A study of the experiences of new graduate occupational therapists employed in rural practice in Aotearoa, New Zealand.

Joy Aiton

A thesis submitted in partial fulfilment of the degree of Master of Occupational Therapy at Otago Polytechnic, Dunedin, New Zealand

November 2022
Declaration of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.
This study focused on "What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa, New Zealand?" The research question was chosen to begin to address the lack of specific information regarding current experiences of new graduate occupational therapists working amid health reforms, varied service provision requirements and increased pressure to address inequities.

Utilising a qualitative methodology and an interpretive descriptive approach, six participants were included in this study. Semi-structured interviews provided the raw data on which the findings were thematically analysed.

The diversity and complexity of the role of a rural practitioner was a common theme which was discussed in the context of working in bicultural Aotearoa. The importance of being able to bounce ideas around in addition to formal support and supervision was another key theme. The process of recruitment and retention in hard to staff rural areas was also discussed alongside the need for resilience when working as a new graduate in rural practice.

Although the sample size was small, there were both expected and unexpected outcomes. The generalist versus specialist debates continues alongside issues of role blurring and professional identity. Having opportunities to bounce ideas around was significant in addition to the importance of belonging and connection especially when subjected to significant change.

Further research is indicated into the impacts of interprofessional education, interprofessional practice, rural generalism from an allied health perspective and support and supervision structures for new graduates in rural practice.
ACKNOWLEDGEMENTS

I would like to thank my supervisors Rita Robinson and Sian Griffiths who tirelessly helped me to navigate through the process of academic writing to be able to produce this thesis.

Thank you also to my ever patient and supportive husband Russ, who has been there through the sometimes-treacherous emotional roller-coaster ride.

And to the participants without whom this study would not have been possible. Your passion and energy have been invigorating.

Ngā mihi nui.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>iv</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter One</td>
<td>1</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Background</td>
<td>1</td>
</tr>
<tr>
<td>The Issue</td>
<td>5</td>
</tr>
<tr>
<td>The Study</td>
<td>5</td>
</tr>
<tr>
<td>Chapter Two</td>
<td>8</td>
</tr>
<tr>
<td>LITERATURE REVIEW</td>
<td>8</td>
</tr>
<tr>
<td>1. Defining new graduate</td>
<td>9</td>
</tr>
<tr>
<td>2. Preparedness to practice</td>
<td>13</td>
</tr>
<tr>
<td>3. What is rural practice?</td>
<td>18</td>
</tr>
<tr>
<td>4. The generalist versus specialist debate</td>
<td>21</td>
</tr>
<tr>
<td>6. Recruitment and retention in hard to staff rural areas</td>
<td>28</td>
</tr>
<tr>
<td>Conclusion</td>
<td>31</td>
</tr>
<tr>
<td>Chapter Three</td>
<td>34</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>34</td>
</tr>
<tr>
<td>Introduction</td>
<td>34</td>
</tr>
<tr>
<td>The Research Question</td>
<td>34</td>
</tr>
<tr>
<td>Study Design Methodology</td>
<td>34</td>
</tr>
<tr>
<td>Interpretive Description</td>
<td>36</td>
</tr>
<tr>
<td>Semi-structured Interviews</td>
<td>38</td>
</tr>
<tr>
<td>Ethics</td>
<td>41</td>
</tr>
<tr>
<td>Socio-cultural considerations</td>
<td>41</td>
</tr>
<tr>
<td>Participants and recruitment:</td>
<td>42</td>
</tr>
<tr>
<td>Data gathering</td>
<td>44</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>46</td>
</tr>
<tr>
<td>Validity</td>
<td>48</td>
</tr>
</tbody>
</table>
Summary ........................................................................................................................... 49
Chapter Four ..................................................................................................................... 51
FINDINGS ....................................................................................................................... 51
Demographics .................................................................................................................. 51
Theme One ....................................................................................................................... 54
Diversity ........................................................................................................................... 54
i.Complexity: .................................................................................................................... 54
ii.An occupational therapy perspective. ....................................................................... 58
Theme Two: ...................................................................................................................... 61
The importance of bouncing ideas around ................................................................. 61
Theme Three: ................................................................................................................... 64
Working in Bicultural Aotearoa ..................................................................................... 64
Theme Four:...................................................................................................................... 67
Supervision and support ............................................................................................... 67
i.Supervision: ................................................................................................................... 67
ii.Support ......................................................................................................................... 70
Theme Five ....................................................................................................................... 72
The employment pathway ............................................................................................. 72
i.Readiness ....................................................................................................................... 72
ii.Recruitment ............................................................................................................... 73
iii.Retention ..................................................................................................................... 77
iv.Resilience .................................................................................................................. 78
Chapter Five ..................................................................................................................... 82
DISCUSSION .................................................................................................................. 82
1.Rural practice and the generalist vs specialist conundrum. .................................... 84
i.Rural practice ............................................................................................................. 84
ii.Rural Generalism ...................................................................................................... 86
iii.Rural health workforce issues .................................................................................. 88
iv.Managerial expectations .......................................................................................... 89
v. Role blurring and professional identity ................................................................. 91
vi.Bicultural practice .................................................................................................... 93
2.Opportunities to bounce ideas around ...................................................................... 94
3.The importance of connection .................................................................................. 97
4. Expect change ................................................................. 101
Summary ................................................................................. 104
Study limitations ................................................................. 105
i. Sample size and profile .................................................. 105
ii. Paucity of research from the context of new graduate occupational therapists in rural Aotearoa .................................................. 105
iii. Data collection process .................................................. 106
iv. Defining rural practice and rural generalism .................. 106
Ideas for future research ..................................................... 107
Research implications ......................................................... 108
Chapter Six .......................................................................... 110
CONCLUSION .................................................................. 110
Research Contributions ...................................................... 111
References: ......................................................................... 116
Appendix 1 .......................................................................... 128
Appendix 2 .......................................................................... 129
Appendix 3 .......................................................................... 132
Appendix 4 .......................................................................... 134
Appendix 5 .......................................................................... 138
Appendix 6 .......................................................................... 140
Appendix 7 .......................................................................... 141
The following definitions provide some clarity and context for this study:

i. **Collaborative practice.**

Collaborative practice is “when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings.” (WHO, 2010, p. 13).

ii. **Health Equity**

According to the World Health Organisation (WHO, 2021)

> Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being. (p.2)

iii. **Interprofessional education**

The World Health Organisation (WHO, 2010) define interprofessional education as “when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.” (p. 13)

iv. **Interprofessional practice**

Haruzivishe and Chipamaunga (2019) define interprofessional practice as “including cohesiveness of the disciplines including reflecting on and developing ways of practicing that provides an integrated and cohesive answer to the needs of the patient.” (p.3)
v. Occupational Therapy

The Occupational Therapy Board of New Zealand (OTBNZ, n.d.) define occupational therapy as:

…*the art and science of helping people take part in everyday living through their occupations*. Occupational therapy is about fostering health and well-being. *It is also about creating a just and inclusive society, so that everyone can participate to their potential.* (Paragraph 1).

vi. Rural

The term ‘rural’ from a health, policy or research perspective is not yet defined in Aotearoa (Nixon, 2018), but Stats NZ (2020) define ‘rural’ by considering the diversity of the social and economic characteristics of people living on an ‘urban-rural spectrum’. The profile classification uses current urban and rural boundaries. Rural areas are classified according to the influences of nearby urban areas.

This study focused on rural areas with low urban influence, where the majority of the population work in rural areas, and highly rural/remote areas which have minimal dependence on urban areas.

vii. Rural Generalist

The term ‘Rural Generalist’ is frequently used to describe allied health professions as a future working model, especially in rural and remote areas. According to Services for Australian Rural and Remote Allied Health (SARRAH, n.d.) the rural generalist allied health professional is “…*a position or practitioner that responds to the broad range of healthcare needs of a rural or remote community.*” (p.1).
viii. Rural Hospital

A definition of a rural hospital is described by the New Zealand Rural Hospital Network Summit document (2020) as “a hospital staffed by suitably trained and experienced generalists, who take full clinical responsibility for a wide range of clinical presentations.” (p.8)
Chapter One

INTRODUCTION

Background

Occupational therapy is considered a science and an art, and a profession that utilises occupation as a tool and a medium to enable people to participate in their occupations of daily living (OTBNZ, n.d.). The Māori translation of occupational therapy is “whakaora ngangahau”. According to Hohepa MacDougall Kaiwhakamaori, Translator, Te Taura Whiri i te Reo Māori, Māori Language Commission (Occupational Therapy New Zealand-Whakaora Ngangahau Aotearoa, OTNZ-WNA, 2010), “Whakaora means to restore to health and ngangahau is an adjective meaning – active, spirited, zealous. In choosing this translation, the Māori Language Commission is conveying the idea of reawakening, or restoring to health one’s activeness, spiritedness and zeal”. This description is arguably more animated than the definition from OTBNZ n.d. noted in the definitions above. Both definitions, however, describe the role of the occupational therapist albeit, arguably, open to interpretation.

In Aotearoa occupational therapists can be found almost anywhere. According to the World Federation of Occupational Therapy (2012)

*Occupational therapists assess, diagnose and work together with people to engage in the meaningful activities they need, want and are expected to do in their everyday life. They work with people at all stages of life who have health conditions, disabilities, injuries or risks to health and/or are encountering social or environmental barriers to carrying out meaningful occupation.* (Paragraph 1)

Clinical practice areas for occupational therapists include paediatrics, physical health and rehabilitation, mental health and wellbeing, social and environmental
fields. Within these broad scopes, occupational therapists specialise in other areas such as housing modifications, driving assessments, wheelchairs and seating, pain, concussion, neurology, sensory processing, oncology, health of older person, orthopaedics, hand therapy, vocational rehabilitation, supervision, and other areas. Arguably, the philosophies of occupational therapy can fit almost anywhere.

As a practicing occupational therapist for over 30 years, I have experience working in most of the clinical fields noted above. I continue to be passionate about the value of our profession, especially in the field of rural health. The focus of this study brings together my professional experiences with a drive for an evidence base on which to build future opportunities for the development of occupational therapy service provision in rural communities.

Of course, change is a fact of life in most cultures, and the progression of health and social care require modification and adjustments to meet the needs of changing societies. Aotearoa is currently in the process of radical health reforms, with rural health and rural generalism being part of the focus on equitable health service delivery. This increasing focus is expressed by Reid (2021) in her editorial regarding structural and cultural reform as she cites both the New Zealand Health and Disability System Review (2020) and stage one of the WAI 2575 Hauora claim to the Waitangi Tribunal (Ministry of Justice, 2022) in her discussion regarding health inequities for Māori, and the current political willingness to address equity issues.

Reid (2021) asks several questions in this editorial, including: “can equitable outcomes be achieved without a culture change within the health sector?” (p.8). But what would a culture change look like in the health sector? Came et al. (2020) consider cultural change from the perspective of the Wai 2575 claim from the viewpoint of decolonizing health systems and propose that the element of
rangatiratanga (self-determination) is one area that is essential to support equitable health outcomes for Māori.

Whilst responsiveness to te Tiriti o Waitangi and improved health equity for Māori is a priority in Aotearoa, the concept of health equity and the cultural change imperative is greater than purely an indigenous population issue. The United Nations Convention on the Rights of Persons with a Disability (2022) recognises that people with a disability also have the right to an equal standard of healthcare, as can rural populations (New Zealand Health and Disability System Review, 2020). The assumption could be made that rangatiratanga and access to equitable healthcare should be a given for all, regardless of race, ability, or social situation in today’s world, but it seems a cultural shift is required.

The World Health Organisation (WHO, 2021) describes the causes of health inequities and recognises the correlation between health and wellbeing and a person’s socioeconomic position which is exacerbated by discrimination or prejudices. This is notable between counties, for example, people in Lesotho have a life expectancy of fifty-one years, compared to eighty-four years in Japan. Alternatively, within some counties children in poor households are twice as likely to die before the age of five years old than in richer households and are twenty percent more likely to experience severe mental health problems.

Reid (2021) states that “the fundamental issue underpinning our culture change is to overcome our addiction to sameness” (p.8). This is a powerful statement that indicates the need to shake things up and look at our health services differently. According to the New Zealand Health and Disability System Review (2020), in Aotearoa, around 80% of a person’s health status is determined by factors outside health care services. The communities that have the poorest population health outcomes usually face multiple economic, environmental, and social disadvantages. It is recognised that people living in rural towns have poorer
health outcomes. Rural communities are considered some of the most vulnerable and priority is being placed on providing access to improved services.

Seemingly, the government and health and disability sectors in Aotearoa now have the appetite to look at health service provision differently, focusing on equity and cultural change and challenging the “addiction to sameness” (Reid, 2021, p.8). Moving towards our future health services in Aotearoa will be an interesting journey, and the opportunity to look at how occupational therapy fits within this new world order is an exciting prospect.

In order to address access to health services in rural areas the New Zealand Health and Disability System Review (2020) recommended interdisciplinary education and rural generalism as ways forward. Much of the evidence relating to rural practice, interdisciplinary education and rural generalism continues to be centered around a medical model. For example, Nixon (2018), in his address for the Royal New Zealand College of General Practitioners (RNZCGP) Conference, describes the concept of rural generalism as “well established internationally and seen as the cornerstone of rural medical practice” (p.102). There is, however, a paucity of research relating to allied health services in rural practice. Still less evidence pertains specifically to occupational therapy.

In terms of new graduate experiences in rural practice, Devine (2006) and Lee and McKenzie (2003) studied new graduate occupational therapist experiences in rural Australia, but to date there is nothing from the context of Aotearoa. The implications of current health reforms on occupational therapy service delivery in rural areas of Aotearoa are not yet clear. Understanding the impact of these changing and developing models of rural practice on new graduate occupational therapists is the driving force behind this study. The aim was to capture the actual experiences of new graduate occupational therapists working in rural practice in Aotearoa during this phase of radical reform.
The Issue

Recruiting to historically hard to staff rural areas is a constant struggle in Aotearoa and internationally. New and innovative ways of working and providing sustainable health services into the future are regular themes in rural health service strategy globally, such as described by the Greater Northern Australia Rural Training Network (GNARTN) Rural and Remote Generalist Allied Health Project Report (2013).

New graduate occupational therapists are being recruited into rural practice positions in Aotearoa without established support structures or training frameworks (George et al., 2019). Lee and McKenzie (2003) estimated that a third of rural therapists in Australia were new graduates when they began their career, but that many allied health professionals tend to leave rural practice after just 13-18 months. Cosgrave et al. (2018) also found that the average allied health professional’s rural tenure in Australia was 3 years, further reducing in remote areas. The reasons behind new graduates leaving rural practice roles so soon remain unclear. The issue of ambiguity in terms of rural practice and how occupational therapy responds within the culture of change and reform is an issue. How these demands and culture of change affect new graduates is an important element to explore in this research.

The Study

This study aims to capture the experiences of new graduate occupational therapists recruited into generalist roles in rural Aotearoa. It is particularly relevant at the present time because of the current health reforms in Aotearoa, and the focus on rural health, rural generalism and equitable health service delivery. Knowledge gained from the research could inform future training, development and support structures required to provide generalist services safely and successfully and or demonstrate gaps for further research. The
research question is: “What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa, New Zealand?”

This thesis includes six chapters:

Chapter one: Introduction. This chapter introduces the rationale for the study, provides some background and an overview, a brief description of the ‘why’, ‘what’ and ‘how’ in terms of the format of the thesis.

Chapter two: Literature review. The literature review considers relevant research, studies and articles that pertain to rural practice, rural generalism, allied health, occupational therapy, and new graduate experiences.

In the absence of much literature specifically from an occupational therapy perspective within the context of Aotearoa, literature has been sourced internationally via several databases. Contemporary literature has been included to ensure valid and relevant research is included, alongside some historical studies, questions and theories that remain applicable today. Six themes emerged in the process of reviewing the literature, which provided a scaffold for the review. This review supplied the evidence which guided the development of the research question and choice of methodology.

Chapter three: Methodology. This chapter explains the rationale behind the choice of approach for this research, an explanation of the methodology, ethical considerations, and descriptions of how trustworthiness and validity are ensured. An interpretive descriptive approach (Thorne, 2016) with semi-structured interviews for data collection, was the preferred approach for this study. A ‘Hui Process’ (Lacey et. al., 2011) was used to guide the interviews to provide a cultural lens in the context of Aotearoa.

Ethical considerations included considerations and contingencies to mitigate safety concerns for participants, researchers, and employers such as
vulnerability, potential for harm, privacy and confidentiality of personal information and data collection, analysis, and informed consent. Socio-cultural considerations are discussed in addition to the decision on inclusion criteria for participants and the recruitment process. The data gathering and data analysis methods are then discussed with descriptions of how validity and trustworthiness were ensured.

Chapter four: Findings. The participants demographics are described followed by the participants responses. This data was reviewed, and a thematic analysis resulted in the evolution of thirteen themes. These were then narrowed down further to five themes which are described in the findings in detail.

Chapter five: Discussion. Following on from the findings, the discussion considers the ‘so what’s’ of the research. The discussion takes a deeper dive into the experiences of the participants. Some expected and unexpected outcomes are considered with literature to support the discussions. The ‘now what’s’ are then discussed including study limitations, future research opportunities and implications arising from the research.

Chapter six: Conclusion. This chapter concludes the thesis. It describes the answer to the research question plus takeaway contributions that this research has made to knowledge in the area of new graduate occupational therapy experiences in rural practice from the context of Aotearoa.
Chapter Two

LITERATURE REVIEW

A review of literature related to rural practice from the perspective of a new graduate occupational therapist was undertaken to provide an evidence base, background, and context in relation to the research question: “What are the experiences of new graduate occupational therapists in rural practice in Aotearoa?”

A literature search was completed by inputting key words into several databases. Key words included: occupational therapy, allied health, new graduate, rural practice and rural generalism. The databases used were Academia.au, CINAHL, Cochrane Library, Google Scholar, Ministry of Health Publications, Otago Polytechnic Research Repository (OPRES), OT Seeker, ProQuest, Pub Med and Rural and Remote Health. Relevant literature from Aotearoa and internationally were included. Documents pertaining to current local and global socio-political issues including chronic staff shortages and equity concerns within rural health practices as well as recent health reforms in Aotearoa were also examined.

The literature reviewed includes perspectives of medical and allied health professionals, consumers and whānau (family) as well as legislative documentation, historic references, and contemporary programs for the development of collaborative rural practitioners and the concept of rural generalism.

Six topics emerged from the literature review:

1. Defining new graduate.
2. Preparedness to practice.
3. What is rural health practice?
4. The generalist versus specialist debate

5. Rural generalism.

6. Recruitment and retention in hard to staff areas.

The following literature review introduces these themes.

1. Defining new graduate

The concept of ‘New Graduate’ and how long this state exists is debateable. Different organisations and professions view it from various perspectives. A simple definition of graduate can be found in any dictionary such as the Collins English dictionary, (n.d.) “In Britain, a graduate is a person who has successfully completed a degree at a university or college and has received a certificate that shows this.”

The Definition of ‘New’ as per the Cambridge Dictionary (n.d.) is “recently created or having started to exist recently.” So, we could assume that a new graduate is someone who recently successfully completed a degree. But how long this state exists is less definitive.

In a description of the stages of clinical competence from a Nursing Theory perspective, Petiprin (2020) describes Benner’s five stages of competence (Benner, 1984). These stages are based on the Dreyfus Model of Adult Skill Acquisition. Dreyfus (2004) summarises the five stages that Dreyfus and Dreyfus originally developed in 1980. This model has been used for decades in organisations such as the United States Airforce, science and industry but is considered equally relevant to nursing theory and continues to be applied today.

model, new graduate, or novice nurses are not expected to work in an autonomous way, their levels of developing skills are acknowledged, and they begin their professional development by following a prescribed list of tasks with set rules and routines. As the nurses move through the stages of skill acquisition, they develop more abstract skills and knowledge that allows for analysis of situations with less focus on following the set rules as they become more experienced.

Whilst the development of skill acquisition is utilised in nursing theory, this model does not define the concept of ‘new graduate’. It can be assumed, however, that a new graduate might begin at stage 1 in terms of competence, but questions such as how long a new graduate status remains and how relevant this is to occupational therapy are not answered by these stages.

Murray et al. (2020) developed a theory of how early career occupational therapists learn once they are practicing. In this study, early career occupational therapists were defined as being “in their first four years of practising” (p.471). This learning theory is described in terms of four learning thresholds and strategies: “Learning Threshold 1: Consolidating professional reasoning, Learning Threshold 2: Navigating into the workplace, Learning Threshold 3: Building competence and confidence, Learning Threshold 4: Developing a personal theory and practise style” (p.473). These learning thresholds co-exist, rather than following stages of progressing development, but allow the early career occupational therapist to develop skills and strategies to navigate each of the thresholds. This study recognises the need for support and supervision alongside opportunities for reflection and collaborative learning while developing a sound professional identity.

In Aotearoa, Te Whatu Ora - Health New Zealand, previously known as District Health Boards (DHBs) require new graduate nurses to complete Nurse
Entry to Practice (NETP) and Nurse Entry to Special Practice (NESP) programmes when they begin their nursing career (Manatū Houora, Ministry of Health, 2019). In mental health and addictions services, occupational therapists are also required to complete a New Entry to Specialist Practice (NESP) programme through Te Pou, a national workforce center for mental health, addiction, and disability in Aotearoa (Te Pou, 2022). This occurs during their first-year post-graduation and is designed to increase their confidence and develop effective clinical practice to provide services in mental health and addictions.

