores how kaiwhakaora ngangahau occupational therapists in Aotearoa are meeting these responsibilities. This study aimed to use a qualitative interpretive description approach, to gain an understanding of how kaiwhakaora ngangahau occupational therapists are incorporating bicultural practice when working with Māori. The thematic analysis of the data found that rapport building, therapist experience and reducing barriers are key components of bicultural practice. The study gives insight into some of the actions that therapists can consider in practice when working with Māori, such as ensuring that interactions are kanohi ki te kanohi, incorporating support people in the process and thinking about the environment in which interactions take place. The research challenges therapists and employers delivering services to Māori, the funder of these services and educators of the

future generation of kaiwhakaora ngangahau occupational therapists to rethink their responsiveness to Māori health and efforts in reducing inequities.

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Appendices

Appendix A: Ethics Approval

17 March 2021

Huhana Whautere

Dear Huhana

Ethics approval for project
Reference Number: 890
Application Title: *Treating with Te Tiriti in Mind*

Thank you for your application for ethics approval for this research project.

This letter is to advise that the Otago Polytechnic Research Ethics Committee review panel has approved your application, following the amendments made in response to feedback.

We wish you well with your work and remind you that at the conclusion of your research to send a brief report with findings and/or conclusions to the Ethics Committee.

All correspondence regarding this application should include the project title and reference number assigned to it.

This protocol covers the following researchers: Huhana Whautere.
Project approval is valid for three (3) years from date of letter.

Regards

Dr. Liz Ditzel
Chair, Otago Polytechnic Research Ethics Committee

Participant Information

Project title Treating with Te Tiriti in mind

General introduction
Bicultural practice is something that we as occupational therapists need to consider on a daily basis, there is little research which discusses how occupational therapists within Aotearoa are doing this.

What is the aim of the project?
The purpose of this project is to gain a better understanding as to how occupational therapists are working with Māori within Aotearoa and share this understanding with others to encourage discussion within the profession with the aim of informing practice with Māori.

How will potential participants be identified and accessed?
What type of participants are being sought?
You have been asked because you are a current practising occupational therapist who works within APM Workcare New Zealand and have recent experience of working with Māori in the last 6 months following injury. You will be chosen using purposive sampling (the research will be deliberately aiming to recruit a diverse sample from a range of places throughout New Zealand, different ethnicities and years of experience) and have been identified as having experience and knowledge relevant to the research.

What will my participation involve?
Should you agree to take part in this project you will be asked to be involved in a semi-structured interview which should be no longer than 1 hour in duration either face to face or via online meeting. The interview will be recorded, you can choose whether it is recorded via audio only or via audio-visual means. You will also have the opportunity to check the transcript to ensure the data truly captures what was intended.

How will confidentiality and/or anonymity be protected?
During the recruitment phase of the research, a confidentiality agreement will be signed by the admin staff member who is sending out the invites to you and receiving the replies. During the interview phase of the research, you will be offered the opportunity to complete the interview outside of worktime to avoid needing to disclose a reason for your absence from work. When discussing the Māori client, you have previously worked with, you will be asked to refer to them by not their real name, nor to give other identifiers such as the name of workplaces. Anonymity will be protected by choosing a name that your information will be associated with. The environment in which the interview is conducted in, will be a private space where conversations cannot be heard by others.
During the dissemination of information stage, confidentiality agreements will be signed by the transcription typist, and the researcher's supervisors. Privacy will be ensured by removing identifiers such as names, Iwis, locations or the service you work within.

What data or information will be collected and how will it be used?
Results of this project may be published. Any data included will not be able to be linked to individual participants.

You will be sent a summary of the results and a full copy of the project will be available at the Otago Polytechnic library.

Data Storage

The data collected will be securely stored and password protected. At the end of the project any personal information will be destroyed. Raw data will be in secure storage for a period of five years, after which it will be destroyed.

Can I change my mind and withdraw from the project?

You can decline to participate without any disadvantage. If you choose to participate, you can withdraw from the project without having to give any reasons. You can withdraw from the research anytime up until 5 days after you have received the transcript for review, if you choose to withdraw any information or data you have provided this will be destroyed.

You can choose not to answer any particular question and ask for the audio/visual recorder to be turned off at any stage.

What if participants have any questions?

If you have any questions or concerns about the project, either now or in the future, please feel free to contact either: Huhana Whautere, email   , researcher
or: Jackie Herkt, email jackie.herkt@op.ac.nz , supervisor.

Appendix C: Consent Form

Project Title Treating with Te Tiriti in mind

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.
I know that:

- my participation in the project is entirely voluntary

- I understand the interview will be recorded via audio only or audio-visual means

- During the interview I am free to choose not to answer any particular question

- I am free to decline to participate without any disadvantage. If I choose to participate, I can withdraw from the project without having to give any reasons. I can withdraw from the research anytime up until 5 days after I have received the transcript for review, if I choose to withdraw any information or data I have provided will be destroyed.

- Any personal data will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for five years after which it will be destroyed. If it is to be kept longer than five years my permission will be sought.

- the results of the project may be published or used at a presentation in an academic conference but my anonymity / confidentiality will be preserved

- That if I want, I can receive a copy of the research findings

I agree to take part in this project under the conditions set out in the Information Sheet.

…………………………………………… (signature of participant)

…………………………………………… (date)

…………………………………………… (signature of researcher)

**This project has been reviewed and approved by the Otago Polytechnic
Research Ethics Committee**

Appendix D: Email to Participants

Kia ora koutou,

You have been selected as a possible participant for a research project being completed within your company which explores the factors that occupational therapists consider when working with Māori clients.

The purpose of this study is to explore how occupational therapists and students work with Māori in practice. It may also be used to develop resources within the company.
In order to be included in this study you will be a current registered occupational therapist, who works for APM and have worked with a Māori client in the last 6 months.
If you are interested in having a korero with me during an interview, please read the documents below and return to (admin).

Please see attached for more information.

Ngā mihi,

Appendix E: Sample of Questions

1.   Setting a scene, tell me about a Māori client you have worked with using a nom de plume, without any identifying factors and why you were seeing the client

2.   When you first received the referral and recognised that it was a Māori client did that impact your actions or thinking if so how?

3.   Tell me about the rapport building process with this client – what was done and what was the impact

4.   In the planning and goal setting phase of your input, do you believe that their culture influenced that? If so, how? If not, why not?

5.   In the treatment phase of your input, do you believe that their culture influenced that? If so, how? If not, why not?

6.   Moving more broadly to your work with all Māori clients. Are there factors that you believe influence your practice and decisions when working with them?

     - do you have examples of actions or ways of thinking that you believe have positively influenced the therapeutic relationship and health outcome

      -do you have examples that in retrospect that you believe impacted negatively on the therapeutic relationship and health outcome

7. What do you see as important to consider when working with Māori?

8. Is there anything else that you want to tell me about your practice when working with Māori clients?