Engaging with poverty:

A New Zealand occupational therapy perspective

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Abstract

Poverty is a significant global issue that is internationally recognised as a violation of human rights, and the United Nations is committed to the eradication of extreme poverty. Although New Zealand does not experience the extreme deprivation seen in developing nations, poverty is an area of growing concern in New Zealand society. Because of the widespread nature of poverty in New Zealand, it is important for occupational therapists to be aware of the impact of poverty on their clients, and on therapeutic interventions.

The aim of this research was to explore how occupational therapists engage with issues of poverty in their practice. Using an interpretive descriptive methodology, interviews were carried out with nine occupational therapists from a range of practice areas across New Zealand. Participants were asked to reflect on what they have seen in relation to poverty in their practice, the impact of poverty on their client's occupational participation and engagement with therapy, how therapists are able to respond to poverty within their roles, and specific challenges they face when engaging with clients who are impacted by poverty.

The participants in this research demonstrated that they engage with poverty in a holistic way. Poverty was identified as a multifaceted issue that encompasses a range of personal and social factors, not simply limited to inadequate finances or physical resources. Poverty impacts clients of occupational therapy, carers and support staff that work alongside occupational therapy clients, community organisations and charities that support vulnerable members of society, and even the very services that employ occupational therapists.

When faced with poverty in practice, occupational therapists engage with their hearts, heads, and hands. That is, they take the time to understand and empathise with their client's situations; they grapple with issues of poverty,

specifically as these issues relate to ethics, justice and human rights; and finally, they act in practical ways to address issues of poverty. The strategies used to address poverty for their clients were the same tools and strategies used by occupational therapists every day in both the presence and the absence of poverty – referrals, documentation, clinical reasoning, peer support and supervision, advocacy, and occupational engagement. Participants also reflected on the way in which personal experiences and professional values shape the way they engage with issues of poverty and deprivation.

While this study has demonstrated the ways in which occupational therapists in New Zealand already engage with poverty in their practice, there was also a sense from most of the participants that occupational therapy is not yet doing enough to engage with and address the ways in which poverty violates human and occupational rights. This research wishes first to celebrate the tireless work that occupational therapists in New Zealand are doing to engage with and address poverty in their practice, and then to stimulate discussion about poverty in occupational therapy practice, both about the successes and the challenges of engaging with this widespread injustice. Recommendations from this research include strengthing occupational therapy discourse about poverty, challenging the way in which occupational therapy and occupational science think about and conceptualise poverty, expanding occupational therapy practice to address poverty more effectively, and evaluating the responsiveness of occupational therapy to issues of poverty. It is hoped that these recommendations will inspire and equip occupational therapists to take further action to engage with and address poverty for individuals, families and whanau, communities, and New Zealand society as a whole.

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Chapter One. Introduction

1.1 Background to the research question

Poverty is a significant social issue in New Zealand. Subsequently, poverty is an issue that can have a considerable impact on occupational therapy practice. Although poverty is unlikely to be the primary reason for a referral to occupational therapy services, a client's lived experience of poverty can drastically impact their engagement with occupational therapy services. While occupational therapists may be aware that some clients are living in poverty, it is likely that poverty is only one of many social and environmental factors considered. At other times, occupational therapists may be unaware of the level of poverty or deprivation clients are living with, but this does not lessen the impact of the deprivation on their lives. It is unlikely that occupational therapists will be able to eliminate poverty in society as a whole, or even in the lives of individual clients. However, better understanding poverty and its impacts will enable work to be done in a way that reduces the impact of poverty on our clients, or at the very least, does not cause additional poverty, deprivation or hardship.

Poverty in New Zealand is not a new issue; it is, however, a social issue that I personally have become more aware of in recent years. This may be because there has been increased media reporting about poverty, or perhaps I have become more aware of the media reports as I have been increasingly interested in and thus sensitised to the issue of poverty. Or perhaps it is a combination of these factors. Either way, I feel a personal and professional responsibility to explore the issue of poverty in more depth and to find out if there is a role for occupational therapy as a profession and for myself as an individual, in addressing poverty in New Zealand.

1.2 What drew me to this study

The research question and approach for this thesis has been through many revisions, and the end result looks very different from the initial idea. But ultimately this research is situated firmly in a topic that is close to my heart – that of social justice. Because of that, it is essential to situate myself as a researcher, a person, and as a professional, in this research process, and explain why this topic has become so important to me. At the beginning of this research process, I did not imagine doing a piece of work about social justice, yet I knew I wanted my research to make a difference. As a novice researcher, I knew I needed a research topic that would engage me deeply to keep me challenged and motivated, and researching poverty has certainly done this.

On a more personal level, I see examples of social justice being enacted all around me and seeking opportunities to minimise poverty and relieve the suffering of others seems to come naturally. In the years prior to commencing this research, my husband and I started providing respite foster care for a number of children, and we became intimately aware of the poverty and desperate need in our community. Our journey as foster parents changed when we welcomed a 7-month old boy into our home, and 18-months later we officially welcomed him to our family when we were appointed as his legal guardians.

When we are not providing care for children in need, we oversee the international missions team within our local church. This role involves maintaining regular contact with the missionaries financially supported by our church, supporting them and encouraging them in the work they are doing in some of the poorest nations in the world. One way we have begun supporting these missionaries, is by taking small teams from the church to visit them and to work alongside them. Not only does this provide support for the missionaries, but it also helps us to better understand the work they do and the challenges they face. Travelling to countries such as Papua New Guinea, Solomon Islands, and Thailand, also exposes us to the extreme poverty and suffering in the world, and

further strengthens the desire to make a difference.

During the course of this research, my husband travelled to Papua New Guinea where he was involved in providing basic health and dental care and also installing rainwater storage in some of the more isolated parts of the nation. He returned home with stories of encountering extreme poverty, of numerous villages that do not have access to clean water, electricity, or other conveniences considered essential for a western lifestyle. It was particularly interesting hearing these stories about the realities of life in Papua New Guinea while also researching the state of poverty in New Zealand. The contrasts are huge and reinforce the relative nature of poverty. New Zealand as a whole is so wealthy by comparison, yet poverty is still so real here. Whereas in Papua New Guinea many people have no access to safe drinking water, clothing, basic health care, basic education, transportation, and even roads, in New Zealand all of these things are available, yet the outcomes of poverty remain the same – worse health outcomes, poor educational outcomes, and social exclusion.

Being involved in these opportunities to care for some of the most vulnerable people in our world in every area of our lives is both a privilege and an awesome responsibility. My personal values are underpinned by gratitude for what all of these relationships have brought into my life. It is these same values and desires to make a difference that initially drew me to occupational therapy. I saw in occupational therapy a profession that can make a positive difference to the quality of life for people who are impacted by a range of personal or health-related challenges, and I wanted to be part of it. Yet after nearly 10-years of working on orthopaedic and general medical wards in acute hospital settings, and then in private practice working on ACC (Accident Compensation Corporation) contracts, I began to wonder if the work I was doing was really making any difference. Perhaps my early perspectives on occupational therapy were somewhat naïve or idealistic, but without these ideals, it was tempting to walk away. Instead of walking away, I decided that it is time

to look deeper – deeper into occupational therapy and the opportunities it can provide. My growing awareness of poverty raises questions about where occupational therapy fits in this vast social issue facing so many in our country and around the world. Intellectually I want to understand the mechanisms underpinning the poverty that I come into contact with and how I can deepen this response in my personal and professional life. I want to understand more about what occupational therapy can offer in addressing poverty. But before I can really understand what more can be offered by occupational therapy, I need first to understand what is already being done by occupational therapy as a whole and by individual occupational therapists. In order to understand where we are going, we must first understand where we have come from. This research is guided by an awareness of the need to look back and reflect on what has gone before, to reflect on what is currently being done, and to use this understanding as a guide for the future.

1.3 Research question

This research aims to explore the ways in which occupational therapists in New Zealand are engaging with issues of poverty within existing roles.

An interpretive descriptive research methodology utilising individual interviews with occupational therapists from a range of practice areas and geographical locations was chosen for this research. This approach was selected as a way to gather a broad overview of how occupational therapists in New Zealand view the issue of poverty, how it relates to their practice, and how they are engaging with the issues they identified. Rather than simply asking what it is that occupational therapists do to address specific poverty-related issues, the question is asked in a way that will elucidate not only what is being done, but also the why and the how behind the doing. An interpretive descriptive research design allows the analysis of the findings to move beyond description, and begin

to conceptualise what the findings mean and how they can be applied in practice.

The decision to keep this topic broad and to interview occupational therapists from a range of areas was a deliberate one. Although the issue of child poverty seems to be of particular interest in the media in New Zealand, children do not live in isolation, rather poverty is experienced by entire households, with children the innocent victims of poverty. A study of childhood poverty from an occupational therapy perspective would be of benefit to New Zealand, and in fact, such research has recently been completed (Leadley, 2018; Leadley & Hocking, 2017). A further benefit of taking a broad approach is that this research is a preliminary look at poverty in New Zealand from an occupational therapy perspective, it will provide a big picture overview of the types of issues facing occupational therapists, and the findings from this research may be useful for pinpointing specific areas of interest for future study.

1.4 Rationale for the study

The research question originated from an area of personal interest, and the research process involved a lot of reflection on my own personal and professional identity and values. At a personal level, this research has challenged me to think critically about my beliefs and assumptions about social issues. At a professional level, this research has also been a journey into understanding how a professional response to poverty can be framed. Yet the challenge of engaging with poverty in practice is not exclusive to me. Thus it quickly became apparent that the significance of this research would extend beyond my own individual experience. The research findings have been presented to occupational therapists, both fellow students and at conferences, at various stages throughout the research process. Each time the research has been well received and has generated a lot of conversation both during and after the presentations. The response from occupational therapists indicates that this is a question that is

shared by many others in the profession.

Personal interest in a topic and even expressions of interest from within the profession still do not provide an adequate rationale for the time and effort required for research. Thus is it important to consider other reasons why research about poverty in occupational therapy practice is necessary. Because this research has occurred in New Zealand, it is essential to consider the relevance of the topic in the current New Zealand social and political climate. As already acknowledged, poverty is a topic that is frequently in the news in both traditional and social media formats. Thus poverty is a topic that is of interest in New Zealand at this current time.

While the purpose of this research is not to provide an in-depth analysis of the state of poverty in New Zealand, a basic understanding of the current situation in New Zealand is necessary to understand the importance of this research. In 2012 an estimated 285,000 or 27% of children in New Zealand were living in households affected by income poverty (Child Poverty Action Group [CPAG], 2014). In 2017 this percentage remained unchanged and it was also reported that 7% or approximately 80,000 children in New Zealand are living in severe poverty, that is households that are impacted by both income poverty and material hardship (Duncanson et al., 2017). While there is little specific data available about poverty rates in the general population in New Zealand, information about employment and economic standard of living provides some indication of the levels of poverty experienced. When compared to other countries in the OECD in 2013 New Zealand ranked 21 out of 33 for Gross-Domestic Product (GDP), and 20 out of 32 for Gross-National Income per-person (GNI). The levels of income inequality increased significantly between 1986 – 1996 with inequality remaining high since this time. Additionally, New Zealand now ranks among the top third of the most unequal countries in the OECD (Ministry of Social Development, 2016). New Zealand does not rank well in terms of income levels or inequality compared to other countries in the OECD.

The picture presented by The Social Report - Te pūrongo oranga tangata (Ministry of Social Development, 2016) is similarly bleak. While the rate of employment of 16-64-year-olds in 2013 was 74.2%, there was also reports of a decreasing proportion of people in full-time employment accompanied by a rising proportion of people in part-time employment. The average hourly wage of part-time employees was significantly lower than that of full-time employees. It was also reported that in 2014, 58.6% of the working-age population was seeking full-time employment.

Not only are income levels low for many people, but the cost of living has also been rising, with the cost of housing being the most commonly reported on cost. In 1988 an estimated 11% of the population spent more than 30% of their income on housing. By 2014 this had increased to 27% of households spending more than 30% of their income on housing costs, with 14% spending more than 40%, and 8% spending more than 50% of their income on housing. Inequality is also evident in the cost of living, with 41% of those in the lowest income quartile spending more than 30% of their income on housing compared to only 10% of the top income quintile. Because of the cost of housing, overcrowding is also common, with 10% of the population reported as living in crowded housing, with this being more common among renters (19%) compared with households that own their home (5%). There is also evidence of income inequality having some bearing on overcrowding with 15% of people in the lowest income quintile living in crowded homes compared with 2% of those in the highest income quartile. (Ministry of Social Development, 2016)

Income poverty and material deprivation also have significant impacts on health and wellbeing. Those with the highest rates of material deprivation were reported to have lower life-expectancy and self-rated health, lower levels of physical activity, less likely to attend early-childhood education (ECE), less likely to gain higher school qualifications, lower levels of job satisfaction, and less social connection. Additionally, those with higher levels of deprivation were also

reported to have higher rates of suicide, psychological distress, obesity, cigarette smoking, hazardous consumption of alcohol, fear of crime, criminal victimisation, and loneliness. (Ministry of Social Development, 2016)

Now that a brief summary of poverty in New Zealand has highlighted the significance of this social issue, it is important to also consider why this issue is of relevance and importance to occupational therapists. These topics will be explored in much greater detail throughout the thesis, but it is necessary to establish the relevance of the topic at the outset. Of key relevance to occupational therapy is the overrepresentation of people with disabilities in New Zealand poverty figures (van Dalen, 2017). Children with disabilities are more likely to live in low-income households (Wynd, 2015), and adults with disabilities face significant barriers to employment despite the fact that employment has been shown to reduce poverty and increase participation and that 74% of people with disabilities who are not in work want to be working (van Dalen, 2017). As occupational therapists predominantly work with people with health issues or disabilities, it is likely that a large number of occupational therapy clients will also be impacted by poverty.

The importance of social issues such as poverty is also highlighted in recent occupational therapy and occupational science literature. Not only are people who live with disabilities more likely to experience poverty, those who experience poverty contend with additional barriers to participation. Thus in order to address barriers to occupational engagement, occupational therapists need to consider the impact of social and structural barriers such as poverty. As stated by Hammell (2015a), "if ability is of little value without opportunity, then conditions such as poverty that constrain the opportunities and violate the occupational rights of so many people ought to be of fundamental concern to Canadian occupational therapists" (p.15).

In summary, personal interest was the initial inspiration for this research. The importance of the topic has been corroborated by an enthusiastic response

from within the occupational therapy profession in New Zealand. Review of current statistical information verifies that poverty is a significant issue in New Zealand, and that is an issue that has particular impact on people who experience disability. The occupational therapy and occupational science literature also promote the investigation of issues related to social justices and structural barriers to occupational participation. The combination of these factors supports the notion that poverty is a topic worth researching further from a New Zealand occupational therapy perspective. The literature review in the next chapter will demonstrate that there is a lot of theoretical discussion about social issues, and there is some research about occupational therapy involvement with specific poverty-related issues, but this has not been carried out in New Zealand. Thus, this research question is both relevant to occupational therapy and timely for New Zealand given the social and political emphasis on poverty reduction. This research is also timely given the challenges being posed in the occupational therapy literature regarding the engagement of occupational therapy as a whole with the issue of poverty globally.

1.5 Overview/structure of the thesis

Chapter one has introduced the research topic, providing some background information regarding the importance of this topic to New Zealand and to occupational therapy. It has also described the personal interest I have in this research topic, as a way of positioning myself in this research and ensuring transparency throughout the research process. Included at the end of this chapter, and all subsequent chapters is a short reflective piece that further situates myself as a researcher and as a person with first-hand and current experiences of poverty.

Chapter two presents a review of a selection of relevant literature. The literature selected comes from a variety of sources, but is primarily focussed on

the relevance of poverty in New Zealand current social and economic climate, and also recent literature from occupational therapy and occupational science that grounds poverty within a framework of occupational and social justice.

Chapter three describes the methodology and specific methods used in this qualitative research project. Also included in this chapter is information about ethics and a brief discussion about cultural considerations.

Chapter four contains the findings from 9 semi-structured interviews that were completed occupational therapists from around New Zealand. These findings are organised into 3 main themes, with each theme described in detail with quotes taken directly from research participants, allowing the participants' voices to be heard.

Chapter five discusses the research findings in greater depth and situates the research findings with current occupational therapy literature. This discussion concludes with some recommendations for occupational therapists engaging with poverty in their practice and highlights areas where further research into this topic would be of benefit.

Chapter six summarises and concludes this thesis.

Poverty was not the topic I originally set out to study for my masters, but I don't really know why I considered anything else. When I look back at the other topics I considered, I realise they all related to occupational justice and social justice in some way, and I guess they all directed me to this point.

Poverty has always been an issue that concerns me. Although I would not say that I grew up in poverty, I realise now that we always lived close to, or possibly below, the poverty line, but my parents shielded us from the realities of that. Now as an adult, I can see the realities of poverty looming ever closer for my parents as they retire.

Poverty didn't seem like such a personal issue when I started, but the further I get into this research, the more personal this issue becomes.

Chapter Two. Literature Review

This literature review draws on literature from a variety of sources. The literature review is divided into two primary sections, starting with general information about poverty, and then considering poverty from an occupational therapy perspective. The first section of the literature review will begin with a brief review of some of the ways poverty is conceptualised in a wide range of literature from different academic disciplines. The focus will then shift to understanding poverty from a New Zealand perspective, including a brief look at the history of poverty and inequality in New Zealand, discussing the way that poverty is measured in New Zealand, and examining the lived experience of poverty in New Zealand. The second section of the literature starts by exploring what is written about poverty and occupational therapy in New Zealand. It then shifts focus to examples of how occupational therapists around the world are engaging with or tackling specific poverty-related issues. Finally, the literature review will conclude with a review of the theoretical frameworks that are most commonly used for discussing and conceptualising social issues such as poverty.