There are no other requirements for new graduate occupational therapists in Aotearoa other than the Occupational Therapy Board of New Zealand (OTBNZ) scope requiring weekly supervision for at least the first 12 months of practice.

The New Zealand Accident Compensation Corporation (ACC) hold several contracts to support people who require medical and allied health services because of injury from accidents. The ACC website (acc.co.nz, n.d.) describes the contracts and services they provide. Contracts differ regarding the years of experience required and the level of support needed to practice. To work as an occupational therapist in the areas of concussion and pain management, a clinician must have more than two years of postgraduate experience in that field of work with additional support and supervision provided. In Vocational Rehabilitation, a new graduate can work but require extensive support and supervision.

Whilst there are currently few requirements, frameworks, programmes, or post-graduate training specifically for new graduate occupational therapists, the OTBNZ are developing standards in specialist areas such as rehabilitation, driving assessment and hand therapy. Regular updates on these are provided
to practicing occupational therapists and on the OTBNZ website (otbnz.org.nz, n.d.). This does not, however, answer the question of when a new graduate is no longer a new graduate, or what training is required to demonstrate competence as an occupational therapist in a specific clinical area such as rural health or rural generalism.

Rural health currently does not have any requirements for additional training or experience for allied health practitioners in Aotearoa. In other countries, such as Australia, Rural Generalist Allied Health Frameworks exist. These are described by The Greater Northern Australia Regional Training Network (GNARTN, 2013), and in the Rural Generalist in Allied Health Professions Resource 2 document from Services for Australian Rural and Remote Allied Health (SARRAH, n.d.) In both documents, training and experience with support and supervision are required to work in rural practice.

Experiences of newly graduated occupational therapists have been studied in several contexts. Moores and Fitzgerald (2017) completed a literature review to better understand support needs for effective transition to practice. A grounded theory study to develop learning thresholds for early career occupational therapists was completed by Murray et al. (2019), who used purposeful sampling and semi-structured interviews. This study included three participant groups, occupational therapists who support new graduates, early career occupational therapists and experienced occupational therapists (more than 10 years of experience) to develop four learning thresholds that make up the theory of learning to practice. Turpin et al. (2021) completed an Interpretive Descriptive study of experiences of new graduate occupational therapists within a large metropolitan hospital occupational therapy department in Australia, utilising semi-structured interviews to capture their experiences so that tailored support and training structures can be developed.
New graduate occupational therapist experiences specifically in rural health have been studied by Devine (2006) in rural Queensland, Lee and Mackenzie (2003) in rural New South Wales, and Gray et al. (2012) in Australia and Aotearoa. But whether the newly graduated occupational therapists are described as ‘new graduates’, ‘newly graduated’, or ‘early career’ the definition remains unclear, and literature differs from utilising one to five years post-graduation for research purposes.

A ‘new graduate’ could then be defined as a therapist who has newly qualified with a degree and registration. The length of time a therapist remains in that state of ‘newness’, ‘novice’, or ‘early career’ however, depends upon the person, context, role, and scope they are working within, and the support and further education required to be competent to work in that specific area.

2. Preparedness to practice

Preparedness to practice is a concern for educational institutions, regulatory bodies, health providers, students, and people receiving occupational therapy services. OTBNZ completed an examination of preparedness for practice of New Zealand new graduate occupational therapists in 2011. OTBNZ required occupational therapists to demonstrate competence in the following seven areas in 2011 to gain their certificate to practice in Aotearoa (OTBNZ, 2004).

1. Implementation of Occupational Therapy
2. Safe, Ethical, Legal Practice.
3. Culturally Safe Practice.
5. Management of Self and People.
6. Management of Environment and Resource
7. Continuing Professional Development.
In “An Examination of the Preparedness for Practice of New Zealand New Graduate Occupational Therapists” report for OTBNZ, Nayar et al. (2011) found that these competencies were comparable to overseas competencies. There were concerns, however, regarding some areas of professionalism including behaviour, ethics, morals, and attitudes, and only 9.3% of New Zealand new graduates felt well prepared for practice. Clinical gaps in Aotearoa compared to international data included interprofessional education and effective support for successful transition from student to professional. This resulted in the condition for weekly supervision for new graduate occupational therapists being established.

Since 2011 interprofessional practice has been recognised as an area requiring improvement and intervention (Halle et al., 2018; Haruzivishe & Chipamaunga, 2019; and Robertson & Griffiths, 2009). Halle et al. (2018) reviewed trends and updates relating to occupational therapy in primary care and recognised that, as a profession, occupational therapists should be able to articulate their role effectively and to demonstrate their particular value outside their profession, such as within an interdisciplinary team. This could be a challenge, however, for a new graduate, still consolidating their learning (Robertson & Griffiths, 2009) and understanding their place in the interprofessional team. Haruzivishe and Chipamaunga (2019) noted that interprofessional education is however, increasingly being recognised as a way of teaching collaborative practice competencies and interprofessional practice skills.

Robertson and Griffiths (2009) studied reflections of occupational therapy graduates from New Zealand regarding their preparation for practice. Using a qualitative descriptive approach and focus groups, this study indicated that graduates were unclear about the roles and responsibilities of their team members, and they lacked confidence in themselves. However, sourcing
information and researching answers when they were unsure were considered strengths and were described as “the shift from knowing about to knowing how” (p. 130).

A study of new graduate occupational therapists’ feelings of preparedness to practice in Australia and New Zealand was completed by Gray et al. (2012). Their findings indicated no statistically significant differences between age, geographical location, registration status and feelings of preparedness in their participants. The highest-ranking areas of preparedness were developing client centred goals, effective communication, confidentiality, and ethics. In general, there were more feelings of competence in areas that involve “managing inwards” such as interpersonal skills, assessment, and intervention rather than “managing outwards” i.e., interactions with other professionals and using evidence and resources. Feelings of competence in clinical areas and profession specific skills were stronger than interprofessional interactions and evidence-based practice or utilising clinical reasoning skills. It is therefore unsurprising that only 13.8% of those working in rural and remote areas, who are more likely to be in isolated roles or working as sole practitioners, felt only somewhat prepared or not prepared at all compared to 16.3% in metropolitan areas.

The OTBNZ report by Nayar et al. (2011) also found that new graduates perceived strengths were in the areas of communication and continuing professional development with comments from participants in the focus groups stating that many new graduates were good at reflecting, which could be compared to the ‘managing inwards’ described by Gray et al. (2012) and strengths in terms of sourcing information and researching answers noted by Robertson and Griffiths (2009). Areas of perceived weakness according to Nayar et al. (2011) were more around implementation of occupational therapy and management of the environment and resources. This supports the concept
of ‘managing outwards’ as areas that new graduates felt less competent in, as described by Grey et al. (2012). Robertson and Griffiths (2009) also found that lack of confidence was related to lack of clarity regarding roles and responsibilities of the new graduates and their team members but did not include external environmental or resource management issues noted by Nayar et al. (2011).

Lee and Mackenzie (2003) included “Becoming an occupational therapist” (p.39) as a theme in their analysis of new graduates in rural practice. Although this was a small study, a significant outcome was that participant’s lack of confidence in their skills and knowledge as new graduates was comparable to their urban peers. Gray et al. (2012) also found that reduced confidence in knowledge and skills as a new graduate was not changed by environment. It was recognised, however, in both studies, that while rural practice provides opportunities for a broad range of clinical experiences, there was an increased demand for feedback and support from other health professionals in the absence of profession specific support and supervision.

Access to support and supervision is considered an important factor regarding the transition to becoming an occupational therapist noted by Lee and Mackenzie (2003) recognising that, without this, the transition could be more difficult. This is also noted by Moores and Fitzgerald (2017), Murray et al. (2019), Robertson and Griffiths (2009), and Turpin et al. (2021) who also note the feeling of being overwhelmed as a new graduate. In addition, Lee and Mackenzie (2003) comment on the possibility that limited access to experienced occupational therapists in rural areas, could increase the need to seek support from the wider interprofessional team. “Participants who were dissatisfied with the support available to them found contact with other professionals useful.” (p.40).
A potential issue relating to a lack of access to occupational therapy specific support for new graduate therapists is noted by Pighills et al. (2019) who describe occupational therapy service delivery as being driven by the problem identified on the referral rather than a comprehensive occupational therapy assessment. This mixed methodology study was looking specifically at falls prevention assessments utilised by occupational therapists in rural Australia, but recognised that, without effective support and supervision regarding occupational therapy specific service delivery, there is a potential risk that intervention could be limited by the knowledge of the referrer or the interprofessional team.

In relation to this issue of therapy services being ‘driven’ by the interprofessional team, Fortune (2000) describes the concept of occupational therapists as ‘gap fillers’ and observed that a lack of clear identity, especially in new graduate occupational therapists can result in a tendency to “accept the identity imposed upon them by their workplace colleagues” (p. 229). Given that a new graduate is likely to have a lack of confidence in their skills and abilities (Roberts & Griffiths, 2009), their competence as a practising therapist could be dependent upon the understanding of the occupational therapist role by their colleagues. This was described by Fortune (2000), who interviewed occupational therapists working in child and adolescent mental health services in Britain. It was clear in this study that there needed to be a sound framework to prevent the therapists from becoming “philosophically lost” (p. 229). In the absence of experienced occupational therapy professional support, there is a risk that the occupational therapy role could fill the gap identified by the team rather than provision of occupational therapy specific interventions (Fortune, 2000).

Although Fortune’s study was written more than 20 years ago, and the clinical areas of mental health (Fortune, 2000), and falls prevention (Pighills, 2019), are
distinctly different, the issues of professional identity have not been resolved and remain valid, as described by Pighills et al. (2019).

3. What is rural practice?

The concept of ‘rural’ in a health context is unclear in Aotearoa, however Peterson et al. (2003) in a study of rural healthcare in Nebraska defined it as “open land of or relating to the country people or life, or agriculture” (p.56). While the New Zealand Health and Disability System Review (2020) acknowledge rural health as being more complex and include socio-economic and cultural considerations, distances and travel issues as well as difficulties with access to specialist services.

OTBNZ in their Occupational Therapist Workforce Report: “Making Sense of the Numbers” Stokes and Dixon (2018) state that around 14% of the New Zealand population live in rural areas. The West Coast, for example has a population density of approximately 1.4 people per square km compared to urban Christchurch which has 270 people per square km. Currently 26 hospitals in Aotearoa meet the New Zealand Medical Councils definition of ‘Rural Hospital’ and 1 in 4 New Zealanders live in or near rural small towns served by this network.

In the New Zealand Health and Disability System Review (2020) it is acknowledged that around 80% of a person’s health status is determined by factors outside health care services. The communities that have the poorest health outcomes often experience multiple economic, environmental, and social disadvantages, and rural communities are considered some of the most vulnerable in the country.
Lee and Mackenzie (2003) and Devine (2006) researched the experiences or perceptions of new graduate occupational therapists working in rural Australia. Lee and Mackenzie (2003) defined ‘rural’ according to population density and distance from urban centres, and Devine (2006) utilized the Accessibility Remoteness Index of Australia to define rural.

Providing occupational therapy services in rural areas is recognised as being different to urban practice with some barriers as well as positive aspects. Looking at the issues of access to therapy services for people with disability in rural Australia from the perspective of the carers, Gallego et al. (2017) conducted a cross-sectional survey and found that access to quality support from occupational therapy, physiotherapy and speech and language therapy was inversely proportional to the distance from an urban centre.

Gallego et al. (2017) also state that barriers to accessing specialist therapy services in rural areas include distance, time, and travel costs. These barriers to accessing services are similar to the issues noted by sole practitioners by Lee and Mackenzie (2003), however, Lee and Mackenzie (2003), viewed these barriers from the perspective of the new graduate occupational therapists rather than the caregivers or consumers and included limited resources, lack of access to training and development opportunities and support as disadvantages from a professional perspective.

Devine (2006) completed a similar study to Lee and Mackenzie (2003), in rural Queensland. Both studies used qualitative methodologies and semi-structured interviews. Devine (2006) discussed the issues of professional isolation and lack of support, but also the autonomy and creativity enabled in roles that include community engagement and a varied caseload. The graduates described the positives of rural practice with a focus on primary healthcare, health promotion and public health.
The diversity of the rural therapist caseload was viewed as an opportunity to build skills in a variety of clinical areas according to Roots and Li (2013). This meta-analysis of recruitment and retention of occupational therapists and physiotherapists in rural regions of Canada stated that some therapists see rural generalism as a good starting point in a career, where they can specialise later, having developed skills and knowledge in several clinical areas. Greater responsibility and personal autonomy are also seen as a bonus by Roots and Li (2013). Conversely, however, support was valued more highly than autonomy by Lee and Mackenzie (2003).

Lee and Mackenzie (2003) also cite the rewarding aspects of a varied caseload which provides the opportunity for diverse clinical experiences, the holistic nature of interactions with clients and the ability to socially integrate into the rural community. In an examination of turnover intention among early career nurses and allied health professionals in rural Australia, Cosgrave et al. (2018) describe this phenomenon as a reason for the high turnover rate of new graduate allied health professionals and has termed Australia’s rural public health services as “professional nurseries” (p.2) by graduates from cities.

Rural occupational therapists are more likely to be sole practitioners, travel long distances and receive less remuneration than their urban peers (Lee & Mackenzie, 2003). Peterson (2003) also noted extensive travel for occupational therapists working in rural Nebraska, this included distances of more than 100 miles (approximately 170 kilometres) per round trip, three to five days per week.

Defining ruralism and generalism, providing professional support, and developing confidence were considered areas for improvement by Lee and Mackenzie (2003), as well as strategies to reduce feelings of professional isolation. Pighills et al. (2019) also recognise professional isolation as an issue
as well as fiscal and geographical constraints of covering large rural areas as noted by Gallego et al. (2017) above, and the sociocultural diversities of the communities being served also documented in the New Zealand Health and Disability System Review (2020).

The biggest barrier to rural service delivery noted by Pighills et al. (2013) was time, including time for completion of paperwork as well as availability and time taken to access equipment and facilitate modifications from outside agencies. This corresponded with the caregiver experiences from Gallego et al. (2017). Participants in the study by Pighills et al. (2019) recommended that a core group of experienced occupational therapists for peer support as well as education to the referrers are possible solutions to the barriers created by the issues related to time and access to services, equipment, and modifications.

4. The generalist versus specialist debate

The generalist versus specialist debate in occupational therapy has been ongoing for decades in both mental and physical health arenas.

Foto (1996, p.4) stated that these conversations have been happening since the 1950’s. She summarised the issues with four questions which remain relevant today and argues that the answer will flow from the following questions:

i. What is each professional’s product?

ii. What is the process by which each produces it?

iii. What knowledge, skills, and judgment do each need to competently produce the product?

iv. Under what circumstances and conditions and at what point are each required to assure a quality product?
To answer these questions from the perspective of a recent literature review, understanding the professional’s product is key to determining generalism, however, literature considers generalism in different contexts.

The process could include working across disciplines. ‘Transdisciplinary practice’ is one area commonly discussed in mental health where case management and key worker roles are performed by several disciplines. Fox, (2013), and Lloyd et al. (2004) discuss the evolution of generic working in mental health.

In terms of the knowledge, skills and judgement needed to competently produce the product, Fox (2013), and Lloyd et al. (2004) conclude that, while generic or generalist working is the primary practice, mental health professionals should be clear about their profession specific roles and unique approaches in order to prevent issues around professional identity, efficacy, team dynamics, collaborative service delivery and client care.

More contemporary circumstances and conditions required to assure a quality product are being addressed through interdisciplinary practice, interprofessional education and collaborative practice. These terms are becoming more prevalent in the context of health service provision in Aotearoa and are superseding the use of the term multi-disciplinary team. Haruzivishe and Chipamaunga (2019) in their concept paper regarding interprofessional education describe the terms. From their perspective, multidisciplinary practice involves several distinct disciplines, or professions working alongside each other, interdisciplinary practice also includes different professions working together but with some interaction between them, and interprofessional practice is more cohesive and collaborative in nature in order to meet the needs of the patient.
Whilst interprofessional practices are regarded as a positive step forward for improved health and wellbeing by bodies such as the World Health Organisation (WHO, 2010), and in the New Zealand Health and Disability System Review (2020) issues of role definition and boundary blurring may become more prevalent. Gray et al. (2011) concluded that boundary blurring, and limited managerial support resulted in feeling like a “Jack of all trades and master of none” (p.1701) as well as fearing a loss of professional skills and knowledge. Peterson et al. (2003) also discussed the concept of being a ‘Jack of all trades’ with occupational therapists in rural healthcare in Nebraska and recognised the need for a broad general knowledge base to provide effective services across vast practice areas in rural practice in contrast to being able to develop specialist clinical skills in urban areas.

When Fortune (2000) discussed the difficulties of maintaining an identity as an occupational therapist, particularly in isolated or sole practitioner roles, she described gap filling as a reality for therapists who practice as “competent all-rounders… with a willingness to take on anything.” (p. 229). This could be due in part to being unable to articulate the role of an occupational therapist within an interprofessional team. Halle et al. (2018) recognised the importance of effectively communicating the occupational therapist’s role and contribution to the interprofessional team, as well as understanding the role of others within the team in primary care. A resultant of taking on roles that others impose on an occupational therapist is that consumers, whānau and communities might not benefit from the unique and specific philosophy of occupational therapy (Fortune, 2000), and the therapist may not have opportunities to increase those profession specific skills and knowledge base (Halle et al., 2018).

A lack of experienced therapists or specialist skills is noted by Gallego et al. (2017) who found that carers of people with a disability in rural Australia
believe that access to timely allied health intervention can prevent more severe or complicated conditions but are frustrated by the lack of choice and availability of specialist services. The need for specialist services continue to exist for people with complex or specific conditions, their whànau and community (Gallego et al., 2017). Meeting these specific needs could be addressed by answering Foto’s (1996), first three questions: “What is each professional’s product? What is the process by which each produces it? What knowledge, skills, and judgment do each need to competently produce the product?” (p.4)

Being able to understand the role of the occupational therapist, articulate this to others and provide this service effectively is more complex than it seems. Mary Reilly, one of the early pioneers of the profession of occupation posed a similar thought. She hypothesised that “Man, through the use of his hands as they are energized by mind and will, can influence the state of his own health” (Reilly, 1963, p. 6). She recognised that a profession based on this hypothesis has huge potential for growth, but “if we wish to exist as a profession, we must identify the vital need of man which we serve and the manner in which we serve it.” (p.10).

Almost 60 years on, occupational therapists continue to be striving for an identity as a profession and to meet the needs of people through occupation as a therapeutic intervention to enable occupation as the outcome. Reilly (1963), discussed this concept as the importance of occupation and postulated that “…the logic of occupational therapy rests upon the principal that man has a need to master his environment, to alter and improve it.” (p. 14). The World Federation of Occupational Therapy (WFOT, 2012) describe occupational therapy as “a client-centred health profession concerned with promoting health and wellbeing through occupation.” (wfot.org). The Occupational Therapy Board of New Zealand (OTBNZ, n.d.) define occupational therapy as: “the art and science of helping people take part in everyday living through their occupations.”
Whilst these definitions are accurate and make sense to occupational therapists, it could be argued that the definition of occupational therapy remains vague to those who are less informed. Role clarity was an issue in the 1960’s and remains an issue, especially for new graduates as noted by Robertson and Griffiths (2009).

Returning to the generalist versus specialist debate, WFOT, in their “Position Statement for Specialisation and Advanced Occupational Therapy Competencies” (2014) require that there must be a structure in place to recognise specialist competencies and accredit them accordingly. However, this statement also notes that “most associations and countries do not have a system or recognise advanced competencies.” (p.1). This begs the question, how do you recognise specialist or advanced areas, without structures in place to measure these? This question was also mentioned by George et al. (2019). Therefore, the generalist versus specialist debate continues, and the definitions for both remain unclear.

5. Rural generalism

Generalism in rural health is a hot topic at the present time, with research and projects designed to build understanding and develop definitions both from national and international perspectives. George et al. (2019) suggest that rural generalist practice is a “better focus” (p.4) for allied health professionals in rural practice. Much of the evidence, however, has been completed through a medical lens (Cosgrave et al., 2018), and within the context of health service reforms, rural generalism is regarded as a potential solution for rural health service provision in Aotearoa (Nixon, 2018).

Australia has been leading the development of rural generalism as a framework for professional development in allied health. The resource document for Rural Generalists in the Allied Health Professions from Services for Australian Rural and Remote Allied Health (SARRAH, n.d.) describes the
rural generalist allied health professional as “a position or practitioner that responds to the broad range of healthcare needs of a rural or remote community” (p.1) and has established a Rural Generalist pathway which includes a formal education program, workforce policy and employment structures and rural generalist service models. The Greater Northern Australia Regional Training Network (GNARTN) completed an allied health project regarding Rural and Remote Generalist Practice in December 2013. The aim of the project was to support the development of training programs for allied health professions to meet the needs of rural and remote communities in Northern Australia. It is acknowledged in this report that there is an assumption that generalism is the preferred workforce model for rural and remote healthcare, but that there is a lack of specificity regarding what it entails.

GNARTN (2013) describes rural generalist practice as “providing services across the lifespan, for a wide range of health needs or across the continuum of care” (p. 9). This project focused on skills sharing across allied health disciplines, using the Calderdale Framework as a method of determining which skills can be delegated and/or shared with other disciplines to meet community health needs in rural and remote regions. This has also been utilized in Aotearoa and referenced in George et al. (2019).

The Calderdale framework was developed in the United Kingdom (UK) as a model of skills sharing safely across disciplines and supporting unregulated staff in the provision of some therapeutic interventions that can be delegated or shared to improve service delivery. This was adopted by GNARTN in 2013 and in Aotearoa in 2015. The South Island Alliance, which was made up of Directors of Allied Health from the District Health Boards in the South Island of Aotearoa, prior to the health service reform in 2021, completed a position statement, signed by all Allied Health Directors which
…recognised the value of the Calderdale Framework model of care for service re-design in Allied Health Scientific & Technical practice settings, including its potential in achieving service improvements and in maintaining a motivated and appropriately skilled Allied Health Assistant and Allied Health practitioner workforce. (SI Alliance, 2015 position statement).

To date, Aotearoa does not have postgraduate training specifically in rural generalism for allied health professionals, but interprofessional education student programs have been developed. These programs provide integrated student placements for senior health professional students from many disciplines, medical and allied health to develop practice ready staff able to work collaboratively on graduation. The Occupational Therapy New Zealand Whakaora Ngangahau (OTNZ-WNA) position statement on Interprofessional Education and Collaborative Practice (2016) describe interprofessional education as: “...an essential step in developing a practice ready workforce which enables effective collaboration and improves health outcomes…it occurs when two or more people from different professions learn with, from and about each other.” (p.1)

The World Health Organization (WHO) Framework for Action on Interprofessional Education and Collaborative Practice (2010) document indicates that 50 years of research has demonstrated that “effective interprofessional education enables effective collaborative practice.” (p. 7). The first Interprofessional Education program in Aotearoa was developed in Tairāwhiti, Gisborne in 2012 through the University of Otago, Wellington, the District Health Board, and the local community (Otago, n.d.). A second is now running on the West Coast (Otago, n.d.). WHO (2010) view the process of interdisciplinary education, practice, and collaboration as a strategy to help improve the “global health workforce crisis.” (p.7). The goal is that future health workers will emerge from interprofessional placements ready to work cooperatively and in partnership with other health professionals.
Roots and Li (2013) acknowledge that rural healthcare is becoming recognised as a specific area with unique challenges. Pighills et al. (2019) stated that occupational therapists in rural and regional settings are required to be “multi-skilled generalists with a wide range of practice knowledge.” (p.348). In Canada, as in other rural areas, a poorer health profile in rural communities with an aging population and increased prevalence of chronic disease and traumatic injury results in proportionately greater demand for health services such as medical rehabilitation and health promotion (Roots & Li, 2013). This is also noted in the New Zealand Health and Disability Service Review (2020).

In a survey of staff in rural hospitals in Aotearoa regarding sedation and analgesia, Kiuru et al. (2021) note that staffing levels in medical, nursing, and allied health are proportionately lower in rural areas. They also recognise that there is no current framework to define minimum standards for rural generalist practice, however, an interprofessional approach which includes the composition and competencies of the team may be more important than the individual practitioner. George et al. (2019) also indicate that rural generalist practice could be a future focus of health delivery in Aotearoa alongside interprofessional practice.

6. Recruitment and retention in hard to staff rural areas

The ‘global health crisis’ is often referred to when considering staffing in rural health areas (Berg-Poppe et al., 2021, Cosgrave et al., 2018; Roots & Li., 2013). Recruitment and retention issues are commonly stated in relation to rural health. Campbell et al. (2016), Cosgrave et al. (2018), Dolea et al. (2010), and Roots and Li (2013) discuss similar themes which demonstrated the value of personal lifestyle preference, family, and personality traits in the drive to seek recruitment into rural positions. Common causes of attrition included lack of professional support, management issues and limited professional development.
Cosgrave et al. (2018) state that being able to attract and retain experienced allied health professionals is one of the greatest challenges currently facing Australia’s rural and remote public health services. This study identified that allied health professionals are twice as likely to leave their rural or remote position than medical practitioners such as doctors and nurses. The short average tenure of allied health professionals in rural practice is concerning, both for the therapists and the communities they support.

In an effort to research both recruitment and retention issues, Campbell et al. (2016) sought to understand how allied health professionals construe the role of the remote workforce by studying the influences of personality traits, comparing rural and urban case studies and how these perceptions enhance recruitment and retention. Indicators of rural and remote workforce potential included positive self-assessment fit, realistic construing of remote working, satisfaction in their role, lower harm avoidance, and elevated novelty seeking. Having a rural background, or family/partner preferences were factors that supported successful recruitment and retention into rural roles, also noted by Nixon (2018).

In contrast, Dolea et al. (2010) looked at more extrinsic factors to analyse the effectiveness of strategies and interventions to address the lack of health care workers in rural and remote locations. They found that there were four dimensions that have a direct effect: attractiveness of rural/remote areas for students and health workers, recruitment, retention, and health workforce or health system performance. A significant gap was noted regarding targeting health workers other than medical or physicians with a recommendation of focus on health teams and situational analysis to be included in policy decisions. This would correspond to the current focus on interdisciplinary practice and collaborative working (WHO, 2010).
Looking at both extrinsic and intrinsic factors in a meta-synthesis of evidence from qualitative studies regarding recruitment and retention of occupational therapists and physiotherapists in rural regions, Roots and Li (2013) focused on proximity to family, desire for rural lifestyle and attractiveness for job opportunities for the spouse, career and family ties as the attractors. The main attrition factors included management structure and lack of professional support and development. This was also noted in the turnover intention theory, used by Cosgrave et al. (2018). Their findings indicated that the decision to leave or remain in a job was determined by the role meeting life aspirations as well as the gap between personal expectations of the position and lifestyle versus the reality. The greatest indicator of turnover intention was professional experiences, specifically relating to the job role, workplace relationships and level of access to continuing professional development. Whilst the outcomes of studies completed by Berg-Poppe et al. (2021), Cosgrave et al. (2018), and Roots and Li (2013) corroborate the importance of lifestyle and career development in recruitment and retention of allied health workers in rural practice, Dolea et al. (2010) state that “there is frequently a lack of coherence between the proposed retention strategy and the factors that matter for health workers in their choice for location.” (p.383). This indicates that although the factors that affect retention to rural positions are known, the retention strategies used do not reflect the needs of the workforce.

Limited access to professional development within different organisational structures is also discussed by Roots and Li (2013), particularly evident if your manager is from a different discipline. Opportunities to develop skills and knowledge into more specialist areas of practice are limited in rural areas due to the lack of population and therefore exposure to clients with specific complex conditions (George et al., 2019). This is exacerbated by a manager that may not understand your profession or value of specific training for
professional growth (Cosgrave et al., 2018; Roots & Li., 2013). This can have an effect on the retention of therapists wanting to develop professionally or have the opportunity to specialise in particular areas of practice (Dolea et al., 2010).

Woolley et al. (2020) completed a cross sectional survey of medical students from a school in Canada compared to a school in Australia. Specifically, they were studying the association between postgraduate training location and a doctor’s practice location post qualification. The geographic maldistribution of urban over rural medical practice worldwide is discussed, and the findings support increasing medical graduate training numbers in rural, underserved areas. Effectively flipping the current training models of outreach from urban centres, to basing speciality trainees in rural or regional clinical settings and rotating into the cities.

Recruiting and retaining allied health staff in rural and remote locations is an issue and social, cultural, and professional considerations have been studied in this regard (Campbell et al., 2016; Cosgrave et al., 2018; Dolea et al., 2010; George et al., 2019; Roots & Li, 2013; Woolley et al., 2020). This literature indicates that there should be greater focus on team working, support and professional development.

**Conclusion**

Contemporary studies such as George et al. (2019) and Nixon (2018) in his Address for the Eric Elder Medal RNZCGP Conference show that the generalist versus specialist debate continues. They recognise the demographics of rural Aotearoa and that rural generalism should be acknowledged as an advanced scope of practice. Frameworks exist in Australia, Canada, and UK, and are perceived as imperative in the development of rural health practices (SARRAH, n.d.). It is acknowledged that
the current models of care are not sustainable, and Aotearoa is adopting some initiatives such as interprofessional education and the Calderdale framework which supports role sharing and delegation (George et al., 2019; WHO, 2010).

George et al. (2019) describe the difficulties associated with maintaining competencies in multiple specialisms and suggest that rural generalism could be a better focus for Allied Health Professionals but raised the question “how does rural generalism become an advanced scope in its own right?” (p.4). While Nixon (2018) is specifically referencing general practitioners, he recognises that rural doctors are only halfway to becoming competent to practice on graduation. This concept of supporting advanced scope or ensuring a competent level of practice is equally relevant to occupational therapists practicing in rural Aotearoa.

Interestingly, despite recurrent themes such as the need for professional support and supervision, peer support, and professional development for effective retention and development of allied health professionals, acknowledged by Halle et al. (2018), Lee and Mackenzie (2003), Murray et al. (2019), and Robertson and Griffiths (2009), rural health services are recruiting new graduates into allied health positions in Aotearoa (George et al., 2019).

Aotearoa is in the process of some radical changes to the delivery of health services at the present time (New Zealand Health and Disability System Review, 2020). There are also developments in the definition of ‘rural’ from a health perspective and a focus on interprofessional education and interdisciplinary working is becoming more prevalent and may provide some needed support for new graduates (Haruzivishe & Chipamaunga, 2019; WHO, 2010). However, to begin to address the question of what supports are needed for new graduates, we must first comprehend the experiences of the new graduates in rural practice and understand what strengths, issues, barriers,
and gaps exist in the present structure. Therefore, this study asks the research question: “What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa, New Zealand?”
Chapter Three

METHODOLOGY

Introduction

This chapter looks at the options available and the strategies used to answer the research question. The choice of methodology and approaches used will be discussed and justified alongside the measures taken to ensure the trustworthiness of this research. The process of ethics approval, recruitment of participants, data gathering, data analysis and validity is explained with some examples of the process as it unfolded.

The Research Question

Having worked alongside and supported new graduates as an experienced occupational therapist in rural practice in Aotearoa, in addition to completing a related literature review, the following research question evolved: “What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa?” The aim was to better understand the actual experiences and perceptions of new graduate occupational therapists recruited into rural practise.

Study Design Methodology

Both qualitative and quantitative methodologies were considered for this study. According to Ellis (2014), a quantitative paradigm is generally used to “investigate and demonstrate cause and effect relationships” (p. 118). This methodology tends to rely on large numbers of participants and uses statistics to provide evidence to support or disprove a hypothesis. This is often the preferred methodology in science and medicine.
In contrast, a qualitative methodology requires an in-depth probe into personal experiences. These descriptions then provide the raw data for the research which could answer the above stated research question.

A quantitative methodology would not provide the type of personal, detailed data required to meet the aim of this research. A qualitative methodology however could provide the deeper dive into feelings, attitudes, beliefs, and understandings of a small number of individuals that this study required. A mixed methodology, or triangulated approach as described by Thorne (2016) could provide a balance of both methodologies. It can, however, be difficult to balance the two opposing methodologies and these studies have tended to favour the quantitative paradigm (Thorne, 2016).

Bradley et al. (2007), concluded that research regarding health services is well suited to qualitative methods. Ellis (2014), also explained that qualitative methodology is better suited to the social sciences, considering the world view of participants and their personal experiences. The resultant conclusion was that a qualitative methodology was a much better fit for this study.

Historically, there are three main foundational qualitative methodologies, these being phenomenology, ethnography, and grounded theory but these did not seem to completely fit this study. Something more flexible was required. Kahlke (2014) discusses another category known as “generic qualitative research”. These approaches are not considered “methodologies” as they are not sufficiently strictly defined, but they are accepted as research approaches and offer opportunities for researchers to “play with boundaries, use tools that established methodologies offer and develop research designs that fit their epistemological stance, discipline, and particular research question” (Kahlke, 2014, p. 38).

Some challenges regarding the use of generic qualitative approaches are discussed by Kahlke (2014) who describes a longstanding debate regarding
rigour in qualitative research. Some have described these generic approaches as atheoretical and are concerned about an “incongruence regarding epistemological, theoretical, methodological and technical levels of research” (Kahlke, 2014 p. 42). It can be argued, however, that the opposite is the case and far from being atheoretical, in order to successfully complete generic qualitative research, the researcher must be well read and have a broad understanding of the range of qualitative methodologies (Kahlke, 2014).

To capture the experiences, thoughts, and feelings of new graduate occupational therapists in rural practice, a generic qualitative approach was chosen. However, two approaches fit into the generic qualitative research category: qualitative descriptive (Sandelowski, 2000) and interpretive descriptive (Thorne, 2016). Sandelowski (2000) suggests that the qualitative descriptive approach attempts to remain as close as possible to the original data to keep inferences and interpretations to a minimum. But to fully address the research question, this study required the flexibility and scope to interpret the experiences of the participants.

An interpretive descriptive approach was the qualitative methodology that was chosen because it uses an “inductive and flexible” approach as described by Fan et al. (2015). This approach provides the opportunity for an iterative process that could change and evolve throughout the research journey. It enables the researcher to gain in-depth data regarding participants opinions and experiences within a context which builds on and includes the knowledge and experience of the researcher.

**Interpretive Description**

Interpretive description was developed as a method of researching practical and social issues using a qualitative methodology. It can be used to better understand health issues from the perspective of those providing the service
and/or consumers of the services (Thorne, 2016). Whilst Thorne began developing this approach in 1991 specifically to answer research questions relating to clinical nursing practise, the opportunity for other health disciplines to gain practical, evidential research specific to their profession or discipline is significant.

Kahlke (2014) and Thestrup et al. (2021) both describe the evolution of the interpretive descriptive approach from traditional qualitative methodologies, utilising constructivist epistemological approaches such as grounded theory and naturalistic enquiry. These assume that knowledge is not absolute, but rather socially constructed and specific to those experiencing it. Interpretive description takes into consideration the context, situation and intent of the research and also draws from the experiences and knowledge of the researcher.

Thorne (2016) describes interpretive description as being by nature subjective and relying upon the researcher to determine the conceptualisations, themes, and relevancy of the data. Transparency, accountability, credibility, integrity, and the use of inductive logic by the researcher demonstrates the validity of the research. The data generated is detailed and constantly developing through an iterative process that creates a comprehensive understanding of the experiences of the participants. In interpretive descriptive studies, the “specific approaches generated by the researcher should be generated on the basis of what they are attempting to achieve beyond methodological precision or technical accuracy” (Thorne 2016 p. 112).

When designing this study, interpretive description was considered particularly pertinent due to the limited number of potential research participants working in rural areas in Aotearoa. Thorne (2016) recommends that five to ten participants provide sufficient information to gain rich research data.
Raw data is generated from experiences and opinions of the participants in context while recognising the experience, potential bias, and interest of the researcher. Open ended data is designed to capture emotive thoughts, feelings, and subjective information regarding a person’s experiences. The data gathered is not purely in ‘what’ information is provided but in ‘how’ it is given. It is then the researcher’s knowledge in the field of research that drives how the data is analysed and informs new knowledge in their specific area of expertise.

Using this approach, the researcher is invited to work on the pressing problems of his or her own disciplinary field and to generate credible and defensible new knowledge in a form that will ultimately be meaningful and relevant to the applied practice context. Thorne (2016 p. 58).

The ‘pressing problem’ in this study is support for new graduates working in rural practice within the bigger picture of addressing health inequities in a time of change and health reforms. The ‘new knowledge’ being generated is not relating to a single practice problem, but rather the new graduate experiences are being captured to provide evidence for a larger issue.

Semi-structured Interviews

Thorne (2016) describes interviewing as “the mainstay of qualitative health research for the past couple of decades” (p.136) but recognises that it has the potential for overuse and issues relating to subjective versus objective knowledge gained through interviews. There are, however, measures that can be implemented to “enhance quality” (Thorne, 2016, p. 139), such as fostering a relationship that allows and encourages detail, clarification, and reflection, and reduces the subjectivity and influence of the interviewer.

In order to gain sufficient information from a small number of individuals, semi-structured interviews were determined to be the most effective research
technique. Adams (2015) explained that there are several different ways of gathering information from people. Structured, closed-ended questions in the form of surveys are useful data gathering instruments for large samples, but this does not provide rich data specific to the individual or enable novel or unexpected information. In contrast, focus groups can provide opportunities to delve deeper into opinions, ideas and feelings. This, however does not provide the individualised responses required in this study and groups would not be possible due to the isolated rural roles being studied.

Semi-structured interviewing provided a balanced combination approach that allowed the in-depth responses from individuals with the capability of adapting and changing during the process of the interview. Some structure and planning allowed for the limitations and opportunities of interviewing via technology required due to the geographical locations of rural therapists.

DeJonckheere et al. (2019) recognised that semi-structured interviews are the most common type of qualitative research used in the healthcare context as they are effective when collecting open-ended data, they capture feelings, thoughts and beliefs and delve deeply into personal or sensitive issues.

In this study, semi-structured interviews were performed individually between the researcher and the participant using a Hui Process (Lacey et al., 2011). This provided a frame of reference as recommended by Thorne (2016). The Hui interview structure included:

1. Mihi: greeting
2. Whakawhanaungatanga: connection
3. Kaupapa: the content of the interviews
4. Poroporoaki: conclusion

A set of guide questions were developed as a starting point for the interviews to ensure bicultural elements were included. This was designed to provide a
cultural lens to encourage participation from occupational therapists in a variety of locations and organisations.

Interviewees were provided with the option of including a Karakia or prayer at the beginning and end of the interview and if so, whether they, or the interviewer completed it.

The guide questions consisted of open-ended questions relating to the area of work and experiences of the individual which, as per Dejonkeheere et al. (2019) and Adams (2018) enabling probing questions into the why, or what, and or delving into unexpected responses without leading the person.

Table one below shows guide questions from the Kaupapa section of the interviews:

<table>
<thead>
<tr>
<th>Guide Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you explain your role as an OT in rural practice?</td>
</tr>
<tr>
<td>(What does rural mean to you?)</td>
</tr>
<tr>
<td>Where are you working and how long have you worked in rural practice?</td>
</tr>
<tr>
<td>What attracted you to this position?</td>
</tr>
<tr>
<td>Can you tell me about your experiences during your first year in rural practice?</td>
</tr>
<tr>
<td>What opportunities have you had to develop your OT skills and knowledge?</td>
</tr>
<tr>
<td>What has been your experience from a bi-cultural perspective?</td>
</tr>
<tr>
<td>What have been the most positive and memorable aspects of this role?</td>
</tr>
<tr>
<td>If you could, what would you change?</td>
</tr>
<tr>
<td>From what you know now about the role, what advice would you give a new graduate OT just starting in this role?</td>
</tr>
<tr>
<td>What is your vision of OT in rural health in Aotearoa 10 years from now?</td>
</tr>
<tr>
<td>Do you have anything else you would like to share?</td>
</tr>
</tbody>
</table>
• Demographics: The interviewee will be asked about their ethnicity and
gender and how they identify themselves.
  a. Ethnicity: How do you classify yourself ethnically?
  b. Gender: How would you like to identify yourself?
  c. Age: 21-30, 31-44, 45 and above.

Consultation with the Kaitohutohu office recommended the inclusion of
demographics in the interview and it was decided that these questions should
be asked at the end of the interview in order to spend the time at the beginning
building connections with the Whakawhānaungatanga and putting the
interviewee at ease.

Ethics

Ethics approval for this study was granted by the Otago Polytechnic Research
Ethics Committee in May 2021 (Appendix 1). This included consultation with
the Kaitohutohu office (Appendix 2) which was essential to ensure the
interests of Māori were considered.

Specific considerations and contingencies were made regarding mitigation of
safety concerns relating to participants, researchers, and employers in the
areas of vulnerability, and potential for harm as well as privacy and
confidentiality of personal information and data collection and analysis and
assurance of informed consent.

Socio-cultural considerations

Culture and local context are essential elements of interpretive descriptive
studies. Many rural communities include lower socio-economic areas and
higher indigenous populations, however, unlike other indigenous cultures,
some rural regions in Aotearoa have fewer than the national average of Māori
residents. This can result in challenges when including the Māori world view in meaningful and relevant ways.

The joining of cultural ethical principles was included in the design of this study by considering the geographical diversity, socioeconomics, and bicultural implications of the areas of service provision as well as bioethical principles. This approach is recommended by The National Ethics Advisory Committee – Kāhui Matatika o te Motu (NEAC, 2019), where Māori principles of Te Ara Tika (to follow the right path): justice, culture, and equity are considered in conjunction with risk mitigation, informed consent, and respect.

The recent Pūrongo Whakamutunga (New Zealand Health System Review, 2020) recommends system level changes that “lead to better more equitable outcomes for all New Zealanders.”(p.3). The focus on equity is an important element in this study, which includes Māori as well as other rural and remote communities and cultures in the understanding of service provision.

**Participants and recruitment:**

Following ethics approval, cultural approval from consultation with Kaitohutohu Office and with guidance of two supervisors, objective recruitment of participants was achieved by sending a request electronically to all practising occupational therapists willing to participate in research through the Occupational Therapy Board of New Zealand (OTBNZ) (Appendix 3).

Utilising the OTBNZ to identify participants provided an objective and anonymous way to recruit participants while protecting them from potential coercion from the researcher.

Inclusion criteria for this study was that participants had a maximum of five years of experience in a rural area of Aotearoa having been recruited directly
into that role as a new graduate. The definition of ‘new graduate’ was contentious and dependent upon many variables, such as clinical areas of work, expectations of employers and the limited numbers of new graduate or novice therapists in rural practice. It was felt that up to five years of experience in the single role would provide a wide enough scope to include sufficient participants in this study.

Roles included generalist rather than specialist responsibilities, working across several clinical areas including District Health Board (DHB), Inpatient Medical, Orthopaedics, Acute Physical, Assessment Treatment and Rehabilitation (AT&R), Community, Mental Health, Primary Health Organisation (PHO), Non-Government Organisation (NGO), Paediatrics and Child and Adolescent Mental Health Service (CAMHS).

Six participants volunteered and met the criteria for inclusion in the study. All of the above clinical areas were covered, and participants lived and worked across diverse geographical regions of Aotearoa. The participant demographics are shown in table two in the Findings Chapter on page 52.

To ensure respect for mana tangata (personal autonomy), potential for harm for the participants, their employer, researcher, or host organisation was explained and documented in the participant information sheet (Appendix 4), which also provided detailed information regarding the study to ensure informed consent. Participants were given two weeks from acceptance into the study to consider their involvement and complete the consent form (Appendix 5).

Participants were informed regarding their right to decline to participate, or to ask questions at any time, mitigating the risk of distress to participant or researcher. Transparency and protection of welfare, trust, and integrity was
upheld through clear communication and adherence to privacy and confidentiality.

**Data gathering**

Subjective data is "foundational" to interpretive descriptive research (Thorne, 2016 p. 135), and in order to answer the research question effectively, it is important to get as near as possible to the experiences of the participants. Thorne (2016) recommends that the researcher understands the strengths and limitations of the data gathering strategy from the outset. In this study, the semi-structured interviews were conducted either in person or via technology. Zoom (a video meeting and communications platform) was used for remote, virtual interviews when it was not possible to meet in person and the interviews were recorded using Zoom plus digital audio recordings as a back-up.

Adams (2015) and DeJonckheere et al. (2019) recommend no more than one hour for an interview but acknowledge that time needs to be taken in building a rapport and establishing the relationship that encourages open responses without leading the individual. As recommended by the literature, each interview took forty-five minutes to one hour to complete.

Participant’s identities were required for the semi-structured interviews, however any identifying information provided during the research was removed during transcription and from any data gathered. Contingency was made (Appendix 6) for ensuring confidentiality should an intermediary be utilised in the process of this research.

To ensure the flow of the interview, following consent from the participants, data was collected via interview recordings through Zoom. The participants identities were protected by ensuring names were removed. Verbatim
transcripts were completed by Rev (an on-line audio transcription service) following the interview, then checked against the recorded interviews by the researcher. Rev guarantees privacy by ensuring files are secure and protected from unauthorized access and all staff have signed confidentiality and non-disclosure agreements. First names only were used in the interviews with no identifying information included for transcription.

Transcripts were corrected by the researcher where there were discrepancies in the transcripts to ensure they were a true representation of the interviews. Notes were also taken by the researcher during interviews to provide specific information to be captured for later reflection. Some medical terminology, accents or colloquialisms were not captured effectively by Rev and were manually edited from the recorded interviews and any names or identifying data such as specific place of work removed. While this added to the workload of the researcher, it helped with immersion into the data. As noted by Thorne (2016), in her opinion, using technology for transcribing data can result in losing attention to detail and nuances that can be interpreted more deeply when the researcher slows down and engages in the transcription process.

Raw data in the form of the verbatim transcripts were returned to the participants for member checking to ensure validation, credibility, and accuracy as described by Birt et al. (2016) within two weeks of the interviews. Participants were given two weeks to respond. All participants responded positively and accepted the transcripts as true representations of the interviews.

Opportunities for feedback and discussion between researcher and participants were encouraged for transparency and cross checking. In addition to these and the support and guidance from two research supervisors, the researcher conducted analysis simultaneously with data collection, using an
iterative, on-going process of comparison, inquiry, and interpretation. This provided verification strategies to support conceptualisations as they emerged as per Thorne (2016).

**Data Analysis**

Bradley et al. (2007) studied qualitative data analysis for health services research and stated that “*there is no singularly appropriate way to conduct qualitative data analysis.*” (p.1760) but recognised that the process is on-going and iterative. Thorne (2016) likened analyzing data to “*choosing how to display a deck of cards*” (p. 163). Using this analogy, the cards could be displayed according to the game to be played, but also by colour, number, suit, or many other ways. The goal is to find patterns or grouping that make sense of the data.

Braun and Clarke (2019) renamed their approach to Thematic Analysis as “*Reflexive TA*”, encouraging a subjective, reflective, flexible, and creative method of interpreting data. They describe the process of reflexive thematic analysis as more of a journey that embraces the assumptions and experiences of the researcher alongside the stories of the participants.

Following the process described by Braun and Clark (2019), raw data was thematically analysed via an evolving and reflective process. This began with immersion into the data to fully comprehend the responses of the interviewees.

The image below demonstrates full immersion into the data. The developing themes were displayed on the wall for interpretation and analysis.
More detail of the reflexive thematic analysis

Armed with several copies of the transcripts, some paper, scissors and glue stick, the written transcripts were reviewed in conjunction with the recordings of the interviews and literally cut and pasted into various themes which provided full immersion into the data.

This could have been achieved via technology, but the hands-on approach was preferred to facilitate a better understanding of the verbal responses in addition to intended meaning, context and/or what was omitted. It also provided a creative medium for a flexible and iterative approach to the data and development of themes. As per Bradley et al. (2007) themes emerged from
the rich detailed experiences of the participants which developed from the initial reactions, responses, learnings, and comparisons across the data.

Utilising this strategy for data analysis also allowed for a literal step back from the data in order to find patterns and relationships as described by Thorne (2016). The initial thematic analysis identified seventeen broad themes which were narrowed down to the five included in the findings. This process is demonstrated in the Findings Chapter, table three, page 53.

**Validity**

In interpretive descriptive research it is more difficult to measure or quantify the trustworthiness of the research due to the extent of personal bias and interpretation that is required. Thorne (2016) describes the notion of “probable truth” (p.238) when discussing validity and acknowledges that there are no complete truths nor is any research absolutely valid. However, measures to consider and improve validity have been put in place. These included support of two supervisors throughout the research process. The interview questions were also archived (see table, p. 40 and Appendix 7).

Accountability, credibility, and integrity were accounted for through the ethics process, ensuring safety for the participant and the researcher. For example, member checking of the transcripts of the interviews were completed by all six participants to ensure confirmability and credibility. All participants agreed that the transcripts were a true and accurate record of the interviews and consented to their inclusion in this study with interest in the research outcomes.

Accountability is also demonstrated by the audit trail that includes the ethics approval letter (Appendix 1), consultation with the Kaitohutohu office (Appendix 2), invitation to participate letter to OTBNZ (Appendix 3),
Participant information sheet (Appendix 4), consent form (Appendix 5), confidentiality agreement for intermediary (Appendix 6), interview questions (Appendix 7) and the pictures included in this chapter that evidence immersion and engagement with the data for thematic analysis.

Feedback, opportunities for cross checking data and discussion between researcher and participants were encouraged to ensure transparency and effective communication. Thorne (2016) encourages researchers to return their feedback to participants. Whilst the transcripts were returned for validation, the findings were not in this study due to time constraints.

Clarity in the development of themes and analysis alongside the iterative process and demonstration of inductive logic demonstrates the validity of the research. This is evidenced through the process of analysis and refining the original seventeen themes into the five discussed in the Finding Chapter.

The reliability of the themes is demonstrated by including direct quotes from the participants. The speaker of the quote is labelled alongside the quote to help with transferability back to the participants’ context, as well as demonstrating the range of views across the participants.

Thorne (2016) emphasises the importance of keeping focussed on the research question and the intended audience the “ultimate research purpose” (p.113). And that keeping these at the centre of the research process will provide validity and credibility. Returning to the literature and the original question has been essential in ensuring the validity of the research and in staying true to the intention of the study.

Summary

Preparation for this study began with an interest in rural practice and potential implications relating to the development of rural generalist practice.
Expectations of new graduate occupational therapists entering this field of practice were being developed alongside changing service delivery options within the context of health reforms in Aotearoa. This provided the drive to complete this research at this time.

Following a literature review, the research question was developed. The nature of the question led to consideration of research methodologies, methods and approaches. Ethics approval was applied for and granted, and the research began. Justification and explanation for the choice of research methodology and approach was discussed in this chapter, supported by literature and examples of how the research progressed.

An interpretive descriptive approach was the qualitative methodology of choice to provide the data that would evolve through the iterative process of semi-structured interviews. Sociocultural elements were considered alongside ethical considerations in order to ensure ethical standards were upheld, with the support of two research supervisors throughout the process.

The research question has been central to the research, and constant reference to the question has helped to ensure the trustworthiness of the interpretive descriptive approach to this study.
Chapter Four

FINDINGS

The aim of this study was to capture experiences of new graduate occupational therapists recruited into rural practice in Aotearoa. To answer the research question: “What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa?” This chapter explains the demographics of the participants and the findings from the semi-structured interviews which formed the raw data for the research.

Demographics

Despite the small sample size, participants worked in distinctly different clinical areas including physical health, mental health and paediatrics. Geographically they spanned the length and breadth of rural Aotearoa across both islands and employers included both District Health Boards (DHBs) and Non-Government Organisations (NGOs). They described their ethnicity and gender in their own ways according to their personal preferences. All identified as female, and described their ethnicity as New Zealander, Pakeha European, two identified as New Zealand European, one as New Zealand European Māori, and one New Zealand Pakeha. Three participants were aged twenty-one to thirty years of age, two thirty-one to forty, and one forty-five and above.

In the interests of privacy and to maintain confidentiality, the participant names and geographical locations are not included.
Table two below shows the participant demographics:

<table>
<thead>
<tr>
<th>Participant</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td>New Zealand</td>
<td>New Zealand, European, Māori</td>
<td>NZ</td>
<td>NZ</td>
<td>NZ</td>
<td>Pakeha</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Age Range</td>
<td>&gt; 45</td>
<td>31-44</td>
<td>21-30</td>
<td>21-30</td>
<td>21-30</td>
<td>31-44</td>
</tr>
<tr>
<td>Years practicing</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Setting</td>
<td>DHB</td>
<td>DHB</td>
<td>DHB</td>
<td>DHB</td>
<td>DHB</td>
<td>NGO</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Physical</td>
<td>Physical</td>
<td>Paediatrics</td>
<td>Physical</td>
<td>CAHMS</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Community</td>
<td>Community</td>
<td>Community</td>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rotation</td>
<td>Inpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital, inpatient, Private</td>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The participants described their experiences which highlighted common aspects on which to base the thematic analysis and describe the findings.

Seventeen themes initially emerged from the analysis of the data. With further analysis five themes with eight sub-themes were identified for inclusion in this study.
Table Three below indicates the themes and sub-themes:

<table>
<thead>
<tr>
<th>Original themes</th>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diversity</td>
<td>1. Diversity</td>
<td>Complexity</td>
</tr>
<tr>
<td>2. Opportunities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Role and Scope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Rural Generalism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Professional</td>
<td>2. The importance</td>
<td>An occupational therapy</td>
</tr>
<tr>
<td>Development</td>
<td>of bouncing</td>
<td>perspective</td>
</tr>
<tr>
<td>6. Isolation</td>
<td>ideas around</td>
<td></td>
</tr>
<tr>
<td>7. Teamwork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Connections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Management</td>
<td>3. Working in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bicultural</td>
<td></td>
</tr>
<tr>
<td></td>
<td>practice</td>
<td></td>
</tr>
<tr>
<td>10. Bicultural</td>
<td>4. Supervision</td>
<td>Supervision</td>
</tr>
<tr>
<td></td>
<td>practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and Support</td>
<td>Support</td>
</tr>
<tr>
<td>11. Supervision</td>
<td>5. The Employment</td>
<td>Readiness</td>
</tr>
<tr>
<td>12. Support</td>
<td>Pathway (4 R’s)</td>
<td></td>
</tr>
<tr>
<td>13. Readiness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Recruitment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Retention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Resilience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Future vision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Theme One

Diversity

Diverse roles and scope from the participants experiences working in rural and or remote areas, either in small teams or isolated, sole practitioner positions were explained. Although their roles were vastly different, they shared many common experiences relating to the expectations of new graduate occupational therapists working across complex clinical caseloads under the broad rural practice umbrella.

Experiences of diversity in rural practice were described from two main service perspectives; complexity and specifically as it pertains to occupational therapy practice.

i. Complexity:

The participants who worked in physical health roles described the complex and diverse range of services they worked in:

*Our service covers community, inpatient, community rehab, and we are supposed to cover outpatients.* (Participant B).

*Since it’s a small hospital, I work in the inpatient wards, I do surgical, medical, paediatrics, if they need me, I do the private hospital as well. I’m quite diverse.* (Participant E).

*I’m currently on a rotation program. 6 months Ortho/Surgical, 6 months Medical/Rehab and 6 months community.* (Participant C)

Participant B preferred to describe her role with a scenario:
Basically, you’ve got to be ready for anything. It might be some 104-year-old lady who’s got pressure injuries on her bum one minute and then the next person you walk in to is a 22-year-old with MS that is having a relapse.

Some recognised the experience of working in a variety of diverse and complex clinical areas as a positive, exciting opportunity for learning and growth:

I realised I quite like the smaller hospitals. You see more variety in the day, and I quite enjoy that. So that’s why rural generalism is really good because you are dealing with different things every day… The most positive thing about my role is how diverse my role is. I get a very diverse range of people and a very diverse range of diagnoses. (Participant E).

I love the variety, working with palliative patients, with hemiparesis and then working with Dementia patients, Parkinson’s COPD, Stroke, Heart Attack, love the variety. (Participant B).

But there were alternative feelings expressed by Participant C who described working with such a wide variety of clients and conditions as “overwhelming and daunting.” Despite being overwhelmed, however, she acknowledged the potential for rural generalist practice but with an element of caution and concern:

I think it [Rural Generalism] has a lot of potential, and I think it can be really interesting if it is done well… The possibilities for rural generalism are great, it just needs to be done in the best way, in the right way. If it’s not patient care will not be adequate. I think it will be quite sub-standard. (Participant C).

Participant B recognised that time could add to complexity and be a barrier to providing effective rural occupational therapy services: “there’s not enough time in the day [to cover all the clinical areas]”. The experience of lacking sufficient
time is exacerbated by the travel required to cover the vast geographical areas covered in rural practice shared by most participants: “I live in my car; I honestly live in my car.” (Participant F).

We’ve got a very big area to cover. It’s sometimes four hours one way, very remote places as well, very little cell phone coverage. (Participant D).

It’s a gigantic area there’s no way we’d be able to go from south to north, east to west, just because there’s so much area to cover. (Participant B).

I’m the sole practitioner in the team in terms of OT. I have three bases that we can work out of and if I was expected to go further, apparently there’s a helicopter. (Participant A).

Flexibility and working across several specialities, diagnoses or areas of practice also increased the complexity of their roles. This was noted by participants as an integral part of their experiences regardless of their place of employment or area of interest.

And being rural you need to be able to have a lot of skills that cover a lot of different areas, not just skills in mental health. You need some physical skills and assessments to be able to use as well because not everybody will fit into that one box. Of course, you’re looking at mind and body when you work in mental health. (Participant A).

You’ve got to be flexible with what you do and who you see.” (Participant B).

“As a generalist you do a variety of different things rather than specialising, You’ve got to be able to do lots of different aspects of practice. (Participant E).

Participant F enjoyed the flexibility and autonomy of her rural role:
The good thing, the really exciting thing about being a rural generalist and a sole practitioner is you have the flexibility to make it your own, to put your own spin on it.

Conversely, she also described challenges related to role:

I worked with children, zero to 18. And the complexity was quite intense. In one area there was a lot of drug induced psychosis. Where I was working was a lot of major depressive disorders and a lot of suicidalities. I was picking up nearly dead teenagers several times a week. It definitely starts to wear thin on your core a wee bit doing that. (Participant F).

Others also shared experiences of complex and demanding roles causing stress and reduced confidence in their competence to practice.

I didn’t feel I had the necessary skills or experience to work with patients in the community mainly because I’d just dealt with ortho stuff generally on the ward, and you don’t get a lot of that in the community. It’s a lot more medical based and a lot more complex. (Participant C).

Some even questioned the suitability of new graduates working in their complex, diverse positions with wide and unclear scopes of practice.

This is not something I would recommend for a new grad. It was a baptism by fire, and I think it was just lucky that I’m the type of person that will kind of grab things like that and run with them. (Participant F)

Community mental health is definitely not a new grad’s place. My personal opinion is I don’t think it’s a place for new grads, particularly in the context I worked in because the scope is massive. You cover key worker role. So, you’re doing the job of a social worker as well. But then you are working as a therapist and providing therapy. (Participant F).
The experiences of the participants in terms of the exposure and expectations of working with diverse and complex cases as a new graduate occupational therapist spanned the emotional spectrum from loving the variety, flexibility, complexity, and interesting nature of the work, to feeling overwhelmed, unsupported, lacking in professional confidence and questioning whether their roles were even suitable for new graduate occupational therapists.

ii. **An occupational therapy perspective.**

As a new graduate, being able to consolidate your learning, putting into practice your knowledge and skills from academia, plus understanding and defining your role and identity as a practising occupational therapist is imperative. Participant D explained how she utilised her learnings from university in her role:

*I see a lot of the things we learnt at Uni, even around the grading of tasks ...*
*I look at their [the children’s] activities of daily living, their leisure, their productivity, their self-care skills, and things the children need to do and grow up to do for themselves.* (Participant D)

Participant F defined her role with passion and excitement:

*I think that’s one of the best things about being a generalist and being rural, is because the need for OT is immense, so immense... You have to try to attach meaningful occupation where you can. Finding that space wherever it is. Because that’s the beautiful thing about our profession. It fits anywhere. If you can apply it, it fits absolutely anywhere* (Participant F).

Others, however, found it more difficult to understand and define their roles. This experience caused confusion regarding their role and scope and how to know if what they were doing was appropriate.
I felt quite confused about what an OT does in Mental Health, feeling undervalued by the inpatient team…When I tried to put a program together in the inpatient unit, which was my job, it felt like they wanted an activities coordinator rather than somebody who could actually write any meaningful reports and interventions for people. (Participant A).

I kept asking for some guidelines or expectations. What am I supposed to be doing here? What skills and knowledge am I supposed to be developing? How will I know if I’m doing well, or being successful? (Participant C).

Experiences of the perceptions of other professionals regarding the role of the occupational therapist and being able to define or demonstrate what the new graduate occupational therapist thought they should be doing was a challenge which several participants shared.

You ask anyone who’s not an OT what an OT does and a lot of the time they’ve no idea. (Participant E).

That’s the thing people at Polytech say ‘you’ll forever be explaining what an OT does’ and it’s true. You’re always explaining what you do. (Participant A)

I don’t actually have a sole definition of what an OT does in my world. If I have to relate it, I relate it to a case study or I relate it to a scenario. I can’t just give a broad definition because it’s too broad from what I work in; I can’t pin it down to any one thing. (Participant F).

Participant C described how her role was perceived by her colleagues and resultant challenging and stressful conversations she has experienced:

So, I sort of get treated by the other clinicians as like the equipment lady. That’s I think what they all think I do. And the odd Mini ACE… I’ve had a
couple of confrontations with nurses because they’re wanting equipment and I’m saying that it’s not appropriate. They haven’t taken to me asking questions, they haven’t taken that very well. (Participant C).

Participant A shared similar feelings regarding the understanding of her OT role by her colleagues and concerns regarding expectations of working outside of her new graduate scope of practice: “I don’t get the feeling that he [the psychiatrist] would know what an OT does half the time, and he’s already tried to get me to go outside my scope of practice that I have concerns about” (Participant A).

From a conversation regarding role blurring, covering diverse roles while maintaining her identity as an occupational therapist, Participant A commented “I do feel like case management stuff kind of overwhelms me at times and I really struggle to identify any OT that I’ve done in a week.” Participant F also described “trying not to assimilate into the role of a social worker, psychologist or physiotherapist”. One of the most powerful definitions was “holding the role of many but fighting for the role of OT” from participant F. She further clarified how she maintains her focus on occupational therapy with another passionate quote:

I think the biggest thing is just find the OT in whatever you are doing. Find the OT practice, find the meaningful occupation because that’s what’s ultimately going to draw it back to your knowledge, that’s going to help that feeling that you’re still connected to that professional body [OT]. (Participant F).

Understanding their role and scope in isolated positions within teams who lacked clarity regarding the role of the occupational therapist was challenging for some. Whilst perceptions of the nature of rural occupational therapy practice were as diverse as the caseloads, the participants shared
the dichotomy of both positive opportunities and overwhelming experiences.

Theme Two:
The importance of bouncing ideas around.

Being able to bounce ideas off others, from the same team, other teams, or other disciplines was identified as an important process for new graduate occupational therapists for collegial support and learning.

Participants B and E discussed the benefits of having access to other occupational therapists in the office to bounce ideas around:

*Just talking with other therapists in the office, just coming in and bouncing ideas around, every therapist has a different view on things, and they do things a little bit differently. Sometimes it takes getting to the third different colleague to get an answer that clicks for you.* (Participant B).

*Supervision proved invaluable for me in my first 18 months. Not only clinical supervision, but just talking with other therapists, coming into the office, and bouncing ideas around.* (Participant E).

As well as bouncing ideas around, being able to work as part of an occupational therapy team was clearly valued by some participants. Participant D expressed this in true Kiwi style “*yeah, na, it’s a great team, and yeah we have a few changes at the moment, but yeah, really good.*”

Participant E expressed her appreciation for the contributions of her teams.

*The teams are really cool; the teams are really neat! Our team is quite close. Everyone’s very open. Their doors are always open to have a chat about*
different issues or concerns that you have with a patient, and everyone’s willing to contribute, which I think is really good. (Participant E).

But this positive occupational therapy team environment was not everyone’s experience:

Being stuck in an office with someone that you have a personality clash with you can’t ask those little silly questions or just things you don’t know, made it really difficult for me. My first-year kind of sucked a little bit in that way and it’s made me realise what I don’t know now. (Participant B).

Other participants worked in sole OT positions and within multi-disciplinary teams with some positive experiences:

The [wider] team were brilliant, really supportive. They were overloaded too, as they all are, but they were wonderful. (Participant F).

It’s not just utilising your team, but other professionals as well, getting to know their roles makes the process of going home easier, for their safe discharge. (Participant E).

Challenges were also noted by participants A and C:

If you’re going to be a sole OT somewhere and only have one other person that is the same level as you to bounce ideas off, how do you ever know if you’re doing a good enough job, if you’re doing the right stuff, if you’re doing it well?... I get support from the psychologist, but from an OT perspective, she can’t help me with that… I don’t use the rest of my team to bounce ideas off. One, because I don’t think the rest of my team care. Two, because I don’t think they know anything about what I do as an OT, and Three, I don’t even think they know what they are doing with children half the time. (Participant A).
So, the scope was massive. But for a new grad, and a new grad who had never worked in an occupational therapy role or had no other OTs to bounce off, it was really challenging. (Participant C).

One of the barriers to bouncing ideas around in rural practice is isolation. Being alone was challenging for some participants: “I found it quite daunting because I’m here by myself.” (Participant C). “I was the only OT on that team. There was another OT working within the DHB but that was a wee haul away from me. I was on my own a lot.” (Participant F). Participant A and Participant B also felt alone: “If the psychologist ever left, I would feel a lot less confident. I would feel quite on my own.” (Participant A) “I guess that’s one of the challenges of rural is that sometimes we’re just so isolated and we’re all in our own little silos.” (Participant B).

Participant F compared her isolation and lack of opportunities to bounce ideas around in the moment to her experience as a student:

When we are studying, we’re constantly around peers and we’re around people all the time and then when you are leaving you are just by yourself. It is isolating, incredibly isolating… As much as all the work we do at tech is very valuable; it’s very much ground base work. Practicing is very different. And so, when you’ve got no-one to bounce things off in the moment, it’s really challenging, really, really challenging. (Participant F)

Working with a staff team of mostly part timers was noted by three participants with some strengths but also challenges in terms of access to others, opportunities for team building, learning, sharing and service provision:

I am full-time, most of my colleagues aren’t. So, I suppose I get the opportunity of seeing everyone in the team and getting to know them in different ways. (Participant D).
The senior therapist on the ward is only part-time so it is very difficult to get in touch with her. (Participant C).

The only other person we had in our office was our one day a weeker and so I was basically trying to prop the service up by myself with very limited experience. (Participant B).

Some of the outcomes of not having access to someone to bounce ideas off were described by Participant C:

It’s sort of more just explaining the clinical reasoning of why something’s not appropriate off the top of my head. Sometimes it’s like, oh, [someone asks] ‘I need a cushion for this guy’, I know that it’s not appropriate, but I can’t explain it to them so they understand. I don’t have enough knowledge about it to share it…Yes [I can provide a reasonable standard of care] but I take an awful lot of time to do it. I think I can do it, but it is time consuming. (Participant C).

Having opportunities to bounce ideas around has been described by all participants as essential in learning and growing as occupational therapy practitioners. Working in isolation, without access to other occupational therapists for profession specific discussion and clinical reasoning as well as collegial support are important considerations for the development of rural occupational therapy practitioners and future services.

Theme Three:
Working in Bicultural Aotearoa

When considering rural practice in a New Zealand context, bi-cultural knowledge and practice is imperative. Participant experiences of having opportunities to learn and practice biculturally were mixed:
I didn’t know what to do as a new grad coming in. Nobody explained what to do, nobody even directed me where to go if we had a Māori client… You’d learn it [bicultural practice] over your teaching to be an OT, but to actually put all of that in practice is quite huge. To feel confident, I’ve had a lot of training through the DHB, and I also have access to a Pukenga Atawhai [Māori cultural support person] on the team. (Participant A).

My experience [bicультurally] has not been great. I think it was quite a shock. Where I grew up powhiri’s were always happening. To coming here, it was a bit odd…nothing which is a bit weird…There’s a lot of old attitudes. I think it’s starting to change but it’s a slow process…I do feel like it is quite tokenistic and that’s not the purpose, doing biculturalism is being genuine and not just applying it to the box. (Participant C).

But there has been limited opportunities around biculturalism which, I think is mainly due to how small the community is. (Participant E).

Conversely, Participant B had quite a different experience and discussed positive observations of having a large Māori population for example: “quite a lot of our population is Māori, and they are very keen to take their whānau home.” She also recognised the disproportionate levels of Māori in lower socio-economic areas of her community “We have quite a high population of Māori and quite lot of poverty and deprivation, which as you know can have quite negative impacts.” This awareness and action to improve health and wellbeing outcomes for Māori is a specific focus for health and wellbeing strategies in Aotearoa and in the occupational therapy competencies required by Occupational Therapy Board of New Zealand (OTBNZ).

Access to Māori liaison and support is recognised as helpful as a new graduate learning how to practice safely from a bicultural perspective:
We do have access to a Māori liaison who’s really, really great and really open and you can always come and talk to him. (Participant E).

The Pukenga Atawhai always knows that we are working with a Māori client. They introduce themselves to the client. Then we work side by side if the client wants their help. (Participant A).

I work in kuras and we go in to Kohangas and work with people with children who are in Te reo based classes. (Participant D).

I introduce myself with a Mihi, start off a collaborative meeting with a Karakia, asking families how they would like things to be done, making sure they have the support they need. (Participant D).

Participant B recognised that her own culture and whānau history was helpful “I think my own prior knowledge and the fact that I do have Māori in me, that’s given me a little bit of a footing.” And Participant A commented that actually having a student was a good way to reflect on her bicultural practice:

I work with Māori clients, and it was interesting having a student because they said, ‘what do you do differently?’ My first thought is nothing, but I do do things differently. You check the ethnicity in the referral, when you interview them, you ask if they identify as Māori and if they do, is there anything I can do differently to make this process easier for you? (Participant A).

Whakawhanaungatanga, or the importance of establishing and maintaining connections when working in rural practice was reported as a significant consideration. Being able to see positive outcomes was an important focus of connection:
Just making connections with people you’re working with, being able to build that rapport with people and then see them make change with your facilitation… You need to coach them [whānau] through what the processes are and get them on board and also collaborating with them, between them, the school, and any other providers that might be involved with them as well. (Participant D).

And just building up that rapport with them I think is really beneficial to get the best results out of your assessments. (Participant E).

Definitely you have to make really good connections otherwise you just don’t get that buy in and they kind of shuffle off a little bit or aren’t quite honest with you. (Participant B).

The participants expressed an understanding of bicultural practice and were self-motivated to seek out the support they needed to effectively work biculturally. Their experiences were mixed but their grounding and intrinsic drive was strong. Another interesting factor is the variances of Māori population demographics in different rural areas in Aotearoa experienced by participants. The significance of establishing and maintaining connection for effective rural practice is an important finding.

Theme Four:

Supervision and support

i. Supervision:

Supervision is a requirement of the Occupational Therapy Board of New Zealand (OTBNZ), and new graduates should receive it weekly for at least their first year of practice prior to demonstration of competence for removal of their new graduate scope of practice. Participant C described a situation she
is experiencing from her manager as a result of this. “I’m getting pressure [from management] to remove my scope of practice because they are wanting to reduce my supervisor’s workload.” (Participant C). This could suggest that the manager is more focused on the needs of the organisation than the new graduate or the intentions of OTBNZ.

The value and importance of supervision is recognised by participants. Some positive experiences include: “I had an awesome supervisor that kept me sane.” (Participant A).

Supervision’s really good. I think my supervisor is lovely, absolutely lovely. I’ve built a really good relationship with her, so we have a discussion around our day-to-day things and have a bit of a laugh and then get on to the topic as well… We also have a new grad program. It helps to integrate new grads into the profession and I’m part of that program. We look at case studies, different areas of practice and policies. It’s basically just a networking and discussion around what difficulties do you have as a new grad and ways to solve that. (Participant E).

For those working in isolated roles, physical access to their supervisors is not possible. Supervision is often provided via technology with mixed reviews:

I get supervision over the phone. She’s been a huge help often and throughout the week ‘so what do I do about this, what are your thoughts on that or what am I missing? What do I need to consider?’ She has been a lifeline. (Participant C).

It’s difficult having a supervisor that is not in this area, but in other ways it’s quite good because she doesn’t have to work within the same structure so I can tell her stuff and it’s not going to go any further. In that way it’s good… I get more out of face-to-face supervision than I do over the phone, however,
my supervisor’s been really generous with her time, and she is accessible by phone within a day if I had an emergency… I don’t like Zoom, but otherwise I’m not ever going to see her face unless I go over and see her. (Participant A).

As noted above, receiving supervision via digital technology is necessary due to geographical limitations, but is not always preferred by supervisees. Participant A described her frustration at not being able to see her supervisor face to face. She felt her supervisor had a lack of knowledge and understanding of her role and rural context because the supervisor is based in an urban setting:

I have been over to see my supervisor twice in the last 2 years, however, she has never been here and that seems to be an issue because she understands the context as far as telling me what’s going on in her team and DHB, but she’s never seen where I work, the environment that I work in, she’s never met any of my colleagues. (Participant A).

Lack of the ability to physically demonstrate competence was also noted:

I can’t really demonstrate [my competencies] to my supervisor easily given the geographic locations and I have to justify why I am seeing her, or she has to justify why she is visiting me. (Participant C).

Supervision is required by OTBNZ and recognised as essential by the participants. Most receive their supervision digitally, with mixed feelings. Findings would indicate at least occasional face to face supervision by a supervisor who understands the context of rural practice experienced by the new graduate would be preferred.
ii. Support

“And just the lack of support you got from the organisation.” was noted by Participant F but this was a common experience among the participants, particularly participants B, C and F, even to the point of them considering alternative employment. “Just trying to work out my role in what seemed like a really unsupportive kind of environment was really hard.” (Participant B).

But it’s the lack of support that’s making me want to look elsewhere because I like the job itself and the role itself… I gave up asking for help and support because I wasn’t getting anywhere. I was told I needed to set some goals and have more confidence…But there’s just really not a lot of support. Even on the ward there actually wasn’t a lot of support. (Participant C)

Burnout was recognised a consequence of the lack of support:

I realise that I’m quite burned out from being here and that’s really sad. But I just don’t have the energy to keep fighting those sorts of battles. (Participant C).

And there was just no support whatsoever from the hierarchy in the organisation and the team was completely stretched. And yeah, it just fried me out…after burning out, I had to really, really reflect upon what I need to do to keep myself in a good space. (Participant F).

Having a manager from a different profession exacerbated the feelings of not being understood, recognised, or supported professionally.

I think she [Allied Health Team Leader] wants to support me but she doesn’t know how. She’s a physiotherapist… I don’t think my manager understands how complex OT is and she was expecting me to work the same way as a physio – see the patient, write the notes and move on. But that’s not the case
for OT, especially the people on my caseload. I spend most of my time doing research… She told me and a few others that the OT Board has deemed that you are capable to practice, you don’t need lots of supervision and professional support. We should just be able to do it. (Participant C).

Our team leader is currently a physio, so physio and OT are kind of together, which kind of makes a little bit of sense but try getting a physio to think OT is just not going to happen. (Participant B).

In addition to recognising the implications of their experiences of lack of support, the importance of connection was described as an effective mitigation strategy.

It’s massive [connection] when you’re a new grad. I’m getting more used to it now and I’ve always had to just forge my way into people’s social circles. When it’s OT’s I just kind of assimilate myself because I want to be part of it, I’ll make myself part of it… It’s hard to say ‘maintain those connections’ because it’s not always as easy as that. But if you can remain connected, even if it’s just with your tutors. One of them is my supervisor now. (Participant F).

Participant C commented how hard it was to make connections when you are moving to different locations as part of your rotation:

I take a while to settle in. I’d just started doing that when I was told I was moving here. But I feel like I’m just getting a social life and making friends and I’m going back soon. (Participant C).

Participant F also recognised the importance of connection and provided an idea to help rural practitioners remain connected:

But I think it would be really cool, having a way we could connect. It’d be cool if there was a way that rural practitioners and generalists had their own
spaces, to meet up or just reach out to each other and to know who’s in the area. Because, as far as I’m aware I’m the only one. (Participant F).

Lack of an effective support structure for half of the participants is a significant finding. The extent of burnout and stress caused by an absence of support, exacerbated by managers from different professional backgrounds is interesting as well as the importance of feeling connected socially and professionally as a support strategy.

Theme Five

The employment pathway.

For this study, the employment pathway includes the process of entering the world of occupational therapy from the perspective of the new graduate; from feelings of readiness to practice to the importance of resilience when working in rural practice. The participants also describe their experiences of the processes of recruitment and retention. This has resulted in the development of the four R’s subthemes: Readiness, Recruitment, Retention and Resilience.

i. Readiness

Participants had mixed feelings regarding their readiness to practice in the rural space. Some described a correlation between readiness to practice and personal circumstances and expectations: “I guess I’m quite lucky because I grew up in this environment, so the rural way of life is not a shock for me.” (Participant B).

I think I felt ready. I’d done a lot of mental health through my training. And I’ve grown up around family members with complex mental health and ASD, and I was okay with it. I like working in those spaces and I’m a very out of the box thinker; that’s why I don’t go with physical health. Mental health gives the ability to be a bit more of a wider thinker. (Participant F).
For others it was not such a clear concept:

I don’t know if I felt ready. I had a bit of an open mind to make sure I was ready for anything. But then when COVID happened, I was like ‘am I really ready?’… I was questioning, ‘am I doing the right thing?’... I don’t think I was ready... I think I’ve learned more in the last year and a half than I have actually in that teaching environment, because I’m actually doing it and I’m actually seeing it. (Participant E).

The concept of readiness to practice in the rural space is personal and difficult to measure, particularly with the inclusion of COVID lockdowns which exacerbated the isolated rural aspects for some participants causing them to question their perception of readiness.

ii. Recruitment

Participants shared their personal stories of recruitment into rural practice and what attracted them to the positions. For some it was home “...and you can’t move the farm” (Participant F). “I got offered four different jobs here to start with. I got lots of job offers. It was home, it was comfortable to me, obviously I grew up here.” (Participant B).

There was an opportunity for change: “Basically, I thought it would be good to try something new.” (Participant E). “I didn’t know anything about the area. I knew it was beautiful because I’d travelled here before but that was only when I was little.”(Participant A) “I’m used to small towns, I’m an outdoor person but I was also keen for a change, I wanted to get out of the city.” (Participant E). Or preferred clinical experiences: “What attracted me to come here was it was a rotational position that did not include a mental health aspect.” (Participant C). “I knew I wanted to do physical health, I didn’t want to do mental health, so that narrowed it down.” (Participant E).
But for others it was more for job stability: “They offered me a permanent position just as COVID was ramping up so that was something I couldn’t turn down.” (Participant C) Or learning opportunities: “I think it’s a great way of learning because all the really complex people go to the urban centre.” (Participant E).

But having been recruited into a position, many of the participants experienced significant changes to their roles after their employment began.

Table four below shows the changes experienced by participants.

<table>
<thead>
<tr>
<th>Role recruited to</th>
<th>Actual role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Adolescent Mental Health</td>
<td>Adult Inpatient Mental Health Unit</td>
</tr>
<tr>
<td>Community</td>
<td>Inpatient</td>
</tr>
<tr>
<td>Inpatient/Community</td>
<td>Community</td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>Children and Adolescents</td>
</tr>
<tr>
<td>Adult physical health</td>
<td>Adult and paediatrics</td>
</tr>
<tr>
<td>Inpatient hospital based</td>
<td>Isolated lone community position</td>
</tr>
</tbody>
</table>

The reasons behind these changes varied from contractual changes driven by work demands such as vacant positions or parental leave, to lack of role clarity and communication:

I did think I was going into Adult Mental Health, but I knew I would be helping out with some form of work with rangatahi...I ended up having to get the organisation to write in my contract that I am able to work with
tamariki and rangatahi because there was nothing in my contract that said I had to. It was written in because my whole caseload was kids. (Participant F)

When I interviewed it was a 50/50 role [inpatient/community], but then my first day here, my team leader dropped on me that she was pregnant and would be covering the 50/50 role. I thought ‘oh my gosh that’s [community] exactly where I want to be’. I actually went full time community straight from the start. (Participant B)

I think it must have been three weeks of orientation in the community and then a role came up in the inpatient because someone was leaving. So, I was like, perfect, that sounds great. (Participant E).

Some participants however, found the experience less positive “What the hell have I done? Why am I here working with adults when I applied for a job with children?” (Participant A).

When I came here, I understood that I was going to be covering all adults. And when I was here for a few weeks I was told that I would be doing paeds as well… I was told that all of my rotations would be here [based in the main hub] but they [management] changed it. They changed their minds, and I was told I was coming here [isolated rural community] with two months’ notice. (Participant C).

We had a bit of a re-shuffle again with the maternity leave cover and me, so I’ve actually gone 50/50 now doing the inpatient and community. But having to step into inpatient after being in community for about a year was crazy. (Participant B).
The difficulties with recruitment in rural areas was discussed. “We really struggle to get staff” (Participant D). Some consideration was given to the reasons why:

I think it also comes down to the rural aspect that they find it really hard to fill jobs here… I’d like to think it isn’t the fact that it’s rural and nobody wants to work in rural. But I guess it’s a little bit of people not wanting to go out to the wop wops. It might even be a fear of the unknown.” (Participant B).

They are an organisation that struggles to find workers because reputation often precedes them. So, they have to pick up people that have either never heard of them or don’t have any experience in the areas that they need to work… It’s hard to recruit because of the problem of just work burnout. (Participant F).

They’ve tried [to recruit experienced staff] but they don’t seem to be able to do it. (Participant C).

I think it’s a small town, sort of feeling so isolated. I think that stops a lot of people coming. (Participant A).

I think some people will go ‘yeah, I need some experience, I wouldn’t want to live there for a long time’. I guess that’s their perception of the area, not so much the actual organisation. (Participant C).

Experiences of recruitment were varied and reasons for applying for rural roles equally diverse and personal. The experiences of changes to roles post recruitment were extensive and organisational issues cited for at least some of the difficulties with recruiting to rural positions.
iii. Retention

Whilst recruitment is often a focus for global staffing issues in rural health, staff retention seems to be less prominent. Participants discussed some relevant experiences. A high turnover rate of staff was reported by participant C “I think the issue is that they don’t keep the staff that have come here.” Participant F shared a more extreme example:

*They don’t even print names on business cards because they lost staff that quickly it was costing them too much to replace cards, so you had to write your name on the card…You had to provide 12 weeks’ notice because they find it really hard to find staff.* (Participant F).

Work burnout also was discussed as a reason for poor staff retention. “I finished there because I had a complete burn out, and that was not a fun place to be.” (Participant F). “I realise I’m quite burned out, and that’s just from being here which is sad.” (Participant C).

*I think that a lot of it [cause for burnout] was the organisation I was working for. So, the team I had within the organisation were really good, but the organisation was picking up contracts left and right and centre and not hiring more people to fulfil them.* (Participant F).

Another reason for retention issues was a lack of understanding and appreciation from the very top of an organisation: “It’s the top-heavy nature of the organisation that makes it incredibly challenging to work for, it’s a shame.” (Participant C).

*Management, higher management, the people who run the show are the ones that need to have more appreciation for those of us on the ground… the Trust, particularly the CEO and the high up staff, there was no appreciation for what you did, nothing was ever good enough. You never saw a word of thanks… I*
called it a company of smoke and mirrors. They [higher management] were putting on a lot of community events and showing off the organisation, but behind the mirror, behind the red curtain the rest of us were completely frying out. (Participant F).

I think it comes from because they [higher management] don’t understand what OT’s do. They just think OTs are happy to work over everything [clinical area] except you’re not. Imagine sticking you somewhere that you are really foreign to and expect it to be done well. I’m learning new skills all the time. So how can you do that if you’re shifting every three or six months?... If you are pushed [by management] into doing something [that you have no passion or interest in], then you will leave. (Participant A)

Another experience was related to a disconnect between the expectations of management and actual capacity in rural health:

And management tended to look at the urban centre and trying to emulate what they are doing. And we can’t do it all. Many of the things we just don’t have the capacity for that. We don’t have the equipment, or we just don’t have the staffing or the skills… There’s no listening, no collaboration. It’s ‘do as I say’. They lost 2 staff because they were told they had to move. (Participant C).

Participants shared their own experiences and insights regarding retention issues in rural practice. Perhaps more focus on retaining staff could help in future service delivery.

iv. Resilience

The American Psychology Association Dictionary of Psychology (2022) defines resilience as “Resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and
behavioural flexibility and adjustment to external and internal demands.” Participants describe strong feelings and experiences that demonstrate the resilience required to function successfully in a rural environment: “You’ve got to be hardy to work in rural” (Participant B).

I thought that the DHB was really chaotic and couldn’t even keep their staff safe and happy to be working in this environment because everybody resigned the time I came. (Participant A).

And I’ve worked so long to be an OT. I feel I know what it should be like, but a new grad just walking into this, I can see why they wouldn’t want to continue. If you think this is what it is like everywhere across the country, why would you want to? (Participant C).

And then COVID happened. All the participants were impacted by the uncertainty and changes to work practices caused by the Coronavirus lockdowns early in their careers. This experience was discussed by many of the participants and demonstrates their toughness or resilience.

So, I had three weeks of orientation around making sure I was competent for the role and so I have a bit of an idea of what the role entailed and then COVID happened… I think that COVID was quite a barrier when I first started, because I kind of felt like I was chucked in at the deep end. (Participant E).

I started at the start of last year and then obviously COVID hit, so it was a very interesting first six months of practice. Yeah, it was an interesting start to my career. (Participant D).

It was very interesting, I just felt like I was getting to grips on how things were working and how I was doing my assessments and getting my documentation done on time and equipment ordered if it needed to be and all that kind of stuff. And then COVID hit and it’s like I was stuck in my office
for six weeks talking to a screen, if possible, otherwise all of my assessments were done over the phone and that was a whole different way of working. (Participant B).

I think the structure of it all collapsed a bit because our roles changed. I had to give [the people] the idea that I knew the right steps, making sure that I was safe and not getting COVID and that the person was safe because we were all condensed into this small environment… I think that [confidence in my role] was quite a hard one to get your head around, especially during COVID, when everything was locked down and you couldn’t thoroughly do your assessments. You couldn’t talk to family members as much because they couldn’t come in and give data on how the person is managing. So that’s really hard to gauge.... I was still learning the policies, learning my role within the big team, learning people’s names and roles and making sure that those patients were safe to head home. (Participant E).

There were, however, some positive outcomes:

…and then not far into it COVID hit. I then got a lot of theory done over COVID, which was nice. I learned a lot, but it was hard not seeing it in practice for a good couple of months. (Participant D).

We’re quite fortunate now, after COVID, to have more accessibility to things like Zoom and that kind of stuff” (Participant B).

But despite all these difficulties, they [the new graduates] remain in rural health. These are some reasons why: “I’m 100% sticking it out, I love my job.” (Participant B).

I guess initially I am still here because I’d brought my son to this foreign place, and I just bloody had to make it work out of determination… I need to make this work because I need to understand what an OT does, and I think
I’ll be good at it and I don’t want to give up… [now] I love my job and the feedback I get is that I’ve made some improvements with that young person so that’s how I’m gaining my confidence, in feedback. (Participant A).

Now I’m loving it. Absolutely love getting involved with the kids, getting into the schools and getting into all the assessments that we have to learn and keep up with. (Participant D).

The employment pathway has been challenging for many participants in this study. The concept of readiness to practice was mixed, but more positive than negative. Recruitment and retention issues were significant, evidenced by the extent of the significant role changes experienced and perceived lack of understanding from management and organizational structures, not to mention the effects of a global pandemic. But despite all this, the resilience of the new graduates and their drive to succeed is evident.

**Summary**

Through semi structured interviews, the participants were able to provide extensive and valuable information in order to answer the research question posed in this study: “What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa, New Zealand?” Thematic analysis has identified some key themes and discussion points. These include the diversity and variety of roles, the importance of being flexible especially in roles that change, alongside the need for supervision, support, and connection. Bicultural practice, recruitment and retention are also important issues frequently considered. In terms of understanding rural practice in the context of new graduate occupational therapists the findings provide some significant considerations, both expected and unexpected that will be considered in the discussion chapter.
This chapter discusses the outcomes from the findings of this study. The aim is to interpret the findings to establish meaning, or the ‘so what’s’ of the findings from the semi-structured interviews to answer the research question: What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa?”

Analysis of the findings provided both expected and unexpected results. Diving deeper into the shared experiences of the participants during the comparison of responses in the thematic analysis provided information and new insights that we can learn from. This process also raised questions and highlighted gaps and barriers to consider for future research or service development opportunities.

When considering the themes and subthemes from the findings, four main categories for further discussion arose from the experiences described by the participants.

Unsurprisingly, the concept of rural practice and rural generalism became a primary topic for discussion. Having opportunities to “bounce ideas around” however was an unexpected outcome and theme in the findings which was expressed by all participants. This concept is important in terms of access to effective support and supervision, being able to function as a competent new graduate therapist in a diverse and isolated role and consolidating knowledge and skills as an occupational therapist in rural practice.

The importance of connection is another discussion point that ran throughout all the themes in the findings. This included personal and professional aspects
of being connected, forming connections, creating a sense of belonging as a new graduate when working in isolation, connecting socially and within the rural community as well as connecting with the people they worked with and their whānau. This aspect of new graduate experiences is a valuable insight into how best to support new graduates in rural practice and provide effective support and supervision, recruitment and retention strategies and develop resilient practitioners.

Of course, experiencing a global pandemic (COVID-19) was included in the experiences of these new graduates and was an unplanned once in a lifetime event. This was expressed in terms of isolation, confusion and feeling disconnected during lockdowns at the beginning of their OT careers.

The final common experience included in this discussion is the extent of change the participants experienced. Even without COVID, the amount of changes these new graduates’ experienced was vast and unexpected and warrants more discussion and consideration.

The strong commonalities discussed in the findings have therefore resulted in the following four discussion points:

1. Rural practice and the generalist vs specialist conundrum
2. Opportunities to bounce ideas around
3. The importance of connection
4. Expect change
1. **Rural practice and the generalist vs specialist conundrum.**

i. **Rural practice.**

Participants in this study lived and worked in rural and remote areas of Aotearoa. Roles included either small teams or isolated sole occupational therapist positions. These demographics correlate with studies completed by Lee and Mackenzie (2003) and Devine (2006). Both researched the experiences or perceptions of new graduate occupational therapists working in rural Australia.

Positive experiences of working in rural and remote areas such as having interesting and diverse caseloads, skill building in a variety of clinical areas, flexibility, and the opportunity to “put your own spin on what you do” (Participant F) are discussed by participants in terms of working autonomously with a degree of fearlessness and independence, which suited some. In addition, opportunities to consolidate learning from university and meet personal goals and aspirations were described alongside the benefits of living in areas of natural beauty, engaging in outdoor pursuits and being close to whānau and friends.

International literature regarding rural health experiences such as Campbell et al. (2016) in a grounded theory study of turnover intention among early-career nursing and allied health professionals in rural and remote Australia, Devine (2006) and Lee and Mackenzie (2003) and who researched experiences of new graduate occupational therapists in rural Australia, and O’Toole and Schoo (2010) who surveyed private allied health practitioners in rural Australia reported very similar findings relating to the positives of working in rural practice.

When considering recruitment and retention issues specifically, Berg-Poppe et al. (2021) completed a survey of physical therapists in non-urban areas of the
USA regarding the values that influence employment acceptance; Dolea et al. (2010) evaluated strategies to increase attraction and retention of health workers in remote and rural areas, and Roots and Li (2013) completed a meta-synthesis of recruitment and retention of occupational therapists and physiotherapists in rural regions in Canada. Interestingly, the same positive experiences of rural practice were described in these studies.

Diversity and flexibility were seen as positive experiences by most and encouraged recruitment into rural roles for new graduates who either sought new and different challenges for their first job as an occupational therapist, did not know what field they wanted to work in or already lived in or had experiences of living in rural locations. These positive experiences are in line with the literature such as Dolea et al. (2010) and Roots and Li (2013) and can be considered when recruiting or preparing new graduates for entering the field of rural practice.

Alongside the opportunities are the risk factors which are also supported by the literature. These included issues of isolation (Berg-Poppe et al., 2021; Roots & Li, 2013), feelings of not being supported effectively, or valued by their manager (Cosgrave et al., 2018), feeling overwhelmed (Turpin et al., 2021) and lacking in confidence regarding competence in the extensive range of clinical services being provided (O’Toole & School, 2010; Lee & McKenzie, 2003), as well as not feeling understood by managers or colleagues from different professions (Roots & Li, 2013). Each of these issues are discussed in more detail later in this chapter.

Despite these issues, risks, and concerns, however, most of the participants in this study intended to remain in their roles at least in the short term and enjoyed living and working rurally, as described as social factors relating to recruitment and retention by Roots and Li (2013).
ii. Rural Generalism.

Rural Generalism was discussed by participants as a concept or model of rural practice which is becoming more frequently referred to by managers or employers, but the definition is not clear. Participants in this study described rural generalism in relatively simple terms “as a generalist you do a variety of different things rather than specialising…you need to be able to have a lot of skills that cover a lot of different areas.” (Participant E). This understanding of the concept of rural generalism partially aligns with the definition from Services for Australian Rural and Remote Allied Health (SARRAH, n.d.) which also includes meeting the needs of the rural community in their definition. In terms of the context of Aotearoa, however, there is yet to be an established definition of rural generalism in allied health.

Despite the variety of roles and experiences of the participants, they each recognised the need for flexibility, the diversity of their roles compared to their urban counterparts and the complexities of the nature of their clinical experiences. These experiences were comparable to those described by both Roots and Li (2013) regarding recruitment and retention in rural regions and Pighills et al (2013) who reviewed current practice in occupational therapy environmental assessments in rural Australia.

Much of the literature pertaining to rural practices refers to physical health roles including Lee and Mackenzie (2006), who studied participants working in physical community and hospital-based positions, and Devine (2006) who focused on public health, primary health care and health promotion. These studies and other literature regarding rural health initiatives including the New Zealand Health System Review (2020) and a review of rural allied health workforce in Aotearoa by George et al. (2019) and Nixon (2018) in his Address for the Eric Elder Medal regarding rural generalism in Aotearoa specify a
medical, physical and or public health perspective on what constitutes rural practice or rural generalism.

During the design process for this study the literature seemed to support an assumption that rural generalist practice primarily included therapists working in the physical health space and across many clinical areas within that scope of practice. Interestingly, however, participants who responded to the invitation for inclusion in this study also included new graduates working in mental health, paediatrics and Child and Adolescent Mental Health Services (CAMHS). All met the criteria for inclusion in this study and so were included.

Some of the participants were not only working as generalists within specific broad specialist areas such as physical health, mental health, or paediatrics, but for some there was an organisational expectation that they would work across the gamut of clinical areas that would be considered more specialist roles in urban centres. This unexpected potential broadening of the scope of occupational therapists working in rural practice may have implications on occupational therapy practice, training, regulation and defining the concept of rural generalism or rural practice as a possible future health service delivery model in rural regions of Aotearoa.

Literature such as Fox (2013) and Lloyd et al. (2004) does not support the incorporation of mental health, physical health, and paediatrics within the remit of rural generalist practice, and yet this has been the experience of some participants in this study. This could be a unique situation, specific to rural practice in Aotearoa, which would account for a lack of international literature supporting this practice. It could also be an attempt to cover services in hard to staff rural areas. Recruitment to rural health roles is an accepted, significant global issue alluded to by Berg-Poppe et al. (2021), Cosgrave et al. (2018), and Roots and Li (2013).
iii. Rural health workforce issues.

A “global phenomenon of rural health workforce shortages” is described by Cosgrave et al. (2018, p.1) in the context of Australian governments developing programs, policies, and targets to increase the size of rural health workforces, both medical and allied health. Despite some increases in staff numbers, however, workforce shortages continue to be an issue. This is corroborated by Roots and Li (2013) who also document strategies to increase allied health staffing in rural Canada that have not successfully improved staff shortages or rural health service provision. Berg-Poppe et al. (2021) used data from US Department of Health and Human Services and noted healthcare provider shortages of 68% in rural areas, significantly more than in urban areas.

Clearly there are global shortages of rural health workers, including occupational therapists, and literature supports this. Surely, however, there are risks associated with the development of innovative generalist models of practice and service provision without research and evidence to support them, particularly as policies and programmes to improve staff shortages to date have been largely ineffectual.

Rural health issues are discussed internationally, not only in terms of chronic staffing shortages, but also regarding socioeconomic and population health and wellbeing. The New Zealand Health System Review (2020) acknowledges that people living in rural towns have some of the poorest health outcomes, and rural communities are some of the most vulnerable in Aotearoa. To address these issues in Australia, organisations such as the Services for Australian Rural and Remote Allied Health (SARRAH, n.d.) have developed The Allied Health Rural Generalist Pathway to support the development of rural generalists that follow similar principles of Dreyfus’ Model of Skill Acquisition, Dreyfus (2004), from which Benner’s (1984) clinical stages of
competence for nurses is based. This pathway includes three mechanisms: formal education, structured supervision and support and rural generalist service model development initiatives. But there are no similar programs in Aotearoa.

One participant described an experience of how she felt her employer failed to support even the minimum OTNBZ requirement for new graduates, which is weekly supervision for at least the first 12 months of practice. She reported that she was being pressurised from her manager to get her new graduate scope removed early to negate the OTBNZ weekly supervision requirement to reduce the workload of the supervisor. This could be perceived as organisational imperatives taking priority over the needs of the new graduate, as well as the supervision requirements of OTBNZ designed to keep the public and the therapist safe.

Support and supervision were recognised by all participants as essential to their professional growth. It is concerning that most of the participants did not feel that the supervision and support they received were adequate. Experiences like these do not improve the confidence or competence of the new graduate rural health workforce. Provision for effective support and supervision for new graduate occupational therapists working in rural practice requires more consideration for the health and wellbeing of the therapists and people and communities they support as well as the future of occupational therapy in rural practice.

iv. Managerial expectations.

McPherson et al. (2006) reviewed extended roles for allied health professionals and discussed that the scope of practice of occupational therapists is extensive but sharing roles and scopes occurs often without any formal education. The findings indicate that the drive for extending the scope of new graduate
occupational therapists without evidence to support it is driven by management. New graduates expressed their feelings of being overwhelmed and burned out (Participants C, B & F) due to excessive demands and expectations from leaders and managers, especially if they were from a different professional background. These included expectations of the new graduate “just getting on with it” (Participant C) without effective training, support, or supervision. Cosgrave et al. (2018) and Roots et al. (2013) also found that management structure and professional experiences were the greatest indicators of role attrition or job satisfaction.

Having a manager from a different profession was a common experience of participants. It was reported as a challenge for some and resulted in feelings of professional misunderstanding or lack of recognition. Comments regarding managers from a physiotherapy background expecting them to work in a similar way without understanding the complexities of the occupational therapy roles and interventions were made by two participants (Participants B & C). Roots and Li (2013) also found that some therapists felt that managers from a different discipline lacked professional understanding which resulted in a lack of professional specific support.

A model of rural practice that has the potential to cross professional boundaries, encourage extended scopes of practice and skills sharing with little formal education and profession specific support is an area that requires more consideration and research.

Whether or not there is a mental/physical health divide, or an age limit, the scope of the rural occupational therapist remains unclear. Perhaps this is at least in part due to the extensive roles and scope of the occupational therapy profession. One participant who worked in mental health commented that “you need some physical skills and assessment to be able to use as well because not
everybody will fit in to one box. Of course, you are looking at mind and body when you are working in mental health” (Participant A). Another (Participant C) expressed her frustrations regarding a lack of clarity and support in her role. She saw the possibilities for rural generalist practice if it is “done well” but recognised the impact this could have on patient care, feeling that the occupational therapy service could be quite “substandard” without effective support, supervision, and training for the therapist.

This conundrum of where generalism stops and specialism begins and how this affects new graduate occupational therapists in rural practice requires further exploration. Defining the scope of a rural generalist occupational therapist and implications on models of service provision including the training requirements and support and supervisory needs are outside the limits of this study, but it is understood that work is currently underway to that end. The success of a project of this magnitude would require co-design and involvement of government organisations such as the Ministry of Health and or with the Occupational Therapy Board of New Zealand (OTBNZ) and the educational establishments.

v. Role blurring and professional identity.

Shared experiences of role blurring and concerns relating to professional identity were expressed. Feeling like a “Jack of all trades and master of none” as described by Gray et al. (2011) and Peterson et al. (2003) plus maintaining an identity as an occupational therapist rather than a “gap filler” discussed by Fortune (2003) are corroborated by the findings in this study.

New graduates expressed feeling that they do not have the knowledge and confidence to fully understand or articulate their roles and responsibilities within multi-professional teams who lack understanding of the scope of occupational therapy. Some commented on challenges relating to role blurring
between occupational therapy and social work or key worker roles in terms of “fighting for the role of occupational therapy” (Participant F) or “not recognising the actual OT they have done in a week” (Participant A). These experiences emulate those documented by Fox (2013) and Lloyd et al. (2004) both of whom reviewed generalist vs specialist models of practice in mental health.

Another situation included expectations of the occupational therapist providing what was requested on the referral rather than completing an occupational therapy assessment or using clinical reasoning to determine needs or solutions (Participant C). This issue was also recognised by Pighills et al. (2013) and can be undermining and challenging for a new graduate without the confidence or knowledge to stand by their reasoning and decision making when working in isolation.

Feelings of being overwhelmed documented by Turpin et al. (2021) in the context of new graduates, were expressed because of the expansive roles, expectations from others, and confusion regarding professional identity. Embedding broad clinical specialties such physical health, mental health, and paediatrics into the role of a rural generalist occupational therapist could increase the risk of burning out. This could lead to issues with retention of staff, noted by O’Toole and School (2010) as well as provision of a substandard service, mentioned by one participant, and the potential dilution of the practice of occupational therapy described by Fortune (2000) as the loss of the specific philosophy of the “therapist of occupation”.

A barrier to successful rural practice has been expressed by the participants in terms of access to effective support and supervision, clear expectations of their role and potential impacts on standards of patient care. In order for occupational therapists to understand and articulate their roles and maintain their professional identities, effective support and profession specific
supervision has been identified as essential elements in the provision of rural practice, especially for new graduates.

vi. Bicultural practice.

Experiences of bicultural practice were mixed. Some geographical regions in rural Aotearoa have a greater than the national average population of Māori, while others have a significantly lower proportion which impacted on exposure to working with Māori and opportunities to experience bicultural practice.

All participants expressed bicultural knowledge and understanding and an awareness of the need for cultural support and training regardless of regional population demographics. Some experienced tokenism and lack of support, while others felt well supported with access to effective cultural support and liaison.

Participants described rural experiences of socioeconomic issues including poverty and deprivation from a bicultural perspective as well as an understanding of the health equity issues faced not only by Māori, but also by rural and remote communities. This is an area that is being addressed within the current changes to health service delivery via the New Zealand Health System Review (2020) and recognised as a priority, but the specific impact of equity and bicultural practice for occupational therapists in rural practice is a diverse topic that changes according to region and demographics.

The findings showed a knowledge and drive from all participants to recognise their responsibilities under te Tiriti o Waitangi and to strive towards equitable outcomes for Māori wellbeing, taking the initiative to find support when needed and to practice responsively to te Tiriti.
Experiences of rural practice from new graduates in this study indicate that there is an expectation from employers and managers of working towards a generalist model of practice, but there are no clear descriptors of what this is, how it will work or what support or training structures are required for occupational therapists working in rural practice. Barriers exist in access to effective supervision and support including understanding and responding to their commitments to te Tiriti o Waitangi despite OTBNZ new graduate requirements.

While rural generalist frameworks for support and training exist in Australia, for example, there is no evidence that similar models are being developed in Aotearoa. There are also no indicators regarding what the scope of a rural generalist is, when clinical practice becomes a specialist area or if specialists should be consulted. Gaps also exist in defining the extent of the scope of practice that ensures safe practice for the therapist, the community and those they support.

2. Opportunities to bounce ideas around.

Having the opportunity to bounce ideas around was an important theme reported in this study. This was an unexpected outcome that was discussed by all participants in different ways, from the positive aspects of having access to a small collegiate team of therapists to share thoughts and ideas with, alongside opportunities with multi and inter-professional teams when working in more isolated roles which were considered valuable for learning and professional growth.

Without access to a team to bounce ideas off in the moment who understand and respect the role of the occupational therapist, there is a risk to effective and safe provision of occupational therapy services as well as the health and wellbeing of the new graduates. Similar issues of needing access to a team for
support and learning were documented by Lee and Mackenzie (2003) and O’Toole and Schoo (2010).

Working in complex and demanding roles in isolated, rural locations was a concern noted in the findings, exacerbated by the lack of occupational therapy profession specific support and someone to bounce ideas off. One participant questioned how they could know if what they were doing was right or how well they were performing if they were working in a sole occupational therapy role with no-one to bounce ideas off. This was also discussed by another participant in terms of the challenge of practicing occupational therapy as opposed to the theoretical knowledge gained from Polytech with no-one available to bounce ideas off at the time.

In a study of new graduate transition to practice, Moores and Fitzgerald (2017) do not specifically mention the concept of bouncing ideas around, but supervision was identified as an important contribution to transition from theory into practice. Support from work colleagues was also noted for providing advice and information and described as a “community of practice” (p.309).

A concerning issue was discussed by a participant who chose not to use their team to bounce ideas off because they did not feel the team cared about or understood the role of the occupational therapist (Participant A). This experience is supported by Gray et al. (2012) who found that new graduate occupational therapists, especially in rural practice, felt more confident with assessment, and interventions than they did with interactions with other professionals.

The lack of opportunities for bouncing ideas around was also discussed in terms of the additional time it took to make clinical decisions. Researching solutions and options and developing clinical reasoning skills to determine
which piece of equipment or strategy is the most appropriate solution for more complex clients takes a significant amount of time when there is no-one to discuss options with. This also leads to reduced confidence to be able to express their clinical reasoning to explain to others why one solution is preferred over another (Participant C). Pighills et al. (2013) also recognised the implications of time constraints when working in rural practice.

Another risk is that service provision could be limited by the expectations of the referrer. This was identified by Pighills et al. (2013) and described by one of the participants (Participant C) who felt she was perceived as the equipment lady, who’s role it was to give people what they wanted, and another in mental health who was providing an activity program as prescribed by her manager rather than a valued occupational therapy professional (Participant A). Without a colleague to share clinical reasoning with or a safe space to bounce ideas around, they did not have the confidence or opportunities to utilize their occupational therapy specific skills, further develop their profession specific knowledge base or voice their concerns.

Lee and Mackenzie (2003) and Pighills et al. (2013) note an increase in demand for feedback and support from other health professions but acknowledge the risks associated with a lack of profession specific support and supervision. Development from novice to more experienced professional as described by Petiprin (2020) requires access to effective support and supervision. Being able to function as a competent new graduate therapist in a diverse and isolated role, understanding and recognising their responsibilities under te Tiriti o Waitangi, consolidating knowledge and skills as an occupational therapist, and building resilience requires a supportive team that can bounce ideas around in the moment in a safe and nurturing environment.
Recognising that most new graduates require opportunities for growth and development that include both profession specific and interdisciplinary sharing and bouncing ideas around for effective clinical reasoning is essential when developing rural practice models in the future. This could also be included in training and development opportunities as well as formal and informal provision of effective supervision and support structures when new graduates are hired into rural practice.

3. The importance of connection.

The value of establishing and maintaining connections was highlighted in this study both from the perspective of service delivery, but also as a support strategy for new graduates themselves.

Building a rapport, making connections, and building positive relationships were noted by participants as important means to gaining better assessments and outcomes from their interventions. Ensuring a sense of connection and belonging, however, is equally important for the wellbeing of the new graduates. This is recognised by Wilcock (2007) who included “belonging” in her concept of occupational balance, adding to her original concept of “doing, being, and becoming” to support health and wellbeing. This is further analysed by Hitch et al. (2014) who look at the interrelationships between doing, being, becoming and belonging.

Brown-Rutledge (2011) considers Maslow’s hierarchy of needs which was originally developed in 1948 but has updated and “rewired” it from the pyramidal concept of basic physiological and biological needs at the bottom, through to self-actualisation at the top to a non-hierarchical system where all human needs revolve around connection or “belongingness” at the centre (p.2).
In a critical analysis of the interactions and relationships between doing, being, becoming and belonging in occupational science, Hitch et al. (2014) state that becoming and belonging are the two most misunderstood dimensions, and that belonging entered the occupational therapy consciousness later and with less emphasis than the other states. How interesting, then, that such as great importance was placed on belonging and connection by the participants in this study.

Living and working in rural and remote locations can be a barrier to making connections due to the time and distances travelled to provide interventions as cited by Pighills et al. (2013). The New Zealand Health System Review (2020) also recognises that rural communities are some of the most vulnerable and priority is being placed on ensuring consumers, whānau and communities are at the heart of the new and emerging health system. It could be argued that building and maintaining effective connections is key to this vision.

“Then COVID 19 hit.” (Participants D and E). The stress and anxieties associated with a global pandemic and resultant lockdowns which impacted on the ability to make and maintain effective connections made for an “interesting” (Participants B and D) start to new graduate occupational therapist’s careers.

Whilst for some it was an opportunity for additional study, for others it was hard to feel that they could competently fulfil their role in areas such as assessments and family meetings via the telephone or using other digital technologies. Feeling disconnected and “chucked in at the deep end” (Participant E) was an issue. Hocking (2020) discussed how to achieve occupational balance from an occupational perspective of population health in a pandemic in Aotearoa. She also comments on the impact of changes to daily routines and a feeling of being disconnected on mental wellbeing.
The use of technology as a tool for connection is discussed by Brown-Rutledge (2011). Many of us recognised the importance of connections and early in the COVID journey we embraced new and innovative ways to maintain connections in our local and digital communities.

Remaining connected during COVID lockdowns incentivised the rapid progression and use of digital technology including telehealth plus enabling meetings, conferences and training from a distance using Microsoft Teams, Zoom, Google and/or other platforms. This provided valuable opportunities for continuity of care and connection within teams, however, there remain limitations, especially when the people we support live in rural and remote locations with limited access to technology. Even prior to COVID, technology was being considered as a viable option to improve connection and access to services in rural and remote areas.

Considering options for increasing efficiencies in occupational therapy interventions, literature regarding the use of technology for home visits has been a global phenomenon. Bishop and Brott (2020) found that, in Aotearoa, the use of an environmental questionnaire and digital photographs was feasible for some people if they had access to suitable technology and the knowledge to use it effectively but recognised that there is a risk of unreliable data being provided if the therapist does not complete the assessment in situ. Similar results were documented by Read et al (2020) in the United Kingdom and Ahlin et al, (2021) in Sweden. A recent study by Giroux et.al (2022) recognised that the ad-hoc Virtual Health (VH) delivery to rural and remote locations in British Columbia as a COVID response could exacerbate inequities.

The findings align with these studies, with participants recognising that there is a place for telehealth. It can be more difficult, however, to develop
connections and to measure the effectiveness of occupational therapy interventions without the physical face to face interventions, even if the clients have access to technology and the competence to use it effectively. Perhaps we can learn from the Giroux et al. (2022) project and work in partnership with the communities to develop virtual health services that reduce inequities in rural health care. This is outside the scope of this research but something that would be very interesting for rural health providers to consider if they are not already doing so.

Supervision is also often provided via digital technology, this enables accessibility to OTBNZ required weekly new graduate supervision remotely, which is understandable for those working in isolated rural roles. For some, having access to supervisors in this way was seen as a lifeline, and the potential for being able to discuss team issues with an outsider was helpful. There were, however, difficulties associated with supervisors not understanding the rural context within which the supervisee worked. Many of the participants recognise that remote supervision is necessary but as noted by Lee and McKenzie (2003), even though technology has advanced significantly since then, would prefer face to face communication, at least some of the time, much like many of the people they support.

The importance of connection was seen as “massive” (Participant E) for a new graduate, and a recommendation from one of the participants was to “force yourself to remain connected.” (Participant F). Access to support was mixed, some could participate in regional new-graduate programs while others felt completely disconnected to the point of actively seeking alternative employment or just giving up asking for support.

Feelings of isolation were also reflected in the findings, both from geographical and professional perspectives. Being a solo occupational therapist within a
multi or interdisciplinary team, time spent alone travelling, or being the only full-time staff member in a team of part-timers generally were seen as positives from the participants who grew up in rural areas, but the participants from more urban areas seemed to find this lack of connection more challenging. This aligns with Campbell et al. (2016) who researched personality traits in relation to recruitment and retention into rural roles and Nixon (2018) who established that people are more likely to be drawn to rural practice having had previous rural experiences.

A recommendation from one participant was that it would be “really cool” (Participant E) if rural occupational therapy practitioners had a way to meet up, reach out or connect with others. Another noted that she felt she was the only person working in her field, but she was not sure because there is no access to other rural practitioners to find out. With technological advances, utilizing digital technology to develop a network that connects rural occupational therapy practitioners is an opportunity that could be further explored.

In terms of connection, one size does not fit all. The need for connection is essential but differs according to context, culture, person, and situation. Instilling a sense of belonging for a new graduate working in isolation may require flexibility and a variety of options, including technology, face to face and community linkages. Including the new graduate in the process of developing individual support networks, choice of technology, supervisor and method of supervision and connection could help better meet the need.

4. Expect change.

Whilst change is a given in any position, the extent and frequency of changes to role and scope following successful recruitment by five out of six of the participants was completely unexpected. For most, the change occurred early
in the recruitment process. While this is within the legal rights of the recruiting organisation, it could be considered questionable from a moral and ethical perspective. It also does not foster trust for a new graduate who was left wondering how they were recruited into a job they did not apply for.

One therapist’s role changed twice in a year from inpatient to community and back again. She found this situation “crazy” (Participant B). Another (Participant C) found that her role changed from adult physical health to include paediatrics and then she was moved from a hospital hub environment to a lone role in an isolated community with just two months’ notice. The physical move with little warning was particularly stressful for this occupational therapist, not only from a professional perspective, but also logistical and social. Having recently moved to the rural area, organised accommodation in one town, started to make friends and be involved in local social activities, she had to move and start again only to return to the initial town within a six-month period. It could be argued that this goes beyond the expectations of a clinical rotational position, especially as the new graduate was not aware of this requirement at the time of recruitment.

It is understandable that new graduates could feel overwhelmed, devalued, lack confidence and self-worth (Participants A, B, C & F) when there is so much change to their roles with seemingly little regard to the social and emotional toll that could result from such managerial decisions. Considering the extensive changes experienced by new graduate participants in this small study, it would be interesting to gain a broader understanding of this phenomenon. There is a paucity of studies relating specifically to the extent of role changes experienced post recruitment for new graduates in rural practice. It could be assumed or hypothesized that this trend is less prevalent in urban areas, but further research is required to develop an evidence base.
The findings illustrated a potential lack of understanding from the top managerial tiers of the organisations. This resulted in participants feeling that higher management did not understand what occupational therapists do, with an expectation that they can work across all areas, regardless of skills or interests. In relation to changing roles, participants questioned how they could be expected to do a job well if they were changing location and/or role every three to six months? This may be the expectation of a rotational role, however, experiencing a rotating position in a large urban location with a cohort of colleagues, support structures in place, consistent living arrangements and social networks is quite different to changing roles and physical, geographical locations from one isolated role to another without effective professional or social support.

One participant (Participant A) commented that you are likely to leave if you are pushed into a role that you have no passion or interest in. Cosgrave et al. (2018) recognised that feeling valued by the manager was an important factor in job satisfaction. It would be difficult to feel valued if your experience was one of constant change, especially if this was not indicated during the recruitment process. Due consideration from employers does not seem to have been given to the implications of frequent role changes and expectations on the new graduate in terms of health and wellbeing and development of competent practice.

The imperative to fill positions and provide a service at any cost seems to override the needs of the new graduate. More could be done to improve the knowledge and understanding of managers regarding the role and scope of the new graduate occupational therapists as well as better preparation for the new graduates regarding demands and changes expected when working in rural practice.
To address the global shortage of staff in rural and remote areas the focus is often on recruitment, but retention is equally important. Cosgrave et al. (2018) state that the average time for allied health professional’s working in rural health in Australia is three years. It is not known what the current average time is for an occupational therapist working in rural health in Aotearoa, but it is not surprising that new graduates leave if they experience such drastic changes to their roles in such a short space of time. Further research on retention and job satisfaction rates for allied health workers in Aotearoa would be interesting as it is not included, specifically in this study.

**Summary**

In summary, new graduate occupational therapists working in rural practice shared experiences which answered the research question and provided some valuable insights into the good, the bad and the ugly when working in this space. Whilst their roles were broad and geographical areas extensive, the new graduates expressed many commonalities when discussing their experiences.

Findings from this research recognise that occupational therapists working in rural practice in Aotearoa must be flexible, self-sufficient and have a very diverse interesting and complex caseload, but there are limitations on how broad and general a role should be for a new graduate. Working across broad specific specialist clinical areas such as physical health, mental health, or paediatrics may be more manageable. Although one participant commented on needing to have some physical and mental health clinical skills to work with the mind and body, expectations of some kind of super-occupational therapist who works across all rural domains may be a bridge too far, especially for new graduates.

The importance of having opportunities to bounce ideas around, was recognised by all participants. This includes discussion and conversation with
peers rather than the more formal professional or clinical supervision which was also seen as essential by new graduates but separate to sharing ideas. Being more isolated limits the opportunities for bouncing ideas around, consolidating knowledge and developing clinical skills in comfortable, safe and informal settings.

The significance of connection or belongingness was another shared experience, perhaps more noticeable in rural and remote locations when the risk of feeling isolated or disconnected is more likely.

Experiences of change were significant, and for some extreme. COVID added to these feelings and issues, but also provided some opportunities, especially in the area of technology noted by participants. Resilience and determination in the face of change was a common outcome.

**Study limitations**

Limitations of this study are described below:

i. **Sample size and profile**

This was a small study; six new graduates met the inclusion criteria and participated. They included several distinctly different clinical specialties but shared the common ground of rural practice across different rural and remote regions of Aotearoa. Whilst the participants provided a cross section of new graduates working in rural practice, their voices were limited.

ii. **Paucity of research from the context of new graduate occupational therapists in rural Aotearoa.**

Whilst the limited literature and research on this topic was the driver for the research question, there is little evidence to support the findings specifically from an occupational therapy new graduate context in Aotearoa. Much of the
supporting literature is from Australia, Canada, United States of America, and Britain.

The findings indicate that there might be some advantages to the occupational therapy profession being better understood by other professionals and managers, which is an on-going debate in terms of raising the profile of occupational therapy, but far beyond the scope of this research study.

iii. Data collection process.

Data was collected by an experienced occupational therapist, primarily via technology due to geographical distances. This provides a potential power imbalance and may limit the connection from face-to-face interviews that could impact on the openness of the responses and the comfort of the participants.

iv. Defining rural practice and rural generalism.

Although the participants expressed a basic understanding of rural practice and rural generalism, it is not clear how this pertains to allied health and specifically occupational therapy.

Defining rural practice, rural generalism and when a clinical interest or scope of practice becomes a specialism has been an on-going discussion point for decades but remains vague. The experiences of participants indicate that organisations are developing models of practice and expecting service provision from new graduates without due regard to evidence-based research, health and wellbeing of the workforce or safety of the public. It is not, however, within the scope of this study to provide definitions or research models of practice for rural practice.

v. Resource constraints
This study was completed as a master’s thesis, as a result, time and resources were limited. With more time allocated to a similar study, additional researchers and possible opportunity for remuneration for participants this could encourage a larger study with additional data to draw from.

**Ideas for future research**

Clearly there are benefits to working in rural areas, and the participants expressed their love of the outdoors and the opportunities to work autonomously and cover a wide variety of clinical areas,

Future research opportunities indicated from the study include:

  i. New graduates in allied health accessing effective support and supervision utilizing a mix of technology and in person supervision with opportunities to network with other rural therapists who understand the rural context.

  ii. Gaining a better understanding of the reasons behind the extent of changes experienced by new graduates in rural practice in comparison to urban new graduates could provide additional context to rural practice and expectations of therapists and employers.

  iii. The lack of understanding and clarity of expectations from managers, organisations and decision makers was experienced as barriers to effective support and professional growth for the new graduate occupational therapists. This could be investigated in more detail when researching support structures and opportunities for learning and development in rural health.

  iv. Review and development of models or frameworks for allied health professionals working in rural health in Aotearoa would be beneficial for
effective recruitment, retention, and development of resilient practitioners in addition to safe, sustainable, and equitable service delivery.

Research implications

In addition to effective support structures, participants expressed the importance of opportunities to make connections and access to people to bounce ideas off as essential elements in the health and well-being of new graduates. Ways to incorporate these into learning and development opportunities would be beneficial. Perhaps the educational institutions, OTBNZ and employers could collaborate on how best to provide this level of support post-graduation.

The development of communities of practice, as described by Halle et al. (2018) for new graduate rural OT practitioners could be established to provide support, growth, and development opportunities and meet the needs for connection and a forum for bouncing ideas around.

Time is another important consideration for new graduate occupational therapists in rural practice. Not just in the time it takes to travel vast distances in rural areas, but the additional time it takes for research and the development of critical thinking and problem solving. This is exacerbated by working alone or in teams with less support than urban counterparts may have access to, in addition to complex and varied caseloads.

Alongside these less formal learning and support networks, effective supervision practices could be developed as described by WFOT (2014) regarding specialist and advanced occupational therapy competencies. Interprofessional supervision as well as profession-specific supervision could be provided. This could be achieved utilising face to face local connections plus digital technology options that include consistent approaches to meet the needs of new graduates. These strategies could continue beyond the
mandatory OTBNZ new graduate supervision and be developed as part of the new health service models of practice.

The lack of understanding and clarity of expectations from managers, organisations and decision makers is a barrier to effective support and professional growth for the new graduate occupational therapist. To improve the experiences of new graduates, better planning, organization, and communication on the part of the employer may help. In addition, if significant changes like the experiences of participants in this study are inevitable, perhaps more could be done to prepare new graduates prior to graduation.

Recognised rural generalist models of practice with established frameworks that clarify expectations and scopes are not yet developed in Aotearoa. It is evident from the literature and this study that the development of specific models of rural practice with effective training, support and supervision structures would help to develop rural practitioners of the future.
Chapter Six

CONCLUSION

This research aimed to understand the experiences of new graduate occupational therapists working in rural practice in Aotearoa.

The literature review provided the evidence base that supported the development of the research question. The methodology chapter established that an interpretive descriptive approach (Thorne, 2016) was the research method of choice for this study. Semi-structured interviews, using a Hui process (Lacey et al., 2011) were completed to capture the voices of new graduate occupational therapists with five years or less experience post-graduation, working in rural practice.

This research provided some answers to the question: “What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa New Zealand?”

This study demonstrated that the positive experiences of new graduate occupational therapists in Aotearoa are in-line with international literature (Berg-Poppe et al., 2021; Campbell et al., 2016; Devine, 2006; Dolea et al., 2010; Lee & Mackenzie, 2003; O’Toole and Schoo, 2010; and Roots & Li, 2013). These include skill building in a variety of clinical areas, having interesting and diverse caseloads, and working autonomously and flexibly to meet the needs of the people they support, whānau and communities. Opportunities to consolidate learning from educational establishments and meet personal goals and aspirations were also described alongside the benefits of living in areas of natural beauty, engaging in outdoor pursuits and being close to whānau and friends.
The risk factors identified in this study are also supported by the literature. These included issues of isolation (Berg-Poppe et al., 2021; Roots & Li, 2013), feeling overwhelmed (Turpin et al., 2021), and lacking the confidence to provide the extensive range of clinical services required in rural practice (Lee & McKenzie, 2003; O’Toole & Schoo, 2010) as well as issues with managerial support including not feeling supported or valued (Cosgrave et al., 2018), or understood by managers or colleagues from different professions (Roots & Li, 2013).

Some limitations of the study are noted in the discussion chapter but taking these into account there are some important takeaway messages, and outcomes that contribute to the knowledge regarding new graduate occupational therapy experiences and rural practice in Aotearoa.

**Research Contributions**

i. There are significant changes in the health sector in Aotearoa at the present time, but the experiences and extent of changes among the participants in this study were significant, extensive, and unexpected. The changes included changes to role, changes to location, changes of management and changes of expectations.

In addition to the changes experienced from a role perspective, the experience of the COVID 19 lockdowns and changes to ways of delivering health services through the pandemic, and the after-effects where also destabilizing. For some, the toll on their health and wellbeing was expressed. For others they saw the benefit and opportunity in finding new ways of working and adapting to frequent changes.