Search strategies included:

1. Search of electronic databases including CINAHL, ProQuest, PubMed, and Google Scholar; and search of the Robertson Library Catalogue. Search terms included various combinations of keywords: occupational therapy, occupational therapists, occupational science, poverty, New Zealand.
2. Manual review of reference lists of key articles, and manual searching of journal indexes.
3. Searching of relevant websites including Ministry of Health, New Zealand Treasury, World Health Organisation (WHO), World Bank, World Federation of Occupational Therapists (WFOT), Occupational Therapy New Zealand Whakaora

> Ngangahau Aotearoa (OTNZ-WNA), Occupational Therapy Board of New Zealand (OTBNZ). These websites were searched for relevant documents, they provided useful background information about poverty, and they were valuable for fact-checking and checking for more up-to-date statistical information.

Because of the extensive nature of literature and resources about poverty, some parameters for inclusion of literature were required. The parameters varied slightly between sections of the literature review, due to the different focus of each section. The parameters that were relevant to all sections was that only material available in English would be considered, and literature was primarily sourced from peer-reviewed journals. The literature also needed to be accessible in the public domain or via the Robertson Library at Otago Polytechnic. The age of the literature was considered, but it was decided not to rule out works published before a certain date. The only limits used regarding publication dates was that only literature published prior to the planned thesis submission date of December 2018 would be included. Some "grey literature" was included where this was considered to be a seminal piece of work, and often it was work that was extensively referenced. The literature review was also informed by seminal texts, including Factfulness (Hans Rosling); The Spirit Level (Wilkinson and Pickett); Inequality: A New Zealand Crisis (Max Rushbrooke); Justice and the politics of difference (Iris Young). The initial searching for general information about poverty was informed by the specific works or authors frequently referenced in occupational therapy or occupational science literature. This was to ensure that the topics about poverty covered would be both relevant and somewhat familiar to occupational therapists.

2.1 Poverty

Poverty is not a straightforward concept to define and thus is not a straightforward issue to solve. When approaching the literature about poverty, there is a lot to consider, especially when deciding what literature is relevant to this particular research topic. While this research project is specifically about poverty as it relates to occupational therapy practice, occupational therapists do not have a monopoly on information about poverty, and it would thus be short-sighted, not first to consider what is being said about poverty by professions outside of occupational therapy. Because it is not possible to describe, or even consider all of the ways in which poverty is conceptualised in literature, the literature that was chosen for this introduction to the topic of poverty was selected for its relevance either to New Zealand or to occupational therapy.

Before trying to define what poverty is, it is worth considering what poverty is not. In 1948 the United Nations general assembly proclaimed the Universal Declaration of Human Rights. Article 25 of this declaration states that:

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*

While Article 25 of the Universal Declaration of Human rights does not explicitly address poverty, it does address the many factors often included in measuring poverty. A person who has adequate food, clothing, housing and medical care would likely not be defined as poor. But how can one determine if a person, or population, have adequate food, clothing, housing and medical care? How can poverty be measured?

2.1.1 Absolute and Relative Poverty

The most common way of delineating the poverty seen in the world today is through the use of the terms "absolute poverty" and "relative poverty" (Sen, 1983). However, there is little consensus in the literature or other media about what these concepts actually mean. Absolute poverty generally refers to a lack of the resources necessary for survival. Since 1990 the World Bank has set a Global Poverty Line which looks at national poverty lines around the world, that is "the line below which a person's minimum nutritional, clothing and shelter needs cannot be met in that country" (World Bank, 2015). The global poverty line is determined based on the national poverty lines of the 15 poorest nations globally. As such, this global poverty line is used to measure and monitor global levels of extreme poverty.

There has been some debate about the usefulness of setting only one poverty line globally, and Rosling, Rosling, and Rönnlund, (2018) recommend using four income categories, as seen in Figure 1 rather than just setting a single poverty line. The rationale for having income categories rather than simply dividing the world into rich and poor, is that having only two categories creates a false gap between the groups. Having four categories better demonstrates the spectrum of poverty and wealth seen around the world, and can also reveal the way in which people and countries can progress through the levels over time.

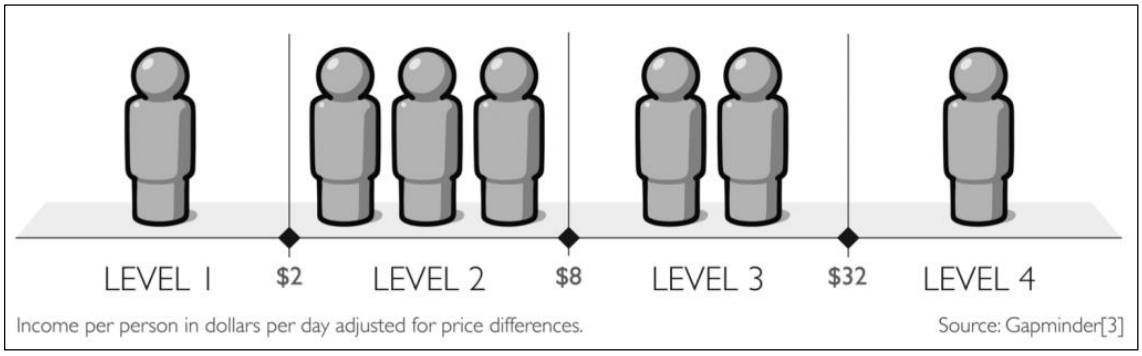

Figure 1: Four income levels as depicted by the Gapminder.
This figure shows the approximate number of people globally on each income level (each figure represents 1billion people). From: *Gapminder: Four Income Levels*. Retrieved from: https://www.gapminder.org/topics/four-income-levels/ CC BY 3.0

The use of these four categories has been adopted by the World Bank but is yet to be used by other global monitoring organisations such as the United Nations (UN) or World Health Organisation (WHO) (Rosling et al., 2018). Again, these categories are useful for measuring and monitoring income levels and trends over time both at a global and an individual country level. But this still does not tell us much about the reality of individuals living in poverty in a high-income country such as New Zealand.

This is where the term of relative poverty becomes of interest, as it generally refers to poverty as a level of resources that is significantly less than others in the same society. This may then be determined either as income below a certain percentage of the mean income of that country or as a standard of living below what is expected as "normal" for that society. A relative measure of poverty takes into account not only the items such as food, clothing and shelter that are necessary for survival but also other aspects of a lifestyle that is considered normal in any given society (Perry, 2002, 2017; Sen, 1983). Defining poverty in relative terms is challenging as there is not one set standard for determining poverty in any given society. However, setting absolute or relative poverty lines based on income still does not describe the lived experiences of poverty or the wide-ranging implications of poverty.

2.1.2 Temporary or Persistent Poverty

Another important factor worth considering about poverty is the duration that a person experiences poverty. The measures of poverty used around the world simply tell us how many people are in poverty at any given moment in time – that is, current poverty. What these measures are not able to provide is an understanding of how long individuals have been experiencing poverty. While some people may only be in poverty during that moment in time when the data was collected, others may not be in poverty at that particular moment in time yet still experiencing chronic poverty (Easton, 2013). There is also an intergenerational impact of chronic poverty. Children growing up in poverty are

likely to have worse health and education outcomes and are thus more likely to experience poverty in adulthood (Easton, 2013). The extent of this is not yet fully understood.

2.1.3 The Precariat and Social Mobility

Another thing that happens with both poverty and inequality is that people can move between levels over time (Rosling et al., 2018). For those living in poverty due to reliance on a benefit, then gaining employment may lift them above the poverty line, although this is not guaranteed. Being employed, or above the poverty line does not guarantee you will stay there. Many people live with precarious or temporary employment, and loss of work is a real fear (Standing, 2015). Unexpected illness or disability can also put people below the poverty line very quickly.

2.1.4 Inequality

Another concept commonly discussed in relation to poverty is that of equality, or inequality, specifically the gap between the richest and poorest groups or individuals in a society. Again, inequality is usually measured by comparing the levels of income or wealth held by specific groups in a population. While it is useful to consider the levels of inequality in society, as discussed by Rosling et al., (2018) it is also important to remember that there is generally a spectrum of incomes in any society. The specifics of what inequality looks like in New Zealand will be further discussed later in this literature review. For now, it is important to understand that inequality exists, and it is a topic receiving a lot of attention worldwide.

Inequality has received increased attention in recent years in both academic fields and popular media. As reported by Skilling (2013), several books have been published by academics for a general audience. These books include: "The Spirit Level: Why Equality is Better for Everyone" (Wilkinson & Pickett, 2010), "Winner-Take-All Politics: How Washington Made the Rich Richer – and

Turned Its Back on the Middle Class" (Hacker & Pierson, 2010), "The Cost of Inequality: Three Decades of the Super-rich and the Economy" (Lansley, 2011), "The Price of Inequality: How Today's Divided Society Endangers Our Future" (Stiglitz, 2013), "Battlers and Billionaires: The Story of Inequality in Australia" (Leigh, 2013); and "Inequality: A New Zealand Crisis" (Rushbrooke, 2013).

There are several possible reasons for this interest in inequality in society. In the mid-1980's-1990's many countries around the world, including Britain, Australia, USA and New Zealand there were major political shifts toward neoliberalism and free-market ideologies (Wilkinson & Pickett, 2010). These shifts lead to increased inequality within societies and not just inequality between various groups or nations.

Another reason for this changing discourse in society about poverty and inequality could be what Rosling et al., (2018) refer to as the negativity instinct which is "our instinct to notice the bad more than the good". While we may tend to focus on the negatives in society, such as increased inequality in some places, there can also be positive changes occurring that may be overlooked. Things can be both bad and getting better. Noticing improvements in the world does not deny the existence of problems. There has been significant progress made in reducing poverty worldwide, but acknowledging this progress does not mean ignoring the number of people in the world still impacted by severe poverty. It also does not excuse ongoing or growing levels of inequality within societies.

2.1.5 Capabilities approach

Another way of considering issues of poverty and inequality is to look beyond simple measures of income and to look at the opportunities available to people. Amartya Sen has discussed the concepts of absolute and relative poverty at length. Sen, (1983) argued for an absolutist measure of poverty, but not one defined in purely economic terms. Although he argues for an absolute measure of poverty, he explains that the "conceptualisation of poverty does, of course,

involve more than just fixing a poverty line" (p. 165). While a standard poverty line may have some use, there is a lot more to be considered regarding poverty than just the financial situation of a person or group of people. "The predicaments of people below the poverty line are not by [any] means homogeneous…since they differ from each other in the size of their respective shortfalls of income from the poverty line" (Sen, 1983, p. 165).

In his Tanner Lecture on Human Values, Sen (1979) argued that "basic capability equality is a partial guide to the part of moral goodness that is associated with the idea of equality" (p. 220). That is not to say that capabilities are the only way to measure equality or inequality, but capabilities form one part of the puzzle. Basic capabilities are described as "a person being able to do certain basic things" (Sen, 1979, p. 218). Sen, however, does not provide any indicators about what these basic capabilities are or should be. He argues that "the notion of the equality of basic capabilities is a very general one, but any application of it must be rather culture-dependent, especially in the weighting of different capabilities" (Sen, 1979, p. 219). While culture certainly influences the importance of certain capabilities, Nussbaum (2003) argues that for the capabilities approach to be truly effective, a list of the most central capabilities needs to be defined in order to "elaborate a partial account of social justice, a set of basic entitlements without which no society can lay claim to justice" (p. 36).

Nussbaum also connects the notion of capabilities to human rights. "Capabilities, I would argue, are very closely linked to rights, but the language of capabilities gives important precision and supplementation to the language of rights" (Nussbaum, 2003, p. 37). However, rights do not ensure capabilities. Although a person may have a right to do a certain thing does not ensure they have the ability to carry it out. Likewise, capabilities do not constitute rights – someone may have the capability to complete a certain action, but that does not guarantee them the right to do so. The connection between human rights and

capabilities will be further discussed later in the literature review, as both of these concepts are discussed within occupational therapy literature.

2.1.6 Social Justice

The conversation about human rights and capabilities also fits into an ongoing public discussion and debate about issues of justice, specifically social justice. Social justice is concerned with the relationship between individuals and society. In a just society, human dignity is upheld, and citizens receive an equitable share of societal resources (Hocking, 2017). One of the primary concerns of early social justice theorists was the distribution of wealth, but more recently social justice theorists have been concerned with more than economics. Rawls (2001) spoke about protecting people's rights and opportunities for leading healthy and fulfilled lives, with a specific focus on protecting the rights and opportunities of the least advantaged in society. His focus was not on redistribution of resources, but the distribution of opportunities in society. This focus on opportunities did not take into account the outcomes of those opportunities, whereas Sen (1979, 1982) was more concerned with the ability that people have to utilise opportunities in ways that achieve outcomes of value to them.

Likewise, social justice theorist and feminist, Iris Young (1990) emphasised that rights are more about doing than having, that is they are more about the opportunities that individuals have for meaningful occupations rather than ensuring that all individuals have equitable amounts of wealth or other resources. She also contested that earlier theories of social justice devalued and suppressed difference. She asserted that every member of society is important, and that "dependency should not be a reason to be deprived of choice and respect" (Young, 1990, p. 55). She also highlights the need for society to accept cultural plurality in order to overcome the discrimination and oppression of some social groups (Hocking, 2017).

The concept of inequality is analysed in social justice literature using a micro and macro lens, thus considering the impact of inequality at an individual, community, government, and global level. There is a recognition that some inequities are created by society, and as such, societies have the power to do things differently to correct these inequities (Hocking, 2017).

Early social justice theorists strongly debated the relationship between social justice and health. While Rawls discussed living a healthy and fulfilled life, he viewed health as a natural good rather than a social good, and thus not part of social justice. Sen, on the other hand, argued that health is a fundamental capability that ought to be protected, and Nussbaum (2011) also listed health as one of 10 basic capabilities. Venkatapuram, (2011) further emphasised the relationship between justice and health and the role society has in protecting, nurturing and restoring people's abilities to be healthy.

2.1.7 Wicked Problems

Another useful way of conceptualising issues such as poverty, inequality, and deprivation is with the terminology of "wicked problems". The notion of 'Wicked Problems' was first proposed by Rittel and Webber (1973) for problems that are not easily defined nor can they be easily solved, rather they require an ongoing process of re-solving, with each attempt at solving the problem having an impact, either positive or negative, on the issue at hand. Adding to the complexity of defining wicked problems is the fact that each person's experience of a wicked problem, such as poverty, will be unique, and the solutions that work for each person will also be unique. There cannot and will not be a one size fits all approach to addressing poverty, rather the experiences of each individual need to be considered and appropriate solutions offered based on this assessment.

Framing poverty as a 'wicked problem' that cannot easily be defined or solved, does not negate the importance of providing some form of definition of

poverty, and it certainly does not imply that no attempt should be made to solve, or at least minimise, the issue of poverty and its wider social implications. However, this understanding that poverty is a wicked problem is helpful to keep in mind while exploring some of the ways that poverty could be defined, and considering which of these definitions would be most appropriate to a New Zealand context, and New Zealand occupational therapists in particular.

2.2 New Zealand Poverty

The next aspect of poverty and its conceptualisation that needs consideration for this research is the issue of poverty within New Zealand. As previously stated, regarding global economic rankings, New Zealand is considered to be a high-income country. However, this does not mean that poverty does not exist in New Zealand, but rather that poverty needs to be measured and understood in relative terms, not absolute terms.

2.2.1 History of Poverty and Inequality in New Zealand.

While there has always been some inequality in New Zealand, levels of poverty and inequality have fluctuated through the years. In the period from 1950 through to the mid-1980s, income inequality was declining in New Zealand. During the 1980s there was a shift to neoliberalism in many English speaking countries around the world, including New Zealand (Wilkinson & Pickett, 2010). During this time, top tax rates were decreased, and GST was introduced. The introduction of GST had a greater impact on those in the lower tax brackets, and the decreased top tax rates meant that the top income earners had more disposable income (Easton, 2013). This period was also characterised by significant welfare reforms that focussed on individual responsibility and framed poverty as a personal deficit rather than an outcome of economic arrangements (Hodgetts, Chamberlain, Tankel, & Groot, 2013). These welfare reforms also included significant benefit cuts in 1991 (Easton, 2013). There were a number of

changes made in the state housing sector with many state houses sold, and market rents applied to state housing rather than the income-based rents that were previously in place.

What these changes meant in New Zealand was a massive increase in inequality. In 1985 New Zealand ranked 20th in OECD rankings of inequality (of 34 countries), putting New Zealand as one of the more equal countries in the OECD. By 2009 New Zealand ranked ninth (out of 34) in the OECD – placing in the top half of most unequal countries. Most of these changes occurred during the decade from the mid-1980s through the mid-1990s (Easton, 2013).

The rising levels of inequality plateaued in the mid-1990s, and this plateau has generally continued. If there have been any further increases in inequality, these changes have been minimal (Easton, 2013). What has occurred in New Zealand in recent years is an increased concern about inequality and poverty and the long-term impact of this. "New Zealanders seem to be more explicitly concerned about inequality and poverty than they were a decade ago" (Easton, 2014, p. 7). This increased concern about inequality and poverty is consistent with the global increase these same issues, and the rise in public discourse about these issues.

While the debate about actual or perceived levels of inequality in New Zealand is outside the scope of this research project, it is important to understand the reality of inequality and poverty in New Zealand. Although research may indicate that the levels of inequality in New Zealand have shown little change in recent years, this does not mean that New Zealand is a fair and equal society.

Likewise, Brian Easton's (2013, 2014) assertion that inequality in New Zealand is not growing does not deny that significant levels of inequality still exist in New Zealand today. The social and political changes and welfare reforms of the early 1990s also did not end there. Since 2011 there have been further intensive welfare reforms, including a reduction in the number of benefit

categories (Beddoe, 2014). The reforms have continued to individualise and stigmatise poverty. The lifestyles of welfare recipients have been increasingly scrutinised. The approach to welfare provision is increasingly punitive as evidenced by financial sanctions that are applied when recipients do not comply with imposed, often discriminatory social obligations or work testing. (Beddoe, 2014; Hodgetts, Chamberlain, Groot, & Tankel, 2014; Hodgetts et al., 2013). While these changes may have met some of the stated purposes of decreasing government spending, the impact on vulnerable individuals and families has been immense.

2.2.2 *Measurements of poverty in New Zealand*

The next question about poverty in New Zealand that needs to be addressed is the way in which poverty is measured in New Zealand. Prior to 2017, New Zealand did not have an official poverty measure. The issue of child poverty was a key priority during the 2017 election campaign and was discussed in terms of both income poverty (poverty defined as income less than 60% of the median income) and material hardship (Maidaborn, 2017). Measurements of material hardship consist of a list of 17 items or services considered essential for quality of life in New Zealand. Children are deemed to be in material hardship when they lack 7 or more of these 17 items, and very high material hardship is when they lack 9 or more of these 17 essentials. The measures of income poverty and material hardship are also used together, to determine the number of children living in income-poor households and material hardship (Duncanson et al., 2017). According to the 2017 Child Poverty Monitor Technical Report, 27% (290,000) of children in New Zealand live in families experiencing income poverty, and 7% (80,000) children live in severe poverty – in families experiencing both income poverty and material hardship (Duncanson et al., 2017). Housing is another factor often considered when measuring poverty. In 2017 it was reported that 38% of children live in households that spend more than 30% of their income on housing costs, and 13% of children are living in

overcrowded homes. For children living in these circumstances, houses are also frequently cold, damp, or have significant mould issues, with these issues being more frequent in rental properties than in owner-occupied homes (Duncanson et al., 2017).

2.2.3 NZ Treasury – Living Standards Framework

Another important thing to consider is the way in the New Zealand government is conceptualising and addressing poverty. In 2011, the New Zealand Treasury released a working paper titled "Working towards higher living standards for New Zealanders" (Gleisner, Mary, & Fiona, 2011). In this paper, the "Living Standards Framework" was introduced with the aim of taking a broader approach to the economy and considering the importance of well-being in setting policy direction. The living standards framework considers more than just poverty, but also the impact of poverty and other socioeconomic impacts on wellbeing. This framework has been included in this literature review due to its relevance to occupational therapy.

New Zealand is not alone in its use of wellbeing measures for evaluating the economy and setting policy direction. In recent decades there has been a growing understanding that while there is some correlation between higher incomes and better happiness or well-being, this correlation is not strong (Easton, 2015). For true growth to occur in a country, the wellbeing of the citizens needs to be considered. The OECD uses a wellbeing framework for comparison of nations. The OECD's wellbeing framework is based on three pillars – material living conditions, quality of life, and sustainability (Ussher & Walker, 2015). By contrast, the original New Zealand Living Standards Framework measured five areas of growth – economic growth, increasing equity, managing risk, social infrastructure, sustainability for the future (Easton, 2015; Gleisner et al., 2011). Central to the framework are four capitals – Physical/Financial, Human, Social, and Natural. These capitals are defined as "asset[s] that can be built up for future use" (Gleisner et al., 2011, p. 2). Physical/Financial capital refers to fixed assets

such as buildings or machinery, or assets with a degree of liquidity such as bank deposits. Human capital is concerned with personal characteristics, skills, education, knowledge, competencies, and experience. Social capital is primarily related to community characteristics such as co-operation, trust, a strong sense of culture, and social cohesion. Natural capital refers to the natural resources of the earth, including both renewable and non-renewable resources. (Gleisner et al., 2011). The four capitals remain unchanged in the latest development of the living standards framework (King, Huseynli, & Macgibbon, 2018).

These four capitals (social, human, physical/financial, natural) seem particularly relevant to the discussion about poverty, as they acknowledge the importance of finances and income to wellbeing, but also recognise that finances alone will not lead a person or a nation to lead fulfilling lives. This multidimensional approach also recognises the interactions between domains, and "the consequences of having multiple disadvantages far exceed the sum of the individual effects for quality of life" (Ussher & Walker, 2015, p. 42).

2.2.4 Culture and poverty in New Zealand

When conducting any research in New Zealand, it is vital to consider aspects of culture, and when researching poverty and inequality, the impact of culture and ethnicity cannot be ignored. There is clear evidence that ethnicity is related to levels of inequality. "As is well documented, objective and subjective measures of wellbeing for Maori generally fall well below those of the dominant European or other non-Maori ethnicities (except perhaps those from the Pacific Islands)" (Grimes, 2015, p. 118). New Zealand is not alone in its indigenous people having worse health and social outcomes than other ethnicities.

Work has been done in New Zealand to close the gap between Maori and European groups, but further work is required. A report from Collins, Ihaka, Tapaleao, Tan, and Singh, (2014) provided a thorough update on the gaps between Maori, Pacific, and Asian populations compared with European

peoples. The figures they used were based on census data and a series of surveys available between 1986-2013. They reported the closing of gaps between Maori/Pacific and European groups in the areas of infant mortality, a range of education measures, life expectancy, and occupational structure (primarily the percentage of people in professional or managerial roles). There was no change in gaps related to imprisonment, personal income, or hourly wages. There were mixed results in areas of unemployment – the gap for Maori was closing slowly, while it was not clear for Pacific people; welfare dependency – the gap for Maori was widening, again it was not clear for Pacific people; children hospitalised due to abuse or neglect – gap for Pacific people has been eliminated, but results for Maori were unclear; and violent offences – the gap for Maori was widening, and the gap was closing for Pacific peoples. The concerning statistics in this report were the measure of employment, home ownership, and children hospitalised with diseases directly related to poverty – the gaps in each of these measures was increasing. All of these measures had seen some closing of gaps during the boom immediately before the global financial crisis (GFC), but these gaps had begun to widen again during and following the recession.

Another way of considering the disadvantage faced in New Zealand by Maori is to look at the users of social services. In a study carried out at Auckland City Mission with 100 families experiencing poverty, the research sample consisted of 40% Maori, 25% Pacific Islanders, 22% European, and 13% Asian. This sample was selected as a representation of families who regularly access the food bank at the Auckland City Mission (Hodgetts et al., 2013). Whichever figures are looked at, it is clear that Maori and Pacific people in New Zealand are disproportionately impacted by poverty and the many impacts of poverty on health and wellbeing. However, the issues of poverty are not isolated issues.

For individuals and families struggling with poverty and inequality, the challenges are often compounded by racism and stigmatising stereotypes. Experiences of discrimination are not unique to those in poverty, with 10% of the

general population reporting experiences of discrimination in the last 12 months, and 6% reporting racial discrimination in the same time period. Racial discrimination is most commonly experienced by those of Maori, Pacific, or Asian descent (Ussher & Walker, 2015). While discrimination is not restricted to one ethnic group or a particular class of society, it is the combination of forms of discrimination that can be the most damaging (Ussher & Walker, 2015). Media representations of poverty and inequality, welfare dependency, and growing disparities, often frame these challenges as moral problems that are related to race or ethnicity (Beddoe, 2014). These discourse works to evoke either sympathy or fear and disgust (Beddoe, 2014), neither of which are helpful responses for addressing the issues at hand.

While it is important to consider the specific challenges related to poverty that are faced by various ethnic groups in New Zealand, this should not turn into an attempt to fix these issues by focussing solely on racial or ethnic differences. Society should instead be more concerned with inclusion and respecting diversity as a way to create opportunities for people to enact their rights. One way this is being done in New Zealand is through Whanau Ora "an inter-agency approach providing inclusive health and social services to New Zealand whanau and families in need" (Ussher & Walker, 2015, p. 53). Whanau Ora is an innovative way of providing services that incorporate Maori cultural values into mainstream practices (Humpage, 2017). One key feature of this approach is the use of 'navigators' who provide a wraparound service assisting whanau in accessing a range of health and government services. This approach moves from an individualised approach to a holistic approach to wellbeing, recognising the importance of family, culture, spiritual dimensions, and the interrelationships between physical and mental health (Humpage, 2017). The use of a Maori specific approach such as Whanau Ora is one way of acknowledging the way in which "colonial processes have undermined Māori social, economic and political structures resulting in a redistribution of power and resources in favour of

Pākehā" (Oetzel et al., 2017, p. 3), and beginning to right the wrongs of the past. While the Whanau Ora approach has not been without criticism, it "holds the potential to improve opportunities for Māori governance over services for Māori" (Humpage, 2017, p. 484).

2.2.5 The lived experience of poverty in New Zealand

Since 2009, the New Zealand Council of Christian Social Services (NZCSS) has published vulnerability reports monitoring the levels of economic and social hardship experienced by everyday New Zealander's. In 2016, the NZCCSS published their final vulnerability report, looking back over the reports of the last six years. This final report captures "a period of relentless change to the social services landscape, of increasing demand for services in communities that plateaued around 2011, but never returned to pre-GFC (global financial crisis) levels, of increased complexity of people's needs, and of no additional funding" (Scott, 2016, p. 1). There were also reports of an increase in the number of "working poor", and more people in work requiring assistance with food and other basic living costs. While the NZCCSS reports give a useful overview of the state of poverty in New Zealand, they do not give much detail about the lived experiences of poverty.

To better understand the lived experiences of poverty, formal research articles were sought, and the primary author consulted for this information is Darren Hodgetts, who was part of a small team of researchers involved in a substantial research project about urban poverty that was carried out in partnership with the Auckland City Mission. The aim of this research (Family 100) was to "bring about a deeper understanding of the experiences of families living in urban poverty in New Zealand. Family 100 seeks to build a detailed picture of the experiences, challenges and strategies for navigating the complexities of daily life that enmesh these families" (Garden, Chamberlin, Tankel, & Hodgetts, 2014, p. 4).

In one of the reports on the findings from the Family 100 study, Hodgetts, Chamberlain, Tankel, and Groot, (2013) highlight recent changes in the New Zealand welfare system that have placed an emphasis on independence and personal responsibility, thus framing poverty as a personal deficit and excusing current economic arrangements for the increase in poverty in New Zealand. This framing of poverty also serves to frame individuals as "maladjusted" and seeks to adjust them to the current system rather than identifying and acknowledging ways in which the social and welfare systems may need to be adjusted. Hodgetts et al., (2013) refer to the work of Hannah Arendt about systems of control and how "a maladjusted system of control becomes increasingly dehumanised, mechanised, and unaccountable to the people directly hurt" (p. 48). Moreover, how does a maladjusted system hurt the people it is meant to be helping? Within the New Zealand context, the individualisation of the issue of poverty has led to an increased number of obligations requiring fulfillment in order to receive support. While this may sound good in theory, to prevent abuses of the welfare system, "being placed under the microscope and constantly examined by agencies can undermine a sense of self-worth among beneficiaries" (Hodgetts et al., 2014, p. 11).

Another aspect of the embodied nature of deprivation that is highlighted in work by Hodgetts et al., (2013) is the seemingly chaotic lives led by many people living in poverty. Rather than this being an issue that needs to be changed by the individual, it may be a by-product of having to "operate in a landscape of diverse, uncoordinated and disconnected services" (p. 54). If the environment in which people are expected to function is chaotic, then it should not be a surprise when their lives reflect this same chaos.

2.3 Poverty in Occupational Therapy Practice

In the first section of this literature review, a baseline understanding of and language for describing poverty has been established, and the state of poverty in New Zealand has been examined. The focus of this literature review will now shift to the relevance of poverty to occupational therapy.

According to the World Federation of Occupational Therapists (WFOT), occupational therapy aims to promote health and wellbeing through occupation (World Federation of Occupational Therapy, 2011). In their position statements on human rights and global health, they also acknowledge that conditions such as poverty threaten the rights of people to engage in occupation and contribute to suffering (World Federation of Occupational Therapy, 2006, 2014). In their position statement on human rights, WFOT endorses the Univeral Declaration of Human Rights (United Nations General Assembly, 1948). While Occupational Therapy New Zealand Whakaora Ngangahau Aotearoa (OTNZ-WNA) does not have specific position statements about poverty or human rights, they fully endorse the WFOT position statements about these issues, and thus implicitly endorse the Universal Declaration of Human rights.

Because this thesis is based in New Zealand, it seemed important to start this review of poverty and occupational therapy by investigating what is being said and done about poverty by New Zealand occupational therapists. Results from initial literature searching were ambiguous (many results were found, but the relevance of these was weak), so a specific search of the New Zealand Occupational Therapy Journal (NZJOT) was completed. Between 2011 and 2018, the word "poverty" appeared in 13 articles in the NZJOT. Of these 13 articles, six were based on conference presentations (Duque, 2016; Emery-Whittington & Te Maro, 2018; Hopkirk, 2013; Kronenberg, 2013; Malfitano & Lopes, 2018; Reed, 2016); one was an editorial (O'Sullivan, 2017); one was an opinion piece about clinical governance (Orton & Hocking, 2017). There were two reviews of literature, the first was about childhood poverty in New Zealand (Leadley &

Hocking, 2017), and the second was a narrative review of the capabilities approach and its relevance to occupational therapy (Mousavi, Forwell, Dharamsi, & Dean, 2015). There was one theoretical piece about occupational therapy and public health(Hocking, 2013); and one article was based on research carried out in conjunction with a panel discussion at an occupational therapy conference (Hocking et al., 2012). Only one practice-based example was located (Lloyd & Bassett, 2012), but on reading this article, it was noted that this was describing occupational therapy practice with homelessness in Queensland, Australia. From these results, it was clear that to understand what occupational therapists are doing in their practice in relation to poverty it would be necessary to look further afield.

Before looking beyond New Zealand for practice examples, further searching of the NZJOT was carried out. A search for "inequality" did not reveal any articles; a search for "unemployment" revealed two new articles, one of which was based on a conference presentation (Erlandsson, 2013) and the other was a review of historical and contemporary literature about occupation (Reed, Hocking, & Smythe, 2012). The search term "socioeconomic" within NZJOT with no other qualifiers revealed three new articles (Alcorn & Broome, 2014; Hollands, Sutton, Wright-St. Clair, & Hall, 2015; Sterling & Nayar, 2013). These articles were reviewed for relevance to this research, and it was found that low socioeconomic status was briefly mentioned in each article in relation to wider issues of immigration or chronic health conditions, or Maori mental health. While the impact of low socioeconomic status was identified in each of these articles, the mention of this was only very brief and did not contribute any new information to this discussion. Thus the literature review needed to go wider and consider what occupational therapists around the world are doing in relation to poverty and a myriad of related issues.

This wider review of the literature revealed evidence of occupational therapists working to address specific issues associated with poverty such as

homelessness, unemployment, and food insecurity. Occupational therapists are working with specific population groups that directly impacted by poverty. They are also doing a lot of work to develop practice in low-income and middle-income countries. In some of these situations, occupational therapists are working directly to tackle poverty and poverty-related issues, at other times poverty is considered as part of the wider context of a persons' life, or specific issues are addressed in the context of poverty. These issues will be discussed in the sections below.

During the course of the literature review, it became evident that there has been an increase in occupational therapy literature about poverty and poverty-related issues in recent years. Occupational therapists have always worked with people living in conditions of poverty, but it seems that the issues of poverty and inequality have been receiving increased attention in the professions academic literature. Perhaps this increased discourse about poverty within occupational therapy is a reflection of the discourse happening in society, which is in part fuelled by the discourse in the media.

2.3.1 Homelessness

Occupational therapists are engaging with issues of homelessness in a variety of ways. Literature about an occupational therapy response to homelessness comes predominantly from Canada, USA, and Australia. Literature about occupational therapy and homelessness fit into two major categories – describing homelessness from the perspective of those experiencing homelessness, or describing occupational therapy interventions with homeless populations.

The research about the occupational experiences of homeless individuals contributes to an occupational perspective of wellbeing (Thomas, Gray, & McGinty, 2017), highlights the detrimental effects of occupational alienation (Marshall, Lysaght, & Krupa, 2017), and suggests that "interventions with this

population should be centred on trauma-informed and strengths-based approaches" (Salsi et al., 2017, p. 238). This research has also been carried out for the purpose of planning and developing occupation-based programmes in homeless shelters (Finlayson, Baker, Rodman, & Herzberg, 2002; Tryssenaar, Jones, & Lee, 1999).

Literature about occupational therapy interventions with people experiencing homelessness includes a review of assessment tools used by occupational therapists in homeless shelters (Herzberg, Ray, & Swenson, 2006), a systematic review of quantitative research about occupational therapy interventions with homeless people (Thomas, Gray, & McGinty, 2011), and a description of an interdisciplinary service-learning experience that involved students from 5 professional disciplines including occupational therapy and physiotherapy working together to provide tutoring and support to adults and children in a homeless shelter in Canada (Gupta, 2006). Fisher and Hotchkiss (2008) describe a model of occupational empowerment that was developed from their work with women in a homeless shelter in the USA. In Australia, Lloyd and Bassett (2012) discuss the challenge of establishing an occupational therapy role in a homeless outreach team, including changing to shift work, managing safety and risk, and maintaining the occupational therapy identity when working in a role requiring much use of generic mental health skills.

2.3.2 Unemployment

Another topic that comes up frequently in the discussion about poverty is unemployment. A specific literature search regarding unemployment was not completed, but a number of articles emerged from the searching about poverty. The primary literature reviewed about unemployment came from a series of ethnographic studies about long-term unemployment, discouraged workers, and precarity in the non-profit employment services sector in the USA and Canada. While this research did not describe occupational therapy, it adds an understanding of the impact of the loss of occupational engagement that comes

from long-term unemployment including anxiety and loss of support (Aldrich & Callanan, 2011), and difficulties with establishing routines and planning the day (Aldrich & Dickie, 2013). This research also challenges traditional categorisations of occupation, proposing that experiential categorisations of occupations may be more appropriate than typological categorisations in situations of unemployment (Aldrich, McCarty, Boyd, Bunch, & Balentine, 2014), and also notes that survival occupations such as resource seeking do not fit within the usual typological categorisations of work, leisure, and self-care (Aldrich, Rudman, & Dickie, 2017). Occupational therapists and occupational scientists are challenged to critically examine categorisations of and assumptions about occupation, a point which will be further explored later in this review. This research also discusses the current political climate that aims to 'activate' those deemed to be at risk of welfare dependency to comply with external expectations about job-seeking and other requirements for receiving welfare support, while also increasing surveillance of behaviours and disciplinary measures for perceived non-compliance (Laliberte Rudman & Aldrich, 2016). These findings are reminiscent of the punitive approach to welfare described by Hodgetts et al., (2014) in New Zealand. An additional finding from this ethnographic research is the precarity of employment in the non-profit employment services sector in Canada (Fanelli, Rudman, & Aldrich, 2017), meaning that the people who are supporting those experiencing long-term unemployment may find themselves in situations that are almost as precarious as those they are trying to serve.

2.3.3 Food insecurity

Another poverty specific issue that occupational therapists are demonstrating and increasing awareness of is food insecurity. In New Zealand, food security is defined as "the assured ability to acquire nutritionally adequate and safe food that meets cultural needs, and has been acquired in a socially acceptable way" (Carter, Lanumata, Kruse, & Gorton, 2010, p. 602), thus food insecurity occurs when these requirements are not able to be met. Food security

is an important issue for occupational therapists as food provisioning is an important and often meaningful occupation for many people (Beagan, Chapman, & Power, 2018), and a lack of adequate food or nutrition is likely to impact on a person's ability to engage in occupations.

In Canada, Beagan et al. (2015) have been carrying out a study exploring the way in which factors such as gender, social class, and place, influence and shape food-related practices. As part of this study, they have also explored the visible and invisible occupations of food provisioning specifically with low-income families (Beagan et al., 2018). In this research, they highlight the complexity of food provisioning. For people with low incomes the task of food provisioning involves knowledge of family food preferences, planning and strategizing meals and grocery shopping, food sharing, regularly checking sales flyers to make the most of sales, knowledge of local grocery stores, knowing how to access a food bank if needed, and food preparation to maximise available food. For many of the research participants, they had to balance the savings they would achieve by travelling further for sales with the additional cost of the transport. Sometimes financial savings also came with increased social or emotional costs, a fact that was especially true for parents who felt they constantly denied their children treats in order to make ends meet. Overall, the task of food provisioning for people with low incomes was described as relentless and frequently rife with unseen challenges.

In contrast to this, Schmelzer and Leto (2018) carried out a participatory action research project in which they developed, ran, and evaluated a 7-week occupation-based programme that used a graded-learning approach to teach a range of skills related to management of food resources. This research identified that many people with low incomes lacked the necessary skills for managing food resources, and they had not been provided with opportunities to learn these skills. The 7-week programme taught skills such as menu planning, strategic shipping, using and storing left-overs, cooking skills, nutrition and dietary

education, and problem-solving and organisational skills. These skills had been identified as skills that research participants needed to learn, whereas in the research by Beagan et al., (2018), participants identified that they already possessed many of these skills. These differences may be due to the different locations of the research projects, or the different research methods used. The conclusion from both research projects was that food insecurity is a significant concern for many people in poverty, and as such should be of concern to occupational therapists. Schmelzer and Leto, (2018) also concluded that the positive results of their research support the use of occupation-based programmes.

2.3.4 Children, youth and families

Children, young people, and families are often overrepresented in statistics about poverty, so it is not surprising that occupational therapists have been talking about poverty in relation to children and their families for some time. Occupational therapy literature in this area includes theoretical reviews; qualitative assessment with youth, solo-mothers, parents, and occupational therapists; descriptions of occupation based programmes; and evaluation of specific occupational therapy interventions.

Opportunities for occupational engagement are often limited for children and families with low-incomes. Solo-mothers who were also migrants in Denmark described high levels of occupational deprivation due to a complex interplay between a range of factors including immigration, illness, and divorce (Kielsgaard, Kristensen, & Nielsen, 2018). For children from low income families, experiences of occupational deprivation in the home may be off-set by attendance at activities outside the home, such as preschool or childcare, that provide a range of occupational opportunities that may be otherwise unavailable (Gronski, Niemann, & Berg, 2013; von Zuben, Crist, & Mayberry, 1991). Likewise, participation at least three structured activities was correlated with lower rates of depression amongst victimised youth with disabilities from low-income

families who were also in contact with child welfare services (Berg, Medrano, Acharya, Lynch, & Msall, 2018). Children and young people from a low-income neighbourhood also benefited from a multi-disciplinary occupation based after-school programme that involved cultural intervention and the use of media (Frank et al., 2001). Occupation based programmes can also be used for the development of specific skills that are related to socioeconomic statuses, such as handwriting in children. The use of an occupation based programme that used a range of sensory and motor strategies in addition to handwriting practice has been shown to enhance the development of handwriting in children from low-income areas (Peterson & Nelson, 2003).

When working with children, it is important that occupational therapists consider both the cultural and economic background of the family and the way these may influence parenting, values, and participation in therapy (Humphry, 1995). Building in the work of Humphry (1995), research was carried out by Andrews, Griffiths, Harrison, and Stagnitti, (2013) to investigate expectations of parents on low incomes when preparing for a child's first therapy session, and these expectations were compared with the expectations of occupational therapists. Families with low-incomes face multiple, complex, and changing challenges in their lives and there may be urgent issues that need to be prioritised over a child's therapeutic needs. These needs also must be managed alongside the parent's expectations of a quick-fix from therapy for their child (Andrews et al., 2013).

2.3.5 Occupation based interventions in low-income communities

Also included in the occupational therapy literature are descriptions of research and interventions that target specific low-income groups or communities. Ciro and Smith (2015) carried out research in a low-income housing community investigating occupational engagement of older adults. Although some activities were available in this community, barriers to engagement were reported including activities were not relevant, lack of income,

lack of transportation, and functional limitations. The researchers developed and carried out an intervention group programme aimed at reducing barriers to engagement. Although there were some improvements reported following the intervention group, the researchers also suggested that health literacy was an unexpected barrier to program design and evaluation and that the issue of health literacy should be assessed and addressed prior to intervention. Mulry, Papetti, De Martinis, and Ravinsky (2017) also carried out research in a low-income housing community and implemented a community mobility training programme, in which they examined supports and barriers to community mobility and provided education about alternative transportation options. The group programme had an experiential component and used homework tasks to encourage practicing the skills taught. Post-intervention follow-up reported significant improvements in community access, increased confidence, improved knowledge of resources and supports, and decreased feelings of loneliness and isolation. Providing support for community mobility increased participation in meaningful activities and contributed to wellness. The key similarity between these two research projects is they promote interventions that overcome barriers to participation for older adults who have low incomes, and that occupational participation contributes to wellness.

Likewise, research with low-income Latina breast cancer survivors identified the importance of occupational engagement for health and recovery (Sleight, 2017). Participants in this research reported significant limitations in occupational engagement due to financial concerns and functional limitations, and a potential role for occupational therapists was identified. This research highlighted the way in which socioeconomic, cultural and behavioural factors converge to impact on occupational engagement and quality of life and emphasise the importance of understanding this interaction of factors in order occupational therapists to be effective working in this area.

A somewhat different approach to occupational engagement was reported by Brandt (2014) who reported on the development of a programme for training occupational therapy assistants who were 'place-bound' and otherwise unable to access educational opportunities. This programme was initiated due to challenges faced by rural communities in recruiting and retaining health practitioners, and the subsequent poor health of these communities who were unable to maintain health services. It was identified that specialist skills were required for working in rural settings, and retention rates were higher when practitioners were closer to family and other pre-existing support networks. While the primary purpose of this programme was to improve recruitment and retention of health practitioners in rural communities and contribute to the health of these communities "the program has realized multiple unforeseen benefits related to breaking the poverty cycle for program graduates and their families" (Brandt, 2014, p. S49).

Yet another way of considering occupational therapy in low-income communities is by considering occupational therapy practice in settings that have limited funding or resourcing. Creek and Cook (2017) reported on a qualitative research project regarding occupational therapists working in marginal settings, that is, in roles outside of mainstream practice. The challenges faced by therapists in marginal settings differ from the challenges faced in mainstream practice. Whereas mainstream practice tends to be procedural, inflexible, controlled, individual, hierarchical, and institutional, marginal practices are more likely to be responsive, flexible, autonomous, collective, collaborative, and local. Creek and Cook (2017) identified several characteristics shared by therapists working in marginal environments that enabled them to face the unique challenges of the marginal setting. These characteristics include agency, openness, commitment, responsiveness, and resourcefulness. This research also suggests that occupational therapists should actively seek opportunities to work on the

margins, as the characteristics developed there would serve the profession well in both marginal and mainstream practice settings.

2.3.6 Occupational Therapy in low and middle-income countries

Thus far the literature reviewed has all come from countries that like New Zealand are classified as high-income countries. There is, however, a substantial amount of occupational therapy research being published in low and middle-income countries. While these countries may be very different from New Zealand in many ways, there is still learning to be had from considering how poverty is addressed by occupational therapists in countries with much higher levels of poverty and deprivation.

In Tanzania, occupational therapists realised that in order for effective rehabilitation to be carried out with children with disabilities, the poverty and hunger experienced by their families needed to be addressed first. Through collaboration with Heifer International, impoverished families were provided with a goat to provide a new source of income-generation. By involving the child with disabilities in caring for the goat, occupational needs and rehabilitation goals were also being met (Hansen, Chaki, & Mlay, 2013). An occupational based programme also proved effective when working with families who had evacuated from poor urban areas in the Philippines due to flooding. The occupational therapist involved in this programme identified specific occupational needs and also advocated for the needs and rights of the evacuees (Duque, Ching, & Amihan-Bayas, 2012). In both of these examples, the occupational therapists recognised that needs related to poverty needed to be addressed before further intervention could be carried out. Collaboration and partnership with other professionals were required to ensure the reduction of poverty and the success of therapeutic interventions.

Poverty is a complex issue with numerous factors that intersect to create a lived experience of poverty. Structural factors including power and

discrimination contribute to poverty, and in countries such as South Africa, this can contribute to chronic poverty that persists not only for the lifetime of an individual but also throughout generations. When poverty persists in families and communities in this manner, community rehabilitation strategies are proposed as ways to engage entire communities in bringing change (Watson, 2013). Chronic poverty impacts on a person's occupational choices, and at times occupations are engaged in out of necessity rather than desire. Activities such as street-vending in South Africa fit into this category of occupations that are engaged in out of necessity despite being undesirable and seemingly culturally unacceptable (Gamieldien & van Niekerk, 2017). When poverty is combined with a physical or mental illness or disability, then increasingly complex intersections occur. Research about the intersections between psychiatric disability and chronic poverty in South Africa highlights the presence of both direct and indirect costs and notes that these costs may be hidden from health professionals (Duncan, Swartz, & Kathard, 2011a). These costs impact not only the person with the disability but also their family. However, a range of coping strategies are employed within family units to manage the impact of disability and poverty (Duncan, Swartz, & Kathard, 2011b).

The impact of the environment in situations of poverty is also evident when observing children at play. When their environments are lacking expensive toys or other structured activities, children show incredible creativity in the ways they use what is available in their environment to engage in play (Bartie et al., 2016). For occupational therapists working in deprived communities, it is important that they are able to adapt their interventions to the resources naturally occurring in the child's environment. Despite the creativity of children in finding ways to play with what is available in their environments, some children face developmental delays and high rates of school failure due to the deprivation of their environments. Van Jaarsveld, Vermaak, and Van Rooyen (2011) found that sensory-motor and cognitive-perceptual deficits were common

in street-children in Potchefstroom, South Africa. As a result of this research, the authors recommended that this issue be highlighted at a governmental level to ensure that teachers and students were provided with support and education to be able to overcome these challenges. Also proposed was occupational therapy intervention to address specific skills needed for success at school.

As has been seen from the literature in high-income countries, occupation-based programmes are effective when working with low-income communities. People living in impoverished communities often experience high levels of stress related to their economic situation. Stress-management programmes that incorporate physical stress management strategies and meaningful activities are one way to enable people to minimise stress levels even when their situation cannot be easily changed (Crouch, 2008). The Model of Human Occupation (MOHO) can provide a framework for conceptualising and developing occupation based programmes. Using the concepts of volition, habituation and performance, du Toit (2008) developed a programme for blind people that gave them opportunities to try activities that could lead to income generation and in doing so to discover their interests and abilities. This empowered the participants to take control of their lives, gain self-respect and self-worth, and develop ways to generate income to overcome extreme poverty. Likewise, a dance programme for young people brought about transformation, bringing hope and promise for the future, enabling young people to imagine a different future and start them on the road out of poverty (Coetzee, 2011).

While the environments of each of these examples are different from the practice environments encountered in New Zealand, many of the principles remain the same. Occupation is valued as a way to bring change and transformation to the lives of individuals and communities. Occupational therapists also need to be adaptable, to modify interventions for the environment in which their clients live. Working in partnership with other professionals and organisations is also an important part of the occupational therapist's role.

2.4 Occupation and Poverty – Theoretical Underpinnings

Within the occupational therapy and occupational science literature reviewed thus far, there have been several dominant theoretical underpinnings evident in the discussions about poverty. Poverty is discussed as an occupational injustice and a violation of human rights. Poverty and social class are also considered as an aspect of culture that may not be congruent with occupational therapy values. The remainder of this literature review will consider these theoretical viewpoints and the implications of these concepts for occupational therapists engaging with clients impacted by poverty.

2.4.1 Occupational Justice

Occupational justice is a relatively new concept that emerged in the late 1990's through an ongoing international dialogue between Townsend and Wilcock about their shared interests in occupation, justice, and client-centred practice (Townsend & Wilcock, 2004; Wilcock & Townsend, 2000), and offered new language for exploring conditions that restrict participation in every day occupations. Occupational justice is viewed as both a part of and as complementary to social justice (Hocking, 2017; Townsend & Marval, 2013; Wilcock & Townsend, 2000). Whereas social justice is primarily concerned with social relations and social conditions (Wilcock & Townsend, 2000), equality (Townsend & Wilcock, 2004), and protection of rights (Hocking, 2017), the focus of occupational justice is what people are able to do within these social structures (Wilcock & Townsend, 2000), and raising awareness of the detrimental effects of people being denied access to engagement in meaningful occupations (Townsend & Wilcock, 2004). The foundational beliefs of occupational justice are that humans are occupational being and as such occupation is a determinant of health and wellbeing; occupations cannot be separated from the context in which they occur, and both structural factors and personal characteristics impact occupational engagement; and finally, engagement in occupations can improve

the lives of people who are vulnerable (Hocking, 2017). An occupationally just society is one in which there is "equitable opportunity and resources to enable peoples engagement in meaningful occupations" (Wilcock & Townsend, 2000, p. 85). Because occupational justice is contextually embedded, manifestations of occupational justice will vary between time, place, and culture (Hocking, 2017).

The concept of occupational justice is not without difficulty. From the outset, there have been concerns raised about balancing tensions between individual and community rights when determining what is occupationally just (Wilcock & Townsend, 2000). It has also been noted that there are some conceptual confusions, overlaps, and contradictions within occupational justice terminology with some concepts being described with multiple terms, or multiple terms being used to define similar concepts (Durocher, Gibson, & Rappolt, 2014; Hammell & Beagan, 2017). When readers of the Occupational Therapy in Mental Health Journal were asked for their views about occupational justice, Kautzmann (2009) found responses were fairly evenly split about the usefulness of occupational justice terminology. While some readers felt that occupational justice was a useful term and served to politicize certain issues, other readers felt that occupational justice terminology unnecessarily complicates issues making it harder for others to understand occupational therapy as a profession.

Despite these challenges, occupational justice terminology remains useful for considering the issue of poverty. It has been identified that poverty can limit possibilities for occupational engagement and thus prevents occupational justice (Townsend & Wilcock, 2004). Occupational justice can help occupational therapists understand our unique contribution to addressing broader social issues, which is important as the profession expands its scope in many places around the world (Hocking & Townsend, 2015).

2.4.2 Occupational Injustice

If occupational justice occurs when people have equal and equitable opportunities to engage in meaningful occupations, then occupational injustice occurs "when participating in occupations is barred, confined, restricted, segregated, prohibited, undeveloped, disrupted, alienated, marginalized, exploited, excluded or otherwise restricted" (Townsend & Wilcock, 2004, p. 77). Like social justice, occupational justice is concerned with factors outside of the individual and the ways in which structural and contextual factors limit participation in occupations, rather than the personal characteristics of a person that may limit their ability to participate (Nilsson & Townsend, 2014; Wilcock & Townsend, 2000). While the focus of injustice may be on external forces or contextual factors causing limitations, these factors interact in numerous and often complex ways with personal characteristics, and thus occupational injustice will be experienced differently between individuals.

Throughout the occupational justice literature, there are a variety of forms of occupational injustices identified. Some of these have received more attention in the literature than others, but they all add different layers of understanding to the issue of occupational injustice. Townsend and Wilcock (2004) initially named occupational alienation, occupational deprivation, occupational marginalisation, and occupational imbalance. Occupational apartheid has now been widely accepted as an additional form of occupational injustice (Kronenberg & Pollard, 2005; Simó-Algado, Mehta, Kronenberg, Cockburn, & Kirsh, 2002). More recently occupational displacement has also been proposed as a further form of occupational injustice (Pizarro et al., 2018).

Occupational alienation is described as a situation where people or populations are excluded from meaningful activity and/or forced into meaningless activities (Durocher, Gibson, et al., 2014). This can lead to feeling disconnected, isolated, and lacking a sense of identity (Townsend & Wilcock, 2004). These feelings of incompatibility with occupations can lead people to feel

that even their basic needs and wants are out of reach, and can then result in social unrest or other behaviours that are harmful to self and others (Hocking, 2017).

Occupational deprivation is the form of occupational justice that has received the most attention in the literature (Durocher, Gibson, et al., 2014). Occupational deprivation occurs due to external barriers or restrictions to occupations that are meaningful and necessary for wellbeing (Hocking, 2017), with these barriers being viewed as hostile (Whiteford, 2000). These external barriers can include social, environmental, economic, geographic, historical, cultural, political, or interpersonal factors (Durocher, Gibson, et al., 2014; Whiteford, 2000). The impact of these barriers are restricted occupational choices and diminished occupational opportunities and can lead to loss of occupational capacity (Whiteford, 2000). Occupational deprivation also occurs over a prolonged timeframe, as opposed to occupational disruption which is considered temporary (Durocher, Gibson, et al., 2014). Occupational deprivation can be experienced by individuals or populations, with marginalised populations such as people who are unemployed, living in poverty, prisoners, refugees, minority groups, and women, being more susceptible (Whiteford, 2000). While some of the external factors that cause occupational deprivation are overt other factors may be more subtle, and thus both Whiteford (2011) and Hammell and Beagan (2017) highlight the need for greater scholarly critique and theoretical development of the concept of occupational deprivation.

Occupational marginalisation occurs when people are excluded from occupations due to invisible social norms and expectations regarding participation (Durocher, Gibson, et al., 2014; Hammell & Beagan, 2017; Hocking, 2017; Townsend & Wilcock, 2004). This can lead to some people or groups being relegated to occupations that are less valued by themselves and the societies in which they live (Hocking, 2017). Although this discrimination may not be overt, it still undermines the need that people have to make micro, everyday decisions

about the things they do, and this can have detrimental effects on health and well-being (Townsend & Wilcock, 2004).

Occupational imbalance primarily refers to situations in which people are under-occupied, over-occupied, or unoccupied (Hocking, 2017; Townsend & Wilcock, 2004). This can occur at an individual level whereby a person spends excessive time on one occupation to the exclusion or detriment of other occupations, or at a societal level where numerous occupational opportunities are given to one group while another group is offered minimal opportunities (Durocher, Rappolt, & Gibson, 2014). While this definition appears straightforward, Hammell and Beagan (2017) argue that occupational imbalance is a culturally specific term, and attention needs to be paid to who determines whether an imbalance exists. In order to decide of an occupational balance exists, it is first necessary to define occupational balance, something that has not yet been attempted in occupational therapy or occupational science literature (Hammell & Beagan, 2017). It has also been noted that occupational imbalance is most often discussed in relation to marginalised groups such as those living in poverty, yet people who are rich, famous or successful may lead occupationally imbalanced lives, but this goes unlabelled as such (Hammell & Beagan, 2017).

Occupational apartheid was a phrase first used by Simó-Algado et al. (2002) in relation to children survivors of war. The term was further defined by Kronenberg and Pollard (2005) as "systematic segregation of occupation opportunity" (p. 59), which serves to deny individuals and populations their rightful access to meaningful and valued occupations. This restriction or denial of opportunities is a deliberate act based on prejudice regarding capabilities and entitlements (Hocking, 2017) on the basis of "race, colour, disability, national origin, age, sexual preference, religion, political beliefs, status in society, or other characteristics" (Kronenberg & Pollard, 2005, p. 67). Apartheid is a politically charged word, and was a deliberate choice of terminology to politicize issues of occupational engagement (Kronenberg & Pollard, 2005), and also emphasise that

this is a "formally institutionalized occupational injustice" (Durocher, Gibson, et al., 2014, p. 421).

Occupational displacement was proposed as a new form of occupational injustice, and has been defined as:

> *a phenomenon in which an individual or group is forcibly removed, dispossessed or displaced by reasons beyond his/her immediate control, leaving behind territories that had occupational/cultural/economic significance, and resulting in impoverishment or limited opportunities for meaningful and ecologically significant occupations* (Pizarro et al., 2018, pp. 6–7).

Occupational displacement is concerned with the relationship between territory, place, and occupational justice, and highlights the situated nature of occupation. Place, identity, and occupation are intimately related, and when people or groups are removed from a place in which they find meaning and identity, their occupational engagement and sense of identity and belonging are significantly impacted. In some cases, this removal from a territory can bring with it impoverishment and/or limited occupational engagement (Pizarro et al., 2018). While the phrase occupational displacement was not used, McNeill (2017) described the way in which colonial practices alienated people from their tribal estates and consequently from tribal ideologies and practices that relate to the natural environment. This situation could be defined as occupational displacement, and effectively highlights the damaging effects of such displacement on both individuals and entire populations.

2.4.3 Occupational Rights

Hammell and Beagan (2017) provide a critique of occupational justice, suggesting that there is a lack of scholarly debate about the concept, and highlight some difficulties with defining occupational injustices. They argue that occupational injustice could be viewed as a violation of occupational rights. They also emphasise the culturally specific nature of justice, and state that "human

rights transcend cultural practices that conflict with fundamental human rights" (Hammell & Beagan, 2017, p. 65), making a rights-based approach more universally appropriate.

However, the concepts of occupational rights and occupational justice are closely linked, and it has been suggested that the definitions of these concepts are so similar that it adds confusion rather than clarity to these important issues (Durocher, Gibson, et al., 2014). Others have suggested that the concept of occupational rights extends the concept of occupational justice by highlighting the importance of equitable access to opportunities for occupational engagement (Hammell, 2015b). Occupational rights are also closely linked to human rights and to social justice as protection of human rights is a basic principle of social justice (Hocking, 2017). The WFOT position statement on human rights (2006) endorses the UN Universal Declaration of Human Rights, so human rights should be of utmost importance to occupational therapy.

Occupational rights have been defined as "the right of all people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities" (Hammell, 2008, pp. 61-2). Engagement in meaningful occupations considered essential for well-being and well-being is a fundamental human right. Thus occupational engagement that contributes to well-being is a basic human right (Hammell, 2017; Hammell & Beagan, 2017; Hammell & Iwama, 2012). Occupational injustice in all its forms is considered a breach of occupational rights (Hammell & Beagan, 2017; Hammell & Iwama, 2012). In a review of the literature about occupational injustice, Hocking (2017) noted that although the literature reviewed did not specifically mention human rights or the WFOT position statement on human rights, breaches of human rights were described.

Use of an occupational rights-based approach requires consideration of social determinants not only of health but also of occupation (Galheigo, 2011; Hammell, 2017). By doing this, occupational therapists also need an increased

awareness of the political nature of human rights and be willing to engage politically with issues that limit equitable opportunities for engagement (Galheigo, 2011; Hammell, 2008). Viewing occupational engagement as a human right also emphasises the importance of occupation "to the well-being of all people, not solely those whose health is already compromised" (Hammell, 2017, p. 212). In this way, a rights-based approach is also congruent with suggestions that occupational therapy practice should seek to expand out of the confines of health and medical based services and to begin working to address social issues (Hocking & Townsend, 2015).

One proposed way that a rights-based approach could be adopted within occupational therapy and occupational science is through the use of the capabilities approach. The capabilities approach highlights both internal and external conditions that impact on occupational engagement (Bailliard, 2016). The focus is not solely on what people have the ability to do, but also whether they have opportunities to use those abilities (Bailliard, 2016; Hammell & Beagan, 2017). This approach could also assist in overcoming what Hammell and Iwama (2012) described as a "preoccupation with individuals' abilities (and more particularly, their inabilities) rather than a commitment to enhancing opportunities through addressing the conditions of people's lives" (p. 388).

2.4.4 Occupational Therapy, Culture, and Poverty

It is essential for occupational therapists to recognise and understand the impact of culture on themselves, their practice settings, the clients they are working with, and on the profession as a whole. In New Zealand, it is explicitly stated by the registering body that all occupational therapists must "acknowledge and respond to the history, cultures, and social structures influencing health and occupation in Aotearoa New Zealand" (Occupational Therapy Board of New Zealand, 2015b). As discussed earlier in this literature review, Maori are over-represented in statistics about health and poverty. Although discussion about culture is essential for any research in New Zealand,

it is all the more crucial in research about poverty. For occupational therapists working to minimise the impact of social determinants of health, culture is a vital concept to consider.

Thus far, culture has been discussed in terms of race and ethnicity. However, culture is about much more than ethnicity. Hammell (2013) states that "culture describes the knowledge, beliefs, values, assumptions, perspectives, attitudes, norms, and customs that people acquire through membership in a particular society or group" (p. 225). Likewise, Gerlach (2012) proposes a broad perspective of culture, one that does not only include race or ethnicity but also includes other social categories such as age, gender, ability, socioeconomic status and class, sexuality, religious or spiritual beliefs. In this way, culture can also be considered as diversity, a way of recognising human differences, and also serves as a reminder that differences frequently become the basis for stereotypes or used to rationalise poor treatment for some and preferential treatment for others (Beagan, 2015). Another important consideration regarding culture is intersectionality, that is the complex interactions between social or structural factors and individual characteristics, and the way in which this can create or sustain marginalisation (Gerlach, 2012, 2015; Hammell, 2013). The factors are considered to be interlocking and interdependent factors that contribute in complex ways to a persons lived experience of marginalization, rather than being viewed as having an additive effect.

There is a growing body of literature within occupational therapy and occupational science about ways that cultural differences and diversity should be addressed. Popular approaches include cultural competence, cultural relevance, cultural safety, and cultural humility (Beagan, 2015). Cultural safety and cultural humility are becoming more favoured approaches as they shift the focus from the client as being different, to relationships. Cultural safety highlights social, political, and economic power relationships (Beagan, 2015), with a specific focus on understanding the historical and ongoing effects of

colonisation (Emery-Whittington & Te Maro, 2018; Gerlach, 2012). Whereas cultural humility emphasises that client and therapist hold equally valid worldviews, and the difference lies in the relationship rather than in the individuals (Gerlach, 2012; Hammell, 2013).

An important aspect of these ways of approaching culture is that they challenge occupational therapists to critically evaluate their personal and professional beliefs, values, and assumptions, and the positions of privilege or power that are held. Gerlach (2012) discusses the need for a critical analysis of the cultural nature of occupational therapy. If we as occupational therapists want to understand and respond appropriately to those from other cultures, "we need first to interrogate the assumptions, values, and beliefs of our own occupational therapy culture" (Hammell, 2009a, p. 7). The cultural nature of occupational therapy is often invisible to occupational therapists who are part of the profession, in large part due to the process of enculturation that happens when becoming part of a professional body whereby cultural values are transmitted, and certain ideas become 'common sense' (Hammell, 2009a).

As occupational therapy practice around the world expands beyond healthcare and work is done increasingly with marginalised individuals and populations, an understanding of the culturally embedded nature of occupational therapy theories is essential. Without this understanding occupational therapists are at risk of theoretical imperialism, where theories are assumed to be universally relevant and are imposed on others. Critical theorists in occupational therapy have recently highlighted that most occupational therapy theories have been developed in the Western world and by predominantly white, middle-class, often middle-aged, female, and able-bodied perspectives, and as such they do not reflect the perspectives of the majority of people in the world today (Hammell, 2013, 2015c).

Because this research is about poverty, then considering aspects of the social through a cultural lens is valuable for this discussion. While discussion

about the western worldview basis of occupational therapy is widespread in occupational therapy literature, there is also a growing discussion about the class-bound status of many occupational therapy theories and the way in which middle-class assumptions influence practice. Beagan (2007) explored the occupational impacts of poverty by coding and analysing essays from occupational therapy students who identified as coming from a lower-class or working-class. This research highlighted that social class is about more than money or financial resources, but is also about "having the right norms, values and experiences to fit easily in middle-class society" (Beagan, 2007, p. 125). The class-based assumptions underpinning health and education services, including occupational therapy, was highlighted in this research. These biases may often seem invisible to those inside the profession, but it is important to recognise that these biases exist, and bring them into our conscious thoughts and professional discourse in order to understand them and the impact they have on our work with clients from different social classes. It is also important to understand the impact of growing up in a lower social class and how that defines a person, even those who have moved up to a higher social class. The lower-class or working-class values and ways of being will continue to impact a person throughout the rest of their life.

2.5 Conclusion

Poverty and inequality are significant issues in New Zealand with an impact on health and wellbeing. Because so many people in New Zealand are impacted by poverty and inequality, it is reasonable to expect that occupational therapists working in New Zealand will encounter poverty within their practice. Within the occupational science and occupational therapy literature, issues such as poverty are framed as occupational injustices and violations of occupational rights. As occupational therapists, we need to be aware of and responsive to occupational injustices in our practice. While the literature provides a framework

for considering injustices such as poverty and provides examples of how this is being done in various places around the world, there is currently no literature about how occupational therapists address issues of poverty in their practice in New Zealand. There were also limited examples of research that explored therapist's perceptions about how they engage with and address poverty and related injustice.

This research project is unique in that it is being carried out in the context of New Zealand. Additionally, this research will take a broad approach and explore poverty in a way that relevant and meaningful to occupational therapists working in a range of practice areas, rather than focussing on a specific poverty-related issue or targeting a specific population.

The next chapter of this thesis will describe the research methods used, and introduce the research participants.

Chapter 4 will present the main research findings and will describe and begin to analyse the interview data.

Chapter 5 will discuss these findings further in relation to the literature, and will also consider the use of an ethical framework another way to consider the issues of poverty that are facing occupational therapists every day.

The reality of poverty seems to be creeping ever closer, and much of what I have been reading I am now seeing reflected in the lives and experiences of those I love most.

Dad has recently retired, and now my parents' sole income is Dad's pension. They are considering moving to a more affordable rental, and have been to Work and Income to try to get some support with this process. So, of course, I have been talking to them about their experiences.

WOW.

Structural violence and institutional racism are thoroughly entrenched in the systems they have encountered. They have been told not to bother applying to Housing New Zealand as they will not qualify because they are "the wrong colour", and they do not have young children. I know that homelessness is no life for a child, but homelessness is also not a situation that our older generation should have to face either.

Chapter Three. Methodology

In this chapter, the research question is re-stated, and then the research design and justification for the research methodology selected is presented. The specific research methods used, including recruitment processes, inclusion and exclusion criteria, data collection methods, and data analysis techniques are described. The research participants are introduced, and ethical issues related to this research are discussed.

3.1 Research Question

The primary research question is: "How do occupational therapists in New Zealand engage with issues of poverty?"

Further aims of the research include:

- To better understand the issue of poverty from an occupational therapy perspective
- To understand how occupational therapists in New Zealand are engaging with issues of poverty within existing roles.
- To explore new ways for occupational therapists to engage with issues of poverty in New Zealand.

The wording used in this research question was carefully thought out, and various iterations of the question were considered before the final wording was decided. One alternative wording of the research question asked how occupational therapists address issues of poverty. The concern about using the word 'address' was that it could imply using specific strategies to reduce or eliminate poverty, and as such may be seen to be outside the scope of many occupational therapy roles. Thus, use of the word 'engagement' was a deliberate choice, as it acknowledges the different ways of becoming involved in a specific issue, without limiting engagement to strategies that aim to reduce or eliminate an issue. The research question and additional research aims also focused on

what is currently being done by occupational therapists, rather than asking therapists to theorise about what could or should be done. Wording the research question in this way ensures that the research is grounded in clinical experience and that the findings will be relevant to a range of clinical practice areas.

3.2 Selection of the research methodology

The development of a research methodology requires careful consideration of the nature of the topic being researched and the type of data to be generated. Previously published research regarding the topic of interest needs to be considered when developing a research question and deciding on the specific methods to be used. This is especially important when there is a lot of existing research about a topic, to ensure that the new research adds something new to the existing knowledge. The main area of interest for this research project is poverty, and as seen in the literature review, poverty is a topic that has been written about from a variety of perspectives within a wide range of academic disciplines. This research is concerned with poverty within occupational therapy practice, and more specifically, within a New Zealand context. While poverty has received increasing attention in occupational therapy and occupational science literature in recent years, there is very little written about how occupational therapists engage with poverty in their practice in New Zealand. For this reason, a research methodology that would generate knowledge grounded in and relevant to clinical practice was needed.

Qualitative methods are best suited to research questions that explore subjective human experience and meaning. Rather than measuring outcomes or testing a hypothesis, qualitative research uses an inductive approach to "generate empirical knowledge about human phenomena for which depth and contextual understanding would be useful and for which measurement is inappropriate, premature, or potentially misleading" (Thorne, 2016, p. 44). Because this

research is investigating what occupational therapists do in clinical practice and seeking to understand a little about why they make the decisions they do regarding issues of poverty, a qualitative research methodology is the most appropriate for this research.

3.2.1 Interpretive Description

Interpretive description is a research methodology that evolved within the field of nursing and is particularly suited to use in other applied or practical science fields. It seeks to develop scholarship that is not simply theoretical, but that is grounded in clinical practice (Thorne, Kirkham, & MacDonald-Emes, 1997). This method developed because of a recognised "tension between theoretical integrity and real-world utility" (Thorne, 2016, p. 37). Prior to the development of interpretive description, nursing researchers, and researchers in other applied disciplines were attempting to utilise qualitative methodologies such as ethnography, grounded theory, or phenomenology that often did not fit well with their research aims. Because of the poor fit of these methodologies, there were concerns raised about the integrity of the research when research methodologies were not strictly adhered to. Researchers in the applied disciplines also wanted qualitative methods that went "beyond mere description and into the realm of "so what" questions that drives all applied disciplines" (Thorne, 2016, p. 36).

In order to better understand what an 'interpretive description' is, it is first helpful to understand each of the words in this phrase independently. According to Thorne (2016), a description is "telling what it is that one observed" (p. 54), and an interpretation asks "so what might this mean?" (p. 56). Thus, an interpretive descriptive project first describes and documents the phenomena in question, and then begins to make sense of the meanings found in the descriptions. Another important feature of interpretive description is that it describes commonalities in experiences and draws conclusions from shared

perspectives, this should be done in a way that ensures that individual perspectives are not lost (Thorne et al., 1997).

Interpretive description, informed by grounded theory, was selected as the primary qualitative methodology for this research project. Initially, a grounded theory approach was considered as a methodology that would enable development of a theory grounded in practice. However, as the research question developed, it was unclear development of a theory would be likely or even possible. It was also recognised that due to time limitations and the challenge of gaining ethical approval for a constantly changing research design, that it would be difficult for a novice researcher to strictly adhere to a grounded theory methodology. Like grounded theory, interpretive description requires immersion in the research data, a process of constant comparative analysis, and the aim to produce research findings that are grounded in the data and would also be relevant to real-world experiences. Thus, interpretive description was decided on as a more flexible, and more appropriate methodology for this research.

One significant difference between grounded theory and interpretive description that needs to be addressed is the use of literature and the timing of the literature review. When grounded theory was first developed "Glaser and Strauss (1967) explicitly advised against conducting a literature review in the substantive area of research at an early stage of the research process" (Dunne, 2011, p. 113). The rationale behind this was to allow categories to emerge from the research data rather than attempting to force the data into pre-existing categories. While this can sound ideal, it can be more challenging to implement in practice. Within interpretive description, it is suggested that understanding of the literature and what is already known about a phenomenon is important for the development of a research question (Thorne, 2016). The reality of the literature review in this research was somewhere in the middle of these methods. A preliminary literature review was carried out to determine what, if anything,

had been written about the developing research question. Awareness of previous research about poverty was necessary to ensure unintentional duplication of research. This early literature review revealed that there was no published research about poverty in New Zealand occupational therapy practice. The process of searching and consulting the literature continued throughout the data collection and data analysis phases, with the final literature review format being decided on after the findings had been developed, but before the discussion of the findings was written. Returning to the literature after data collection and during the data analysis enabled better integration of literature and findings, and also revealed new research that had been published in the time since the initial literature searching was completed.

3.3 Research Process

Interpretive description does not prescribe specific processes for research. Rather it provides a framework within which the research process can be organised coherently. The first stage of this process involved writing a detailed research proposal which was submitted to the post-graduate supervisors' groups at Otago Polytechnic for review and approval, a process which was influential in the development of the research question. Following this, ethics approval was obtained from both the Otago Polytechnic Ethics Committee (Appendix 1) and the Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa (OTNZ-WNA) ethics committee. Ethical considerations will be discussed in detail later in this chapter.

3.3.1 Sampling

Within qualitative research, there are several sampling strategies that can be used depending on the type of sample that is required. Purposive sampling was used to find participants with "direct experience of the phenomenon and [who] fit the inclusion criteria" (Stanley & Nayar, 2014, p. 7). The use of

purposive sampling aims to generate a 'representative sample', and although variations are sought to ensure the credibility of the findings, maximum variation in the sample is not the ultimate aim (Thorne, 2016). As will be seen in the description of the recruitment process, participants with relevant experience were sought for this study, and there was significant variation represented in age, gender, length of practice, practice area, and geographical location. As with any research, it is difficult to state if the sample was truly representative. There were some easily identifiable gaps in the sample in terms of practice area (specifically regarding paediatrics), so it is not possible to say that this sample was representative of occupational therapists in all practice areas in New Zealand.

3.3.2 Recruitment of participants

Participants for this research were recruited via OTNZ-WNA, with an email (see Appendix 2) sent to members of the following special interest groups (SIGs): OTNZ Issues; Acute Care; Adults with intellectual disabilities; Children and young people; Health of Older People; Mental Health; and Physical Community. These SIGs included approximately 720 occupational therapists. These SIGs were selected to represent a wide range of practice areas, with deliberate inclusion of special interest groups focusing on populations such as older people and children who are known to be over-represented in statistics about poverty. In retrospect, a more representative sample may have been achieved if recruitment had been carried out through the Occupational Therapy Board of New Zealand (OTBNZ) as the recruitment email would have reached a larger audience and potentially resulted in a larger sample.

The email inviting occupational therapists to be involved in this research was sent on 13th June 2017, and participants were requested to respond with an expression of interest via email on or before 26th June 2017, giving approximately 2-weeks for potential participants to reply. During this 2-week period, 13 occupational therapists responded with an expression of interest. A participant information sheet (Appendix 3) was then emailed to 12 of these respondents with

additional information about the times and days available for interviews. From this, one person was not available during the time allocated for data collection, and one person did not respond regarding the additional information sent. Interviews were scheduled with the remaining 10 participants, although one of these people withdrew from the research for personal reasons prior to the scheduled interview time.

3.3.3 Sample Size

There are a number of ways to determine the appropriate size of the sample in qualitative research. In grounded theory data collection ideally continues until theoretical saturation has been reached, that is there are no new concepts emerging, and all aspects of the developing theory have been substantiated (Stanley & Cheek, 2003; Stanley & Nayar, 2014). While this sounds like an ideal scenario, it is a time-consuming method, and it is not possible to predict the final sample size or the amount of data that will be collected and thus require analysis. As the research proposal required a prediction of the sample size, this open-ended method of sampling was not suitable. Within interpretive description, determining a sample size includes giving consideration to the type of knowledge that is needed, and how this knowledge can be gained. Interpretive description also acknowledges the reality that the sample size for many studies is decided in large part by the amount of time and resources available for the research.

Any research at a master's level is constrained by time and resources, and this research was no exception. Prior to recruitment, it was decided that 8 – 10 individual interviews lasting up to 1-hour in duration would provide the amount of data that could reasonably be managed in this research. This is a relatively small sample size, so drawing generalizable conclusions from this research needs to be approached with caution. However, even a small sample is able to contribute to the preliminary understanding of a topic that has not previously been researched in this manner. In reality, the size of the sample in this research

was ultimately decided by the people who responded to the request for participants. All initial respondents were invited to participate, and those that responded with a time that they were available while data collection was occurring were subsequently interviewed. If there had been a smaller number of respondents, then additional recruitment processes would likely have been required, as new themes continued to emerge throughout the nine interviews completed. Because of the continued emergence of new concepts throughout the interview process, no claims regarding theoretical or data saturation are being made in this research. There are multiple ways of understanding saturation in qualitative research. In grounded theory tradition, theoretical saturation is said to be achieved when no new themes are emerging from data collection, and the theoretical categories are well developed (Saunders et al., 2018). Because of the sampling methods used, that is interviewing all participants available from initial recruitment, claims regarding theoretical saturation cannot be made. However, the data that was collected contained richness that allowed the development of complex conceptual categories with sufficient data to provide a depth of understanding of each category.

3.3.4 Inclusion/Exclusion Criteria

To ensure that participants in this research were somewhat representative of the population of interest, it was necessary to set some criteria regarding inclusion or exclusion from this study. Participants included in this research were occupational therapists who were registered and practising as occupational therapists at the time of data collection. Participants were also individual therapists who identified that some, or all, of their clients, are impacted by poverty. Participation in the research was completely voluntary, and no incentives for participation were provided.

People who would not have been considered suitable for inclusion in this research were those who were not currently registered as occupational therapists, anyone who was not currently practising as an occupational therapist, or

occupational therapists not currently employed in New Zealand. All of the respondents to the recruitment email met the inclusion criteria, and thus none were excluded based on these criteria.

If the situation had arisen in which the number of responses to the research had been overwhelming, then invitations for participation would have been sent out based on the time the expression of interest was received. That is, the first people to respond to the recruitment email would have been invited first. A specific number of interviews required was not determined prior to data collection. However it was hoped that the sample could include at least eight, but probably no more than 12. Because of the small number of responses to the recruitment email, no further decisions regarding inclusion or exclusion were required.

3.3.5 Research Participants

The following table provides basic demographic data about the participants who were included in the research sample. While there was substantial variation in the sample, there were also some significant gaps identified in terms of age and practice setting. The youngest research participant was 36-years old, slightly older than the researcher who was 35-years at the time of the data collection. The age of participants has not featured in the analysis of the data, but for future studies, it could be beneficial to investigate if different age groups are more, or less, sensitised to social issues such as poverty. One significant and surprising gap was that none of the participants worked solely with children and young people. Several participants stated that their role encompassed people of all ages, and some also worked with both individuals and families. However, given the prominence of child poverty in New Zealand, it was somewhat surprising that occupational therapists working in paediatrics or education were not among the respondents.

Table 1 - Overview of Information About Participants

Number of Participants	9	7 female; 2 male
Age of Participants	30-40 years	2
	40-50 years	3
	>50 years	4
Years since graduation	<5 years	2
	10-20 years	4
	>30 years	3
Practice Area	Mental Health	4
	Physical Health	2
	Non-traditional roles	3
Geographic Location	Auckland, Hamilton, Rotorua, Wellington, Nelson, Christchurch, Dunedin	
Age range of clients	18 – 65 years	3
	>65 years	1
	No specified age range	5

3.4 Data Collection

A wide range of data collection techniques can be used within interpretive description, and there are a variety of potential data sources available to the researcher in interpretive description. Individual, semi-structured interviews were the data collection used for this research. Interviews are the most familiar strategy used in qualitative research, and interviews can be completed with individuals or groups. Interviews can be unstructured, semi-structured, or structured, and the choice of method is guided by the type of knowledge that is being sought. Semi-structured interviews are usually scheduled in advance, and occur outside of usual or everyday events, as opposed to unstructured interviews that can take the form of a guided conversation and may occur concurrently with observation (DiCicco-Bloom & Crabtree, 2006). Prior to commencement of semi-structured interviews, 5-10 specific questions are developed to guide the interviews (see Appendix 5 for the interview guide). Because of the iterative nature of qualitative interviews, these questions may change or develop during the data collection process (DiCicco-Bloom & Crabtree, 2006). Interviews can take place face-to-face, via telephone, or using technology such as Skype.

Although face-to-face interviews can yield additional information regarding body-language and other non-verbal communication, the use of face-to-face interviews was not possible as the research participants were from multiple geographic locations across New Zealand, and travelling to the location of each participant would have been costly and time-consuming. Instead, all the interviews took place via telephone and were digitally recorded. Unfortunately, there was a glitch with the equipment used during the fifth interview, which resulted in only the researcher's side of the conversation being recorded. For the remaining interviews, a second recording device was also used to minimise the risk of this occurring again.

During the interviews, notes were taken to assist with understanding the stories being told, to provide prompts for the researcher about points that required further clarification, and to ensure that all relevant questions had been asked and answered as required. These hand-written notes proved invaluable when it was discovered that the fifth interview had failed to record correctly. Short reflections, were written immediately following each interview, and in the case of the recording failure, extensive notes were made based on recollection of the conversation, using the handwritten notes as a guide. Each interview was also transcribed verbatim, with eight of the nine interviews being sent to rev.com for professional transcription (Information about the protection of sensitive data is described later in the chapter in the discussion about ethical considerations).

In qualitative research it is preferred that all interviews are transcribed by the researcher, but due to time pressure on the research process, this was not possible. One interview was not sent to rev.com for transcription due to the number of Maori words used in that particular interview which could have proved difficult for transcription to occur outside of New Zealand. Being able to complete the transcription for this one interview was beneficial for understanding the transcription process, and also for the data analysis process. When interview transcripts were received from rev.com, each transcript was

checked for accuracy. The check for accuracy involved listening to the recording while reading the corresponding transcript, and making changes, corrections, or clarifications as required. This process of listening to the recordings while reading and correcting transcripts was an invaluable part of the data collection and analysis process, which will now be described in greater detail.

3.5 Data Analysis

Data analysis is a key component of qualitative research. The analysis process involves making sense of the information collected, discovering similarities and differences within the data, and presenting a coherent and logical argument based on the research findings. One of the significant challenges facing qualitative researchers is attempting to understand the essence of the data, answer the research question and draw legitimate conclusions based on all the data, yet still maintain the integrity of each individual story.

Data analysis in interpretive description occurs from the start of data collection. The analysis process is inductive in nature, that is questions such as 'what is happening here?' and 'what am I learning about this?' guide the analysis rather the imposing pre-existing theoretical frameworks on the data. Repeated periods of immersion in the data are suggested prior to beginning coding, along with periods of time immersed in the data interspersed with time spent in the field collecting data (Thorne, 2016).

3.5.1 QUAGOL

The Qualitative Analysis Guide of Leuven (QUAGOL) was used to guide the data analysis process (Dierckx de Casterle, Gastmans, Bryon, & Denier, 2012). This method was developed as a systematic and comprehensive method that aims to "truly capture the rich insights of qualitative interview data" (Dierckx de Casterle et al., 2012, p. 363). Although not developed from a particular

methodological framework, this method fits well with the constant comparative processes described and recommended for Interpretive Description.

The QUAGOL method is broken down into two parts – preparation for coding, and the coding process. There are five stages in each of the two parts. Although these stages are described and summarised as separate events occurring in a linear process, in reality, these stages are "iterative processes of digging deeper, constantly moving between different stages" (Dierckx de Casterle et al., 2012, p. 363).

Preparation of coding process

The first part of data analysis is preparing for coding. It has been suggested that qualitative researchers can be overwhelmed by the quantity of data collected, and rely too heavily on data analysis software (Dierckx de Casterle et al., 2012). Because there is a temptation when using data analysis software to begin coding immediately, the first part of the QUAGOL process includes paper and pencil work. It has been said that researchers must "first *look at* their data – in order to discern what they should *look for* in their data" (Sandelowski, 1995), and this first part of the process assists with opening the researcher's mind to the possibility of multiple meanings and perspectives within the data.

Stage 1. Thorough (re)reading of the interviews

The QUAGOL method recommends that interviews are transcribed verbatim by the interviewer immediately after the interview and that a short report is completed with additional contextual information. Due to the time-frames of this research, this was not possible. As described above, digital recordings of the eight of the nine interviews were sent to rev.com for professional transcription. Each interview transcript was read closely while also listening to the audio recordings to check for accuracy, and this process also assisted with immersion in the data. During each interview, handwritten notes were made to ensure that all necessary information was gathered, to make a note

of any points that required clarification from the interviewee, and to record initial thoughts from the interview. Further descriptive notes were made immediately following the interview. The combination of these hand-written notes was invaluable for the data analysis process and especially useful in the case of the interview that did not record correctly. Once checked for accuracy, the interview transcripts were printed with double-line spacing for ease of reading and re-reading, and providing space for making notes throughout the reading and analysis process.

Stage 2. Narrative Interview Report

The second stage in preparing for coding is preparing a short narrative that captures the essence of each individual interview that articulates a holistic understanding of the experiences described in the interview. The writing of these narratives is guided by the research question. A narrative interview report was written for each interview within 6-weeks of completion of all the interviews (example narrative interview report provided in Appendix 6). Identifying information about the participants and their workplaces were not included in the narratives, although brief notes about the workplace and role were included to remind the researcher of the context of each interview. The narratives were read and re-read several times, and selected narratives were used for a coding practice exercise with fellow-students and supporting academic staff at Otago Polytechnic, which strengthened the analysis process.

Stage 3. From narrative report to conceptual interview scheme

The next stage of data analysis takes concrete information from the data and begins to develop concepts that give insight into the research question. In this research, this process was not carried out exactly as described, and the conceptual interview schemes produced did not take the same form as the example schemes provided in the literature about the QUAGOL method. Instead, initial concepts were noted in the margins of the narrative interview

schemes, and then these concepts and several concrete ideas from each interview were recorded on a whiteboard, links were made between ideas, and key concepts were identified from each interview (see Appendix 7 for examples).

Stage 4. Fitting test of the conceptual interview schemes

In this next stage, "the appropriateness of the conceptual interview schemes is being verified by iterative dialogue with the interview data" (Dierckx de Casterle et al., 2012, p. 366). This stage took several forms in this research. First was a brainstorming exercise of themes and concepts from all interviews completed on a whiteboard (see Appendix 9). The second was compiling of themes from the conceptual interview schemes (see Appendix 8). This facilitated the iterative process of comparing themes, comparison of themes to interview data, and determining if there was a fit between the conceptual themes and the actual data collected.

Stage 5. Constant comparison analysis

As progress through these stages continued, there was a process of constant comparison analysis, that is moving forward and back between within-case and across-case analysis (Dierckx de Casterle et al., 2012). This process is much like the constant comparative analysis technique used in grounded theory whereby each new piece of data collected is compared with previously collected data and categories that have emerged, and emerging categories are compared with both the data and other emerging categories (Charmaz, 2005). This process aims to search for relationships between concepts, and identify key concepts or themes required for theory generation (Nayar, 2012; Stanley & Cheek, 2003). This was a very reflective process and was assisted by presenting the developing concepts and themes to fellow students for feedback and discussion.

The actual coding process

The first five steps have described processes by which researchers develop a conceptual understanding of the individual cases and of the entirety of the

research data collected. This conceptual understanding forms the groundwork for the coding process for which qualitative software can be used. For this research, Quirkos was the qualitative software chosen, as this enabled easy input of research data, simple coding of interviews, relative ease of shifting, renaming, or combining concepts, and also provided graphic depictions of the conceptual scheme developed (see Appendix 10 for examples). Quirkos software can also be used for producing reports that include a graphic depiction of themes, highlight any overlap of information and concepts, and provide statistics about the data such as how many quotes from each interview have been coded. Not all of the features of Quirkos were required for this project, but various options were explored for their relevance.

Stage 6. Draw up a list of concepts

This stage of the analysis process was very closely linked to the previous stages. A short list of concepts had been developed for each interview, and these concepts were then compared and collated into a coherent list. At this stage in the process the concepts were not put into any hierarchical order, nor were they linked to interview data, but they were simply loaded into the analysis software (Dierckx de Casterle et al., 2012).

Stage 7. Coding process – back to the ground

Stage seven is where the actual coding process begins. At this point, all the interview data and preliminary concepts had been loaded into the analysis software. To begin coding, each interview was read again in full in conjunction with the list of preliminary concepts. As sections of the interview data began to be coded in this way, there was reflection on the concepts initially identified to determine if they properly conveyed the message of each interview, if they were too abstract or too concrete, if there were any significant stories that did not fit a particular code, or if there were codes that did not fit with any particular portion of the data. Consideration was also given to the frequency of occurrence of each

code – some codes appeared in all interviews and others did not, and there needed to be clarity about why this occurred (Dierckx de Casterle et al., 2012). Additional thoughts and reflections were recorded throughout this process. And as described earlier, various stages of the analysis process were presented to fellow-students who then assisted with a deepening understanding of the codes and concepts chosen.

Stage 8. Analysis of concepts

This stage of analysis was also closely linked to the previous stages of analysis. In this stage, all the interview data were coded, and every story and quote was checked to ensure it was a good fit for the code it had been assigned. Some concepts were able to be combined at this stage, and other codes that contained large amounts of data needed to be refined or split into smaller sub-categories. This stage also involved beginning to articulate the meanings of the concepts and required deeper analysis to be able to describe the concepts well and to ensure that each concept was grounded in the data.

Stage 9. Extraction of the essential structure

Once the codes and concepts had been analysed and refined, the aim of this stage was "to integrate all these concepts in a meaningful conceptual framework or story-line in response to the research question" (Dierckx de Casterle et al., 2012, p. 368). This conceptual framework had several iterations in this process, with substantial changes being made to the framework after presenting one iteration of the framework to fellow-student and several academic staff at Otago Polytechnic. The first framework is shown in the screenshot from Quirkos in Appendix 10. The revised structure was not put into Quirkos as it would have required significant time replicating the coding process. Although the structure and key concepts had changed, many of the sub-categories remained the same, and most sub-categories remained in similar groupings. The purpose of this framework is to "allow us to describe and explicate all the

individual interview stories" (Dierckx de Casterle et al., 2012, p. 368), which the final conceptual framework was successfully able to do.

Stage 10. Description of the results

A description of the results of this research is presented in this thesis, with the primary description occurring in the next chapter, followed by a further discussion about the results and implications for practice in the remaining chapters. Throughout the writing of this thesis, the constant comparison continued, with further refinement of themes and sub-themes occurring. The interview transcripts, narrative interview schemes, and preliminary concepts have all been reviewed to verify the fit of the final framework and to check for any concepts that had not been covered. In this case, several key concepts were identified that did not fit within the conceptual framework developed, and it was determined that these concepts did not directly answer the research question.

3.6 Rigour

Rigour is an essential component of qualitative research and is also one of the most significant challenges facing researchers (Finlay, 2006). Producing research that is both rigorous and credible requires an understanding of the fit between the research question, methodology, methods, and data analysis methods selected (Stanley & Nayar, 2014). Consideration needs to be given to methodological rigour (ensuring best practice in the research process itself) and interpretive rigour (to ensure data collection and analysis is trustworthy).

The rigour of this research has been demonstrated throughout the research process. Justification has been given regarding the appropriateness of the research methodology selected. The data collection and analysis processes have been described in detail, and further details about these processes have been provided in the appendix as a way of ensuring openness and transparency of the research. Interview transcripts and narrative interview schemes were made

available to participants for review, and all data collected has been provided to the research supervisor to ensure findings have not been misrepresented. Participation in online discussion groups with fellow masters students and attendance at post-graduate schools has provided a forum for presenting various stages of the research and receiving feedback on the data analysis processes and findings.

The next section of this chapter will describe and discuss two specific techniques related to ensuring rigour – journal writing, and reflexivity.

3.6.1 Memo-writing and journaling

Memo-writing is a commonly prescribed method for establishment of rigour in grounded theory research and is also recommended for Interpretive description research. Memo-writing is used to stimulate and record developing thinking, including initial themes, comparisons of data and categories, and the progression of emerging theories (Sbaraini, Carter, Evans, & Blinkhorn, 2011).

A research journal was used throughout this research to record thoughts and questions about the literature, interviews, findings, and data analysis. Initially, the plan was to use a journal for writing 'memos', but the journal ended up being used for much more than this. The research journal(s) became a place for brainstorming ideas throughout the research process, making notes about findings and data, recording learning about research methods and process, and a multitude of other reflective and learning exercises. Although not strictly memoing, this journaling process was invaluable as it fits well with the researchers learning style, and information was processed more clearly with pen and paper than through purely mental processes.

3.6.2 Reflexivity

In qualitative research, it is important for a researcher to be explicit about their positioning within the research, and seek to avoid bias. While researcher objectivity is often deemed desirable, it is usually impossible for qualitative

researchers own views and beliefs not to influence the research process and analysis. Rather than denying the subjective nature of qualitative research or trying to bracket the researcher's experiences and opinions, reflexivity encourages critical reflection and honest positioning of the researcher within the research process (Savin-Baden & Fisher, 2002). The impossibility of completely removing personal experiences, thoughts, and opinions has been especially true in this research. As described in the introduction, poverty is an issue of both personal and professional interest, and during the research process, the effects of poverty on everyday New Zealanders became a particularly salient issue due to a range of family circumstances. This has necessitated careful reflection throughout the research and writing process. Although the research was not about personal or family experiences, the impact of these experiences has been impossible to ignore. One way that these personal experiences have been separated from the research findings and discussion is through the use of personal reflections in the form of journal entries included at the end of each chapter. It is also hoped that these reflections, rather than detracting from the research, will instead strengthen the findings and demonstrate how the framework used to organise the findings can be used at a personal and/or professional level.

3.7 Ethical Considerations

Ethics approval for this research was sought from Otago Polytechnic Ethics committee, and ethical approval was received before the recruitment of participants or any data collection commenced (see Appendix 1). Ethical approval was also sought via an official process and received from OTNZ-WNA prior to distribution of the recruitment email via the SIGs. Consultation with the Kaitohutohu office at Otago Polytechnic was also carried out as part of the ethics approval process. Although this research contained minimal risk to participants, several ethical issues were considered and will be described.

3.7.1 Vulnerable Participants

All the participants in this study were occupational therapists, so there were no concerns identified regarding power imbalances and the research participants were not deemed to be a vulnerable population. Participation in this research was entirely voluntary, and it was clearly explained to participants that they could withdraw from the study at any point prior to completion of an interview, or within 10-days of completion of the interview.

Although there were no issues regarding power imbalances between the researcher and research participants, there was a risk that research participants could feel vulnerable or distressed during the interview process. Prior to beginning the interviews, it was acknowledged that poverty is a particularly difficult and often sensitive topic which has the potential to cause feelings of discomfort or distress when discussed in depth. For example, occupational therapists may feel they have been unable to address issues of poverty effectively for some of their clients due to restrictions within their role, or they may have felt the need to engage in 'underground practice' at times to address identified needs for clients. This may be more difficult for occupational therapists working in more socially deprived areas when they are constantly confronted with huge amounts of needs in their clients, client's families, and communities. It was also identified that discussion regarding poverty and deprivation might also raise memories of times therapists have experienced poverty or deprivation in their personal lives. Because of the sensitive nature of the research topic, a plan for managing situations of distress was established prior to the commencement of the interviews. Although these strategies were not required during data collection, they are detailed here. If feelings of distress or discomfort had been identified by any participant throughout the interview process, that participant would have been given the opportunity to take a break or discontinue the interview. Support would have been offered as able, and the participant would

have been encouraged to speak with their professional supervisor or another support person if required.

Recruitment for this research took place via an email sent to all members of specific SIGs associated with OTNZ-WNA. The recruitment email was sent by OTNZ-WNA to its members, and thus the researcher did not have access to the names or email addresses of the members of the special interest groups. Recruitment through OTNZ-WNA special interest groups is a standard procedure that is well accepted within the profession. Involvement in SIGs is completely voluntary, and members of the SIGs are aware that they are under no obligation to participate in any research opportunities that are sent via the SIG. The recruitment information was worded as an invitation, and it was clearly stated that therapists were in no way obliged to participate in this research. The email also specified that the research was not being carried out by OTNZ-WNA.

3.7.2 Confidentiality

Confidentiality of all research participants was a priority. All identifying information about research participants, their workplaces, and their clients were removed from research findings, and numbers (1-9) have been attached to each interview to ensure that research participants cannot be identified. All information pertaining to this research has been stored on my personal laptop which is password protected. Interviews were audio-recorded using either Skype recording software or the laptops built-in audio recorder, and a dictaphone was placed next to the computer/telephone as a backup recording device. Interviews were transcribed using a professional transcription service (rev.com). Audio recordings were deleted after transcripts were checked for accuracy. All interview transcripts were de-identified, with each interview assigned a number (1-9). The hard copies of interview transcripts have been stored in a locked filing cabinet when not in use. Interview transcripts were accessible only to myself (researcher) and my supervisor (Dr Mary Butler). A digital copy of all transcripts with identifying information removed is being

forwarded to Otago Polytechnic on completion of this research, to be kept in secure storage for 5-years.

The demographic information collected included participants age, years of practice, practice area, type of service, previous experiences. This was not intended to constitute 'extensive demographic and employment information'. Rather, it was the information that would normally be required to explain the composition of the sample. The collection and presentation of these basic demographic data enable the reader to judge the range of opinions and experiences covered in this research. Demographic data has been presented earlier in this chapter in table form.

3.7.3 Informed Consent

Detailed information about this project was provided to research participants, and consent forms (see Appendix 4) were signed by participants and returned to the researcher via email prior to the commencement of interviews. Participants were provided with an opportunity to ask questions about the research at the start of each interview. All information regarding this research was sent to participants via email, and contact details (phone number and email) for both the researcher and supervisor were included in this information. Participants were reminded at the end of the interview that they could contact the researcher or supervisor at any time if they had further questions, wished to add any information, or if they wished to withdraw from the study after the interview had occurred. Participants had the right to withdraw from the research without question and without penalty. The informed consent form provided information to participants regarding time frames for withdrawing from the study, that is, participants were able to withdraw from the study any time prior to the interview occurring, or within ten days of the interview. One participant chose to withdraw from the study prior to the scheduled interview. The remaining nine participants participated in the interviews as planned, and none chose to withdraw following the interviews.

3.7.4 Potential Harm

Because of the sensitive nature of the issue of poverty, there was a possibility of interview participants experiencing feelings of stress, anxiety or inadequacy when discussing personal experiences or challenging work-related situations. As part of the research planning and ethical approval process, systems were developed for how to manage these situations if they were to arise. Verbal support was to be offered in the first instance if concerns were raised during the interview. Participants would have been given the option to pause or terminate the interview. If the issues were of a personal nature, then participants would have been encouraged to seek support from family or friends. Finally, as all the participants were registered, practising occupational therapists, they would have been encouraged to discuss any issues of a professional nature with their supervisor. Fortunately, none of these strategies needed to be utilised during the data collection phase of this research. As a novice researcher, it was reassuring to have thought through these scenarios prior to commencing data collection so that a plan was in place if needed.

3.8 Conclusion

This chapter has presented, described, and justified the methods and methodologies used in this research. The primary aim of this research is to describe and interpret the information gathered about how occupational therapists engage with poverty in New Zealand and to present this information in a way that is understandable and can be applied by occupational therapists. The following chapter will begin the process of describing, in rich detail, the findings from this research, in preparation for the analysis and connections with existing literature that will be made in the final chapters of this thesis.

The further I get into this research project, the more aware I am of the challenges facing my family. If they are struggling, then how many other people in my community are struggling? Have I been oblivious to how bad it is getting in the place I call home and community that I love?

I know I need to keep my research objective, but it is proving difficult as this topic becomes so personal to my loved ones and me.

I can't ignore the impact of my family's struggles on my work, so I need to find a way to use these dilemmas to strengthen my research.

Chapter Four. Findings

4.1 Introduction

The findings in this chapter have been organised into three themes: Heart – Understanding poverty, Head – Grappling with Poverty, and Hands – A Practical Response to Poverty, to demonstrate the way in which occupational therapists engage their whole selves with issues of poverty in practice. In the first theme, understanding poverty, there is a sense of wanting to understand the bigger picture. Not all of the information about poverty is within the occupational therapy scope or role, but it is all relevant as part of the context in which a client lives. Another part of understanding poverty is the way therapists reflect on personal experiences with poverty and the way these experiences impact their practice.

The second stage, grappling with poverty, is an intellectual process in which therapists take the information they have about poverty and determine what is relevant to their practice. There is often a sense of frustration at seeing issues that are not able to be dealt with. Therapists also work through a process of deciding if each issue is their responsibility, or what they should do with the information they have. There was often a sense of wanting to push back and effect change, accompanied by uncertainty about what to do or how to do it.

In the final stage, a practical response to poverty, therapists build on their understanding of poverty and grapple with identified issues until a solution is found. They then use their hands to engage in a practical way with issues of poverty. Each stage of this process is important and necessary. While the practical response to poverty may seem to be ideal, this does not minimise the importance of understanding the impact of poverty on a client even when there is seemingly nothing that can be done directly to address the issues at hand.

In this chapter, each of these themes is explained in detail and demonstrated with quotes and stories from research participants. Each interview

transcript was assigned a number (1 – 9), and identifying information has been removed to ensure the anonymity of participants, their clients, and their services.

4.2 Heart: Understanding Poverty

Initially, this theme was labelled 'awareness of poverty' as awareness of an issue must occur before one can engage with an issue. Awareness indicates knowledge of the existence of an issue, and without this knowledge then one would not have a reason to engage with the issue. When it comes to poverty, it would be very difficult to live in a country like New Zealand and be unaware of the existence of poverty. For this research, participants were invited to talk about their experiences of poverty within their practice. If occupational therapists were not aware of poverty or its impact on their practice, it is unlikely they would have responded to this research invitation. Thus the term awareness was not adequate to describe this stage of engagement.

Understanding goes beyond awareness and implies an active process of finding out more about an issue and the impact of that issue on individuals and communities. Thus engaging with the heart and understanding poverty involves a process whereby therapists work out where they fit in relation to issues of poverty. Engaging at a heart level could also be described as an emotional response to the pain caused by poverty, and the heart level response was often characterised by empathy. In this research, participants demonstrated an understanding of poverty by the ways they described different types of poverty, the impact of poverty on therapeutic input, and the way that poverty and disability intersect in complex ways. Personal and family experiences of poverty contributed to the understanding of poverty in practice, and encountering poverty in practice, in turn, influenced participants personal and family lives.

4.2.1 Complexity of Poverty

Poverty is a complex issue, and as seen in the literature review, there are a variety of ways of defining poverty, and there are many different forms of poverty that people can experience. Early on in the research process, the decision was made that, for the purpose of the interviews, a definition of poverty would not be provided. The intention was to allow participants to describe poverty in a way that was relevant to them and their practice. The descriptions provided were rich in detail and explored a greater variety of types of poverty than anticipated. Knowledge of the multiple forms of poverty and the complexity of interactions between these forms of poverty provides the foundation for understanding a clients experience of poverty.

Participants reflected the complexity of poverty as they spoke about what they see and hear regarding poverty in their practice. A deep understanding of poverty was evident in the way these complexities were described and discussed. While financial poverty was often the first type of poverty described, participants also named and discussed other forms of poverty that they encounter in their practice.

> *"Obviously, when you hear poverty you naturally think financial. But…because we're seeing people in their own homes, we come across poverty in all forms. It may be somebody that's at home quite isolated socially. They're missing out on things." (1)*

Financial poverty was usually described in relation to employment or a lack of employment and the subsequent need for benefits from Work and Income New Zealand (WINZ).

> *I can only count on probably one hand out of all my adult clients the ones that are actually financially independent and in full-time employment. (6)*

> *The majority of referrals we receive are for people that are on some sort of benefit with WINZ. (1)*

Receiving a WINZ benefit is essential for survival for many people, yet these benefits are frequently described as subsistence-level income, leaving clients with very small amounts of money to live on each week.

> *I would say probably 70, 80, 90% of the folks that we work with, most of their income is generated through the Ministry of Social Development, through Work and Income. And however you want to play it, that's a subsistence-level income, at best, and if you add on top of that people with coexisting problems, like addictions, or fraught families, high housing costs…A lot of our folks have $30 to $40 to live on to buy food and everything else after the bills are paid. (7)*

Financial poverty was also described as being more than simply not having money. It also includes a loss of hope for many people as they cannot see any way of getting more money.

> *I think that's where the poverty is, that you don't actually see any way of getting money. You don't see any way of striving to earn more money, so it's an ever-decreasing circle…they don't want to spend anything because they know they haven't got any more. (8)*

When a person has barely enough money to pay their bills and cover expenses that are essential for survival, their occupational choices are severely restricted due to the cost to engage in many occupations.

> *The impacts of that are a hugely limited range of choices about what do, about what to eat, about where to go, about what to do for balancing up your lifestyle in terms of getting some recreation and some occupation other than work. (7)*

It is important that occupational therapists understand the limited finances of many clients, and adapt interventions to the client's circumstances as needed. Without an understanding of the client's financial situation, therapists may propose solutions that are not realistic for their clients. An example of this was given by a participant who had a client express an interest in woodwork:

> *We've got a client who accesses a vocational service…And they've identified that he'd like to do some woodwork and they found him a course…but it's going to cost him $150, so he just doesn't have that cash…It's so far out of the price range. It's an inconceivable amount. (9)*

Although the option proposed by the vocational service would have been a meaningful solution for the client, it was simply not realistic due to the cost. More investigation was needed to find other options that would be both meaningful and affordable. In this particular case, the financial cost of the course was not the only barrier. The client also had an addiction to tobacco that consumed most of his disposable income. When this addiction combined with the client's concerns about his ability to succeed at the course, continuing to spend money on tobacco was a more attractive option than saving the money over a period of time in order to afford the course.

> *One of the few things that he is motivated to do, he's not able to because all his money goes on tobacco … When you might be worried the course might be a bit hard, that you might fail, when it's a little out of your comfort zone. But tobacco's well within your comfort zone. (9)*

Smoking and other addictions were frequently discussed by research participants as a source of concern or frustration. Clients were described as going without medication because they had spent money on tobacco. Other times clients would get deeper into debt from spending money on alcohol, drugs or

gambling. There was an understanding of the nature of addictions and the way in which addictions provide meaning or enjoyment to clients whose lives were otherwise very limited.

> *Smoking's another bugbear…we see people that are not taking their medications because they're unable to afford their prescriptions but they'll be sitting there with a pack of cigarettes beside them…Smoking is probably the only enjoyment they get out of a day, but they need the medication. (1)*

There was a sense of ambivalence expressed by participants regarding addictions such as smoking. While they were often frustrated that a client would choose cigarettes over medication, there was also a sense of empathising with the reason for the decision. Therapists also considered the way addictions impact a person's level of poverty, their quality of life, and the work the therapist can do.

> *Addiction's one that really compounds poverty…and the impact that has on people's quality of life, because that adds a whole level of other barriers and issues…and other social impacts…all these wider facets that go on, that link together [and] impact on the kind of work you can do with people. (3)*

Likewise, poverty was described as a self-perpetuating trap. Being caught in a poverty trap can create feelings of hopelessness in people which they seek to numb with alcohol or other substances. This use or abuse of substances can contribute to financial hardship and lead to increased feelings of hopelessness.

> *It's self-perpetuating. And families feel like that, that's why they use, that's why they drink because they feel like they're in this trap and they can't get out. And there's no future for them. (4)*

This poverty trap and feelings of hopelessness not only impact the individual but can extend to the wider family group, producing generational poverty. For

young people growing up in financial poverty, issues such as not having enough food become normalised and are passed on to later generations.

> *Because it's hard to get out of the poverty trap once you are in it…if you grow up not having enough food on the table, and having mum and dad argue, and mum and dad not even living together…you grow up with thinking that that's normal. (4)*
>
> *Maybe it's a generational thing because that's what their parents did, and their parents. It's just normal… (8)*

The impact of poverty on families and the intergenerational nature of poverty is particularly evident when multiple generations of a family live together, leading to overcrowding and a perpetuation of the poverty cycle.

> *Overcrowded housing is a situation I see a lot of, where an older person owns the house or is the [primary tenant] …Their children …and grandchildren are living with them… everyone's on a benefit; there's no employment, no additional wages. (2)*

In some cases, generational poverty has been attributed to the effects of colonisation. Colonial practices in New Zealand saw large numbers of Maori forced off their tribal lands and away from traditional lifestyles and income generating practice. This was just the beginning of poverty for many families and whanau, and the impacts of this are still evident today for many Maori.

> *We are seeing grandchildren, great-grandchildren now, and obviously great-great-grandchildren that are still living with the fact that they lost that income, and some of them still are in that poverty trap, because their income was taken away all that time ago, they weren't on equal par with the settlers to be able to negotiate their way in the world. (4)*

Loss of land and income for Maori has led not only to financial poverty that has persisted throughout generations but has also brought about cultural poverty, whereby people are disconnected from cultural beliefs and values.

> *There's poverty, not just financial poverty, but there's poverty of culture as well, in that they've lost who they are, they don't know who they are, they don't know their stories of their ancestors and the achievements of their ancestors. (4)*

Cultural poverty comprises a loss of belonging that often begins with the loss of land, being disconnected from cultural values and practices, and stories of ancestors being lost or forgotten. Cultural poverty contributes to a loss of hope and intensifies lived experiences of poverty.

> *If they haven't had the stories of their ancestors and the success of their ancestors, then they've got nothing to be proud about…that doesn't give them any hope, because they don't have those stories. It's not just the stories either, but the processes too, like using karakia [prayer]. (4)*

A loss of cultural practices also deprives people of choice, as they are unable to choose to use tools or practices that they do not know.

> *So they don't know how to use prayer to cleanse their house, or if something happens and they have no way of using prayers to calm themselves down or calm their children down or use the wairua, which is the Maori spirituality, in a way that can help them. And if they don't know the proverbs of their tribe or their iwi, they don't have those guiding their lives either…not that all Maori would use those things, but they don't even have the choice to use them or not because they've been denied access to it. (4)*

4.2.2 Poverty and Disability

Building on an understanding of the multiple types of poverty, participants in this research also frequently discussed the complexity of the interactions between types of poverty and the interaction between poverty and disability. One example of this complex interaction is the social poverty triggered by an inability to drive a vehicle. When a person is unable to drive, they rely on alternative forms of transport including public transport. However public transport can be physically inaccessible for some people with disabilities, or financially inaccessible for those in poverty. This combination of financial poverty and physical disability leads to social isolation and limits access to occupational opportunities.

> *I guess for a lot of people I see, the folks that are maybe dealing with obesity or the older folks that are no longer able to drive, transport is a big one…actually having the ability to get outside of their own house and just complete everyday things like shopping or meeting friends for coffee. Or even physically being able to get out of the house to do exercise. That's something we come across quite often, inability to afford transport. That leads on to quite a lot of social isolation. (1)*

Unexpected illness or disability was described as leading to financial poverty. One participant explained how difficult it is for people who become terminally ill if they do not have health or income insurance, especially if they are under-65 and unable to access a pension. It is also common for partners to also reduce their work hours or stop work entirely to care for an unwell family member. While a Support Living allowance is available through WINZ, it is significantly less than a full-time income.

> *You go from an income to going on a benefit and having to get your head around now living within that means…[it's] really, really difficult for people, especially when you've still got all the same*

> *outgoings that you used to have because it's not something you plan for…So people were having to downsize their homes. A lot depends on your situation and if you've put money aside, but all that ripple effect of how that will impact on your quality of life because of your income. (3)*

These situations are incredibly difficult for people as they not only come to terms with an unexpected illness or disability, with all of the challenges that entail, but they also have the added challenge of adjusting to a significant change in their financial situation.

Also related to health and wellness, some participants reported that clients and their children do not see the doctor when they are sick due to the financial cost of medical care. Although doctors visits are free for children aged 0-12 years in New Zealand if parents with unpaid medical bills still avoid taking their children to their family doctor when they are unable to pay outstanding fees.

> *We see children not going to see the Doctor, even though it's free for them to go because mum and dad still owe money at the Doctor. And so the children get really sick and end up in hospital. (4)*

Yet, there is increased financial impact on the whole family if a child becomes unwell and requires hospitalisation. One or both parents may need to take time away from work to care for the child. If a child is transferred to a hospital outside of their home region, then the financial strain is even greater. One parent would usually travel with the unwell child, while another parent or family member needs to stay at home with other children.

> *Then the illness side of it as well, the cost of this one kid is hospitalised, and one of the parents has to stay in the hospital…it just makes the whole thing terribly hard. It's just amazing stress on them. (8)*

It was also reported that decisions about where to live can be affected by illness or disability. Access to hospitals and healthcare services is essential for many people to maintain a quality of life, but the cost of living in larger centres is often more expensive.

> *If you have got complex health issues, then you are going to want to be near a major hospital…Or if you've got a spinal cord issue you're going to want to have access to a spinal unit, and to hospital care when you need it because you're going to have these ongoing complex health needs. (6)*

Another way the link between disability and poverty was described was regarding differences in presentation of people with similar disabilities from different socioeconomic backgrounds. One participant described that a client with a mild intellectual disability from a deprived background presented worse and appeared lower functioning than a client with a moderate intellectual disability from a more privileged background. This difference in presentation was not due solely to financial resources but was also impacted by the presence or absence of opportunities and social resources.

> *That person's presentation isn't necessarily due to the level of intellectual disability, but more of the way that they've been brought up. (9)*

A person's physical appearance also contributes to the way they are viewed by society.

> *But in terms of doing the laundry and taking care of their clothes, it's quite a bit easier when you've got nice, new clothes. If you've just got shabby clothes…people see them differently. If you present in this quite shabby downtrodden way, it affects how people react to you. (9)*

People with disabilities, both physical and mental, often face greater exclusion from society than those who are able-bodied. Social exclusion is also common for people living in poverty. When disability and poverty are combined, experiences of exclusion are heightened.

> *We do try and get them opportunities for sort of paid work…But then they're doubly excluded because they're poor and they've got an intellectual disability…most people with mental health problems, oh anyone with disabilities is doubly excluded, aren't they? (9)*

The physical environment in which people live also impacts their experiences of disability and this is particularly true for people who live in low-income areas.

> *The way that [the city] is planned, and especially in the poorer suburbs, you've just got rows and rows and rows of low-cost housing and not a lot of shops that would be easily accessible in a wheelchair really. Even with a power wheelchair, people can be quite isolated. (6)*

The combination of physical disability, an inaccessible environment, and financial poverty contributes to poverty in other areas of a person's life. An inaccessible environment contributes to experiences of social isolation and occupational deprivation.

4.2.3 Impact on Therapeutic Input

As occupational therapists seek to strengthen their understanding of poverty-related issues, there needs to be consideration given to the way poverty impacts on a clients ability to engage with occupational therapy. Although there are many poverty-related challenges for clients that are not directly relevant to occupational therapists, anything that impacts a client's life and ability to engage with the occupational therapist should be of concern to the therapist. One example of a situation that has a significant impact on a client but the therapist is

not able to change, is when clients who are reliant on social housing are forced to move from a home they have lived in for many years because the house is needed for someone else.

> *"…you've got these folk that have lived in the same house for 20 - 25 years and then Housing New Zealand have come in to say, "You're in a three-bedroom house. We need this for another family. There's only the two of you now. We're going to move you to a one-bedroom house." They're like, "We've been here for 25 years. We've looked after the property, the garden and everything." In that sense, maybe dealing with somebody with poverty, when they're relying on social housing is that they don't have this sense of control over where they live. It's in somebody else's hands in a way. (1)*

Although there was little that could be done to change the situation for this particular client, hearing the clients story and understanding the injustice of the situation enabled the therapist to respond with empathy. Stories such as this also highlight the numerous challenges outside of their control that people living in poverty face every day. While many of these challenges are outside the occupational therapist's scope of practice, therapists need to be aware that these challenges can impact on the way in which a client is able to engage with the occupational therapist and with the therapeutic process.

> *…addressing those issues of housing and the social issues, and work issues, it's not really in my scope with wheelchairs and seating, but I can see the impact of that on the outcomes, equipment outcomes, of what I'm providing. (6)*

In some cases, the impact of poverty on therapy is evident. There are other times when a change in circumstance will change the interventions needed in the future. One participant told a story about a client who was underweight because

the family were not able to afford the specialised food that the client required and thus medical intervention in the form of a gastrostomy button was required to address the nutritional deficits.

> *So part of the factor for why they decided that maybe they should put a gastrostomy button in is because that will ensure that he will get enough calories to function a bit better every day…I found that quite upsetting actually. And that's going to have a really big impact, because say he will go onto a PEG [gastrostomy button], and he will have enough calories going in, and that's going to be really good because that means that hopefully, he's going to gain weight, and he's going to grow, … and then I'll be looking at more equipment for him… (6)*

Although the therapist was not the one making decisions about medical interventions, they needed to know about the decisions being made in order to consider the impact of these decisions for the client's future. In this case, the client is likely to need new equipment in the future and knowing this already means the therapist can monitor the situation and step back in with further intervention and equipment when it is required.

Awareness about clients going without food was an issue raised by several participants in this research. Although food was not always spoken about by therapists, when clients reported going without other basic necessities because of the cost, there was an assumption that they were also going without food because of the cost.

> *I suppose the fact about not having food, not being able to budget for actually feeding people. That's a major concern. It's one of the questions on assessments form is, have you ever gone without heating because of the cost. We don't even talk about food, but if*

> *they're going without heating because of the cost, they're definitely going without food because of the cost. (8)*

Participants also raised concerns about people experiencing nutritional poverty, as the food that is affordable does not contain much nutritional value.

> *We look at the food choices that people are making, and these grocery bags of $1 loaves of bread with almost zero nutritional value, that tendency to rely on cheap, nasty food. So we're dealing a lot with problems associated with poor nutrition, problems with obesity, and the impact that has. (7)*

Although providing food or nutritional advice may be outside of the scope of most occupational therapists, these stories highlight the importance of therapists being aware that clients may be hungry or malnourished, as this is likely to impact a person's ability to engage with therapy. If a therapist is aware of a person's hunger or malnutrition, and they are aware of programmes in their communities that provide food for children or families, then they can have an opportunity to link people with necessary services. Without this knowledge and the ability to make these links, then therapeutic outcomes may be compromised.

4.2.4 Personal Experiences of Poverty:

When discussing ways that occupational therapists understand issues of poverty, it is also worth considering the factors that contribute to this understanding. Throughout this research, participants spoke freely of personal experiences of poverty and supporting loved ones through financial hardship. These personal experiences served to sensitise participants to the poverty-related issues facing their clients, and generally lead to a more empathetic response.

Although not directly related to poverty, one participant spoke of the impact of experiencing mental health services as a support person for a family member. The personal experiences of these services were described as a driving force for professional practice.

> *I guess that's the other thing about me personally that kind of drives me is having people with experience of major mental health problems in my extended family…So I'm very driven to provide the sort of service that I'd like my [family] to be able to access. (7)*

The way in which personal experiences shape professional practice was a recurring theme in the interviews. Another example of this was that participants who had personally dealt with WINZ and other government agencies spoke strongly about the need to support clients in these interactions and to advocate for clients to ensure they get the support they are entitled to.

> *It gives you a lot of empathy from your own background, but then working in that industry to help advocate for people, I think you get really good at learning about systems and…understanding and having really good networks helps you achieve and work alongside people to get and advocate for them to achieve a reasonable quality of life for people. (3)*

Another therapist shared a story about a time when her husband was unexpectedly unemployed when their children were young. Initially, they were unaware of the supports that were available and thus they struggled to afford food and mortgage payments. Although they had family support, this was a difficult time, and when they realised they were able to access financial support from WINZ, this came as a huge relief. But this support was not something they wanted to rely on long-term, and the budgeting advice given by a community organisation made the participant more determined to get back to their occupational therapy career.

> *It just made me really determined to get back to my career and to be financially independent again. But I think I'm lucky because occupational therapy is a qualification, and it has desirable skills,*

> *but if you haven't had that opportunity and support to get a good education when you were a kid...(6)*

This story highlighted a sense of understanding the privilege of having extended family that can provide support and financial assistance, as well as the advantage of having a background in a needed profession and thus having a career to return to. It also acknowledged the privilege of education and the way in which this sets people up for the future.

Participants not only told stories about their own experiences with poverty, but they also shared stories about their extended families' experiences and how this has shaped their understanding of and response to poverty. One story told was about a family member who through an unexpected loss found themselves going through return-to-work training at WINZ to be eligible for a benefit. The training was described as a being poorly-run, with course handouts photocopied so many times they were barely legible, and course content not tailored to the needs of the audience. The course attendees were described as being primarily from professional backgrounds, yet the course facilitator told them *"Now, you need to brush your teeth and have a shower"* when preparing for a job interview.

> *How demoralising is that for people who have got professional backgrounds and things like that, but that's an example of the hideous, kicking you in the guts when you're down kind of stuff that places that are supposed to be supporting you do. (3)*

A recurring theme throughout this research was that this type of experience is not uncommon with WINZ. The way the welfare system in New Zealand is set-up makes it very difficult for people to get ahead, and there is little support given to people who are genuinely struggling. One therapist reflected on a situation with her daughter struggling to find work after finishing a degree, and equally struggling to get financial support from WINZ.

> *She did go to WINZ, and she did get this $175 a week, but then as soon as she did find any sort of work, like casual work, then they'd want her to give all that money back…So in the end, we just said, just don't. We'll just have to support you until you find work, but there isn't actually the work out there for a lot of young people. (6)*

Because this therapist was aware of the challenges facing her daughter, she was more sensitised to her clients experiencing similar difficulties with finding employment and gaining independence.

> *I've seen that with my clients, that even as young adults…if they aspire to more independent living, they're probably not going to be able to afford to do that. They are living at home probably for a lot longer. (6)*

The stories about personal and family experiences with poverty highlighted two main themes. First is a heightened understanding of the lived experience of poverty, and a desire to support their clients through the challenging systems that exist.

> *It does help to advocate and understand how intimidating they are and appreciate that for people. (3)*

The second theme evident in these stories was therapists expressing a greater appreciation for the privilege in their own lives, and gratitude for the simple things in life.

> *I think anyone who works in health, really, you appreciate what you've got while you've got it…You come home and go, "Gosh." It makes you appreciate the small things. (3)*
>
> *I look at my kids, and they hear a lot of speeches around how lucky they are. (3)*
>
> *Yeah, it really makes you appreciate what you've got. (8)*

> *I'm glad I'm not poor. It makes you feel quite privileged working in this sort of setting. (9)*

There was also a sense of respect for clients who are living in poverty. Therapists acknowledged how difficult life is for some people, and how well they cope in the face of hardship.

> *I think as a therapist, I've definitely learnt not to judge. You can't judge because you just don't know what it's like in somebody