Further research is indicated if we are to better understand if this experience of change is usual for new graduates, or if it is more pronounced in rural practice versus urban areas. There may also be an opportunity for students to build
resilience and expectations regarding the likelihood of change prior to graduation, which could be a takeaway message for both employers and educational establishments.

ii. Experiences of participants indicate that there was a lack of clarity of their roles prior to recruitment which led to some of the issues above relating to change. Establishing the role of the new graduate occupational therapist in rural health by employers prior to recruitment could be beneficial. To improve the experiences of new graduates, better planning, organization, and communication on the part of the employer may help clarify expectations.

iii. There is a gap in terms of defining rural practice and rural generalism from the perspective of occupational therapy and how expansive the role and scope should be. Interprofessional education and collaborative working practices are successfully providing training opportunities for students in rural Aotearoa now, however, rural generalist frameworks post-graduation, such as those developed in Australia (SARRAH n.d.) do not yet exist in Aotearoa. The development of a rural generalist allied health model or framework in the context of Aotearoa might help to clarify roles, scope and expectations for therapists, managers, and employers.

iv. Access to effective support and supervision was described by participants in terms of being able to “bounce ideas around”. The ability to share thoughts and ideas with likeminded individuals in terms of support and professional growth was seen as essential. Whilst formal supervision, either in person or utilizing technology is a requirement by OTBNZ, less formal opportunities to work things out and throw ideas around can be difficult to access when working alone or in small teams. Learning the value of this kind of support for new graduates could influence the development of communities of practice (Moores & Fitzgerald, 2017) to provide the kind of opportunities that would meet this need. It would
not, however provide the ‘in the moment’ conversations noted by participants. Another opportunity might be the establishment of communities of practice, or inclusion in existing communities of practice prior to graduation if students have an interest in working in rural health. Perhaps developing networks and communities of rural occupational therapy practitioners might enable access for the ‘in the moment’ conversations as well as planned meetings.

v. In addition to less formal learning and support networks, the participants expressed a lack of effective supervision. Some participants preferred face to face supervision but recognised that this is not always possible in rural areas. Interprofessional supervision as well as profession-specific supervision could be provided with a specific focus on rural practice. This could be achieved utilizing face to face local connections plus digital technology options that include consistent approaches to meet the needs of new graduates. These strategies could continue beyond new graduate supervision and be developed as part of the new health service models of practice.

vi. The importance of belonging is well established in the field of occupational therapy (Wilcock, 2007), this concept was expressed by participants in terms of connection. This concept of connection was broad, covering the personal need for connection with others for health and wellbeing, professional connection with peers especially when working in isolation including connection with your profession and interprofessionally, and the connections required with the people you are supporting, whānau and the communities. When developing rural practice models and support structures, it is important that making connections and fostering a sense of belonging is central, much like the Brown-Rutledge (2011) rewired model of Maslow’s hierarchy of needs.

vii. Recognising that new graduate occupational therapists in rural practice need more time allocated to their work, or a smaller caseload than their urban
counterparts could be helpful. Whilst there are technological advances in service delivery options, especially since COVID, the participants recognised that some people need to be seen in situ for assessment and interventions. This resulted in increased time to travel vast distances, and additional time for research and development of critical thinking and problem solving when working alone or in small teams with less support than urban counterparts may have access to.

viii. Participants demonstrated a knowledge and drive to recognise their responsibilities under te Tiriti o Waitangi and to strive towards equitable outcomes for Māori wellbeing, taking the initiative to find support when needed and to practice responsively to te Tiriti. This evidences a readiness for the current health reports and focus on health equity and the requirements of OTBNZ for competence to practice.

In conclusion, in answering the research question: “What are the experiences of new graduate occupational therapists working in rural practice in Aotearoa New Zealand?” The experiences of new graduate occupational therapists provided some interesting contributions.

The health reforms that are currently afoot and the uncertainty of a pandemic have been challenging experiences for the new graduate occupational therapy participants. These have potentially exacerbated some of the feelings of isolation, confusion regarding role and scope, and lack of effective support. But regardless of all these challenges and changes, the participants demonstrated great resilience and for the most part love their jobs and the rural lifestyle.

Much could be done to improve these experiences and develop rural generalist practice models for the future. With effective support structures in place, there are opportunities for the therapists of occupation to be integral in the rural health services of the future. Being mindful of cultural responsibilities and equitable access to services for all, including Māori, socially disadvantaged and disabled
individuals in rural and remote communities the new graduate occupational therapists could find their place. Through building connections, establishing professional roles and scope, interdisciplinary collaborative working models and communities of practice specific to rural practice as well as effective use of evidence informed models and use of technological advances, rural practice in the future could be an exciting adventure for a new graduate occupational therapist. In the words of one of the participants:

*I think that’s one of the best things about being a generalist and being rural, is because the need for OT is immense, so immense… You have to try to attach meaningful occupation where you can. Finding that space wherever it is. Because that’s the beautiful thing about our profession. It fits anywhere. If you can apply it, it fits absolutely anywhere.* (Participant F)
References:


https://doi.org/10.1177/

https://www-proquest-com.op.idm.oclc.org/scholarly-journals/digital-age-occupational-therapy-home-visits/docview/2436134334/se-2


Cambridge Dictionary (n.d.).
https://dictionary.cambridge.org/dictionary/english/new


https://doi.org/10.1371/journal.pone.0167256

Collins Online Dictionary (n.d.)
https://www.collinsdictionary.com/dictionary/english/graduate

findings from a grounded theory study. *Rural and Remote Health* 2018; 18: 4511. [https://doi.org/10.22605/RRH4511](https://doi.org/10.22605/RRH4511)


Manatū Hauora, Ministry of Health, New Zealand (2019).


https://doi.org/10.1258/135581906778476544

Ministry of Justice (2022). Waitangi Tribunal


MoH Sector Engagement Allied Health Workshop (2019).


https://doi.org/10.1177/0308022619876842

the preparedness for practice of New Zealand new graduate
occupational therapists. Prepared for the Occupational Therapy Board of New
Zealand. Auckland, New Zealand: AUT University.

New Zealand Accident Compensation Corporation (n.d.)
https://www.acc.co.nz


Care, 10(2), 102–105. https://doi.org/10.1071/HC18025

Office of Māori Development, Otago. (n.d.). Introduction to the Treaty of
Waitangi. www.otago.ac.nz

Occupational Therapy Board of New Zealand (2004). Continuing Competence
Framework for Recertification Practitioner Handbook. OTBNZ.

Occupational Therapy Board of New Zealand (n.d.) What is occupational
Therapy? https://www.otboard.org.nz/site/about/OT?

Occupational Therapy New Zealand Whakaora Ngangahau (2010). Hohepa
MacDougall Kaiwhakamaori / Translator, Te Taura Whiri i te Reo Māori /
https://www.otnzwna.co.nz/occupational-therapy/what-is-occupational-
therapy

Occupational Therapy New Zealand Whakaora Ngangahau (2016). Position
statement on Interprofessional Education and Collaborative Practice.
https://www.otnzwna.co.nz/otnz-wna/otnz-wna-documents/


[https://doi.org/10.1080/14427591.2007.9686577](https://doi.org/10.1080/14427591.2007.9686577)


[https://doi.org/10.22605/RRH5835](https://doi.org/10.22605/RRH5835)

World Federation of Occupational Therapy (2012).

[https://wfot.org/about/about-occupational-therapy](https://wfot.org/about/about-occupational-therapy)


[https://www.wfot.org](https://www.wfot.org)


[http://www.who.int/hrh/nursing_midwifery/en](http://www.who.int/hrh/nursing_midwifery/en)
10 May 2021

Joy Aiton
c/- School of Occupational Therapy
Otago Polytechnic
Private Bag 1910
Dunedin 9054

Dear Joy

Ethics approval for project
Reference Number: 902
Application Title: A study of the experiences of new graduate occupational therapists (Ots) employed in rural practice in Aotearoa

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: Joy Aiton.
Project approval is valid for three (3) years from date of letter.

Regards

Dr. Liz Ditzel
Chair, Otago Polytechnic Research Ethics Committee
Appendix 2

Consultation with Kaitohutohu office

Joy Aiton

Student ID

May 2021

Project title

A study of the experiences of new graduate occupational therapists (OT’s) employed in rural practice in Aotearoa.

Overview:

The term ‘Generalist’ is frequently used to describe allied health professions as a future working model, especially in rural and remote areas.

This study aims to answer the question: What are the experiences of new graduate occupational therapists working in generalist roles in rural Aotearoa, New Zealand?

The study will use an Interpretive Descriptive approach with semi-structured interviews to capture the experiences, thoughts, and feelings of Occupational Therapists 5 or less years post-graduation who are working in rural areas.

The recent Pūrongo Whakamutunga (Health System Review 2020) recommends system level changes that “lead to better more equitable outcomes for all New Zealanders”. The focus on equity is an important element to this study, which includes Māori in the understanding of service provision to rural and remote areas.

This research is not being conducted by Māori, and so this consultation process is imperative as is the consideration of the 3 Te Tiriti articles:

1. **Kawanatanga.** The right to govern by the Crown was accompanied by a commitment to protect Māori interests. This research is interested in the experiences
of new graduate OT’s and their perceptions of service provision and their role within this. Ultimately this includes the OT’s ability to protect Māori interests.

2. **Tino Rangatiratanga.** The process of self-determination and autonomy may be part of the discussion of some participants depending upon their experiences and culture as well as the cultures of those they support.

3. **Oritetanga.** Equality and equity of services for all is perhaps the most pertinent of the 3 articles to this study. Provision of services to hard to staff rural and remote areas has been a driver for rural generalism as a way of attempting to provide equitable services. This study aims to learn from new graduate OT’s from their perceptions of this strategy.

**Socio-cultural considerations:**

Results will be interesting and relevant to Māori as many rural communities include lower socio-economic areas and higher indigenous populations, however, unlike other indigenous cultures, some rural regions in Aotearoa have fewer than the national average of Māori residents. This can result in challenges when including the Māori world view in meaningful and relevant ways. Considering the Te Ara Tika ethical principles (NEAC 2019) in combination with bioethical principles ensures inclusion of bi-cultural components with a focus on socioeconomics, justice, culture, and equity alongside risk mitigation, informed consent, and respect.

In small and rural communities maintaining anonymity and confidentiality can be more difficult. Strategies to minimise this risk include recruitment of participants via the Occupational Therapy Board of New Zealand as a third party, effective informed consent, explicit information, and consent forms signed by both parties, identifying information will be removed from transcripts and absent from any publication.

5 – 10 participants will be recruited. Inclusion criteria: New graduate Occupational Therapists, or OTs with 5 or less years’ experience who work in rural and remote geographical areas of New Zealand. Their roles should include generalist rather than specialist responsibilities, working across several clinical areas including Medical,
Orthopaedics, Acute Treatment and Rehabilitation (AT&R), Community, Mental Health, Primary Health Organisation (PHO) and Paediatrics.

The first 5 suitable participants will be selected initially, following this, purposive selection will be utilised to include representation from different regions. This will be dependent upon interest and numbers of volunteers.

A Hui Process (C. Lacey et al., 2011) will be followed for the semi-structured interviews. This will provide a cultural lens that may encourage participation from OT’s in a variety of locations and organisations.

Demographics that encourage and invite Māori participation will be requested and will include:

- Ethnicity: How do you classify yourself ethnically?
- Gender: How would you like to identify yourself?
- Age: 21-30, 31-44, 45 and above.

The interviews will include:

1. Mihi: greeting
2. Whakawhānaungatanga: connection
3. Kaupapa: the content of the interviews
4. Poroporoaki: conclusion

The researcher will be mindful of possible power imbalance which could inhibit natural conversation and impact on data, or the potential to ‘fit the data’ to their own theories and either miss alternative conceptualisations, prematurely close discussions, influence outcomes or unintentionally restrict discussions. The style of communication will be friendly, supportive, and non-judgemental. The relationship will be respectful, equitable and the data collected will be checked and cross checked for accuracy. Feedback from participants will be encouraged and acted upon throughout the process. Research will also be peer reviewed prior to publication.
Appendix 3

Invitation to participate in a research study.

Letter for OTBNZ

You are being invited to participate in a research study titled “A study of the experiences of new graduate occupational therapists (OT’s) employed in rural practice in Aotearoa”.

This study is being completed by Joy Aiton as part of a Master’s degree in Occupational Therapy through Otago Polytechnic. Joy is being supervised by Sian Griffiths and Dr. Rita Robinson, lecturers from Otago Polytechnic to ensure process and rigour is adhered to.

This study aims to define ‘rural generalism’ and to capture the experiences of new graduate occupational therapists recruited into generalist roles in rural Aotearoa. This information could inform future training, development and support structures required to provide generalist services safely and successfully and or demonstrate gaps in this proposed service structure for further research.

I am seeking new graduate Occupational Therapists, or OT’s with 5 or less years’ experience who work in rural and remote geographical areas of New Zealand. Roles should include generalist rather than specialist responsibilities, working across several clinical areas including Medical, Orthopaedics, AT&R, Community, Mental Health, PHO and Paediatrics.

Participants will have a maximum of 5 years’ experience in a rural area of New Zealand having been recruited directly into that role as a new graduate.

Rural and remote is defined using the Statistics NZ classification relating to low urban influence and remote areas.

The research involves a semi-structured interview 1:1 with the interviewer via technology. This interview should take approximately 45 minutes. Any identifying information will not be included in this study. Your participation is entirely voluntary.
If you are interested in taking part, please download a copy of the participant information sheet here [provide download link] and retain this for your records. If you have any questions, please email AITOJF1@student.op.ac.nz or call 0800 762 786 and ask for Sian Griffiths.

Supervisors contact details: sian.griffiths@op.ac.nz

Thank you for participation.
Appendix 4

Participant Information

Semi-Structured Interview

Project title

A study of the experiences of new graduate occupational therapists (OT’s) employed in rural practice in Aotearoa.

General Introduction

The term ‘Generalist’ is frequently used to describe allied health professions as a future working model, especially in rural and remote areas. Rural Generalist, specialist generalist, and expert generalist are all terms used, but with little tangible evidence for, or consistent definition of the terms.

Recruiting to historically hard to staff rural areas is a constant struggle. New and innovative ways of working and providing sustainable health services into the future are regular themes in health service strategy globally.

Whilst literature refers to rural generalism as an experienced, specialised role or extended scope of practice, new graduates are recruited into these roles. If rural generalism is to be a future health workforce strategy in Aotearoa, it is important that a clear definition can be determined and that we learn from international experiences as well as research the impacts of this strategy on new graduate OTs to ensure they have access to effective training and learning support both before and after graduation.

What is the aim of the project?

This study aims to define ‘rural generalism’ through a literature review and to capture the experiences of new graduate occupational therapists recruited into generalist roles in rural Aotearoa. This information could inform future training, development and support structures required to provide generalist services safely and successfully and or demonstrate gaps in this proposed service structure for further research.
The question is: What are the experiences of new graduate occupational therapists working as generalists in rural Aotearoa, New Zealand?

**What types of participants are being sought?**

I am seeking new graduate Occupational Therapists, or OTs with 5 or less years’ experience who work in rural and remote geographical areas of New Zealand. Roles should include generalist rather than specialist responsibilities, working across several clinical areas including Medical, Orthopaedics, AT&R, Community, Mental Health, PHO and Paediatrics.

Participants will have a maximum of 5 years’ experience in a rural area of New Zealand having been recruited directly into that role as a new graduate.

Rural and remote is defined using the Statistics NZ classification relating to low urban influence and remote areas.

**How will potential participants be identified and accessed?**

A request will be sent electronically to practicing OT’s willing to participate in research through OTBNZ. 5 to 10 Participants for the semi-structured interviews will be recruited from interested participants who meet inclusion criteria.

The first 5 suitable participants will be selected in addition to purposive selection to include representation from different regions.

**What will my participation involve?**

Semi-structured interviews will take place via technology 1:1 with the interviewer and take approximately 45 minutes to complete. An Interpretive descriptive approach will be used, considering both what and how responses are given.

Any information you share will be checked with you to ensure the researcher has understood your feedback correctly.

The process will be collaborative, your experiences will not be judged or criticised.

**How will confidentiality and/or anonymity be protected?**
Names of participants will remain confidential. Only those involved in this project will be aware of who the participants are.

Your identity will remain confidential at all times unless specific consent is gained from you in writing.

**What data or information will be collected and how will it be used?**

Personal information: your name, contact details and place of work will be held on the cloud (one drive/google docs/teams) password protected and accessible only by the researcher and supervisors from Otago Polytechnic.

Joy Aiton, Sian Griffiths, Rita Robinson and any intermediary who signs a confidentiality agreement (Appendix 4) will have sole access to the data and personal information.

Raw data will be collected in the form of notes taken during the interview by the researcher and electronic recordings securely password protected in Microsoft Teams through Otago Polytechnic or on the Otter (transcription) App. Paper notes will be scanned into the cloud-based password protected documents and the originals destroyed.

Results of this project may be published but any data included will in no way be linked to any specific participant without prior consent.

**Data Storage**

The data collected will be securely stored so that only named researchers will have access to it. This will be retained in secure storage on USB for a period of seven years (July 2029), after which it will be destroyed.

**Can participants change their minds and withdraw from the project?**

If you choose to participate, you may withdraw from the project at any time, without giving reasons for your withdrawal.

You can withdraw any information until 2 weeks from your receipt of transcripts for review.
You can also refuse to answer any particular question, and/or ask for the audio to be turned off at any stage.

**Supervision**

Supervision will be provided throughout the research process by Sian Griffiths, lecturer at Otago Polytechnic. This supervision will support the lead researcher through the process of the plan, research, analysis, and documentation and will ensure ethics and research protocols are followed for safe and academically rigorous completion of the study.

**What if participants have any questions?**

If you have any questions about the project, either now or in the future, please feel free to contact:

Joy Aiton

Email  AIJOF1@student.op.ac.nz

Phone: 0800 762 786 and then ask for Sian Griffiths

Or my supervisor Sian E Griffiths

Email  sian.griffiths@op.ac.nz
Appendix 5

Consent Form

Semi-Structured Interview.

A study of the experiences of new graduate occupational therapists (OT’s) employed in rural practice in Aotearoa.

I have read the participant 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 and I am free to refuse to answer any particular question.
- I am free to stop participating at any time.
- I can choose to withdraw information provided without giving reasons and without any disadvantage.
- I will have the opportunity to read and comment on my transcript prior to the data being analysed up to 2 weeks from receipt of transcript.
- The lead researcher will be supervised by Sian Griffiths, lecturer at Otago Polytechnic and Rita Robinson, principle lecturer, Wintec throughout the study to ensure a rigorous process is adhered to.
- I cannot withdraw any information I have supplied after 2 weeks from my review of my transcripts.
- My data including personal information – name and contact details and interview notes, transcripts and electronic, audio data will be destroyed at the conclusion of the project. Any raw data on which the results of the project depend will be anonymized and retained in secure storage on USB, held at Otago Polytechnic for seven years (July 2029) after which it will be destroyed. If it is to be kept longer than seven years, my permission will be sought.
- Only the researcher, supervisors and official intermediaries will have access to the data.
The results of the project may be published and/or used at a presentation in an academic conference, but my anonymity/confidentiality will be preserved.

I will receive a copy of the research findings for review and feedback.

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

…………………………………………… (signature of participant)
…………………………………………… (full name of participant – please PRINT)
…………………………………………… (signature of researcher)
…………………………………………… (full name of researcher)
…………………………………………… (date)
…………………………………………… (signature of supervisor)
…………………………………………… (full name of supervisor)
…………………………………………… (date)
Appendix 6

Confidentiality Agreement
For an intermediary

Researchers must obtain a signed confidentiality agreement from anyone, such as research assistants, who will process any data which contains personal information. This should cover agreement to not disclose, retain or copy information.

Confidentiality Agreement
For an intermediary removing any identifying information from questionnaires.

Project title: A study of the experiences of new graduate occupational therapists (OT’s) employed in rural practice in Aotearoa.
Project Supervisor: Sian Griffiths
Researcher: Joy Aiton

I ………………………………………………………………………………………………………( Full Name – printed)

• I understand that all the material I will be asked to work with is confidential.
• I understand that the contents of the Consent Forms and questionnaires can only be discussed with the researchers.
• I will not keep any copies of the information nor allow third parties access to them.

Intermediary’s signature: .....................................................………………………………………………
Intermediary’s name         .....................................................………………………………………………
Intermediary’s Contact Details (if appropriate):   Date:

Researcher’s Contact Details (if appropriate):
Joy Aiton
Email: AITOJF1@student.op.ac.nz

Note: The Intermediary should retain a copy of this form.
Appendix 7

Semi-structured Interview Guide Questions

A study of the experiences of new graduate occupational therapists (OT’s) employed in rural practice in Aotearoa.

Using the Hui Process (C. Lacey et al., 2011)

1. Mihi: Greeting

Karakia starting

Kia tau te rangimarie Let peace be with us
Kia horahia te marino Let the calm be widespread
Kia whakapapa pounamu te moana Let the sea glisten like greenstone
Kia tere te kārohirohi And let the shimmer of summer dance
Ki mua i te huarahi Across thy path
Ae Amen

2. Whakawhanaungatanga: connection

Both interviewee and interviewer will provide information regarding their history and background so that links and connections can be made.

3. Kaupapa: the content of the interviews

(These questions are a guide and may change dependent on the interview).

1. How would you explain your role as an OT in rural practice?
   i. (what does rural mean to you?)

2. What is your understanding of generalism from a rural OT perspective?

3. Where are you working and how long have you worked in rural practice?

4. What attracted you to this position?
   i. Examples to encourage dialogue if needed:
   ii. Lifestyle
   iii. Close to Whanau and friends
   iv. Clinical interest
   v. Positive fieldwork experience in this clinical/demographic area
   vi. Other
5. Can you tell me about your experiences during your first year in rural practice?
   i. (e.g. What was the transition like from student to OT).

6. What opportunities have you had to develop your OT skills and knowledge?

7. What has been your experience from a bi-cultural perspective?

8. What have been the most positive and memorable aspects of this role?

9. If you could, what would you change?

10. From what you know now about the role, what advice would you give a new graduate OT just starting in this role?

11. What is your vision of OT in rural health in Aotearoa 10 years from now?

12. Do you have anything else you would like to share?

13. Demographics: The interviewee will be asked about their ethnicity and gender and how they identify themselves.
   i. Ethnicity: How do you classify yourself ethnically?
   ii. Gender: How would you like to identify yourself?
   iii. Age: 21-30, 31-44, 45 and above.

4. **Poroporoaki: conclusion**

Thank you for your participation

**Karakia ending**

E te Atua
Nāu nei mātou e arahi tae noa mai ki te mutunga o tēnei hui
Awhinatia mātou ki te mahi i a mātou mahi
Ki runga i te tika, i te pono, i te aronui
Tētahi ki tētahi
Haumi e, hui e, tāki e

Our Lord
Who has guided us from the beginning until now, the end of this gathering/meeting
To follow the right, to be truthful and to care for Each other
Yes, we all agree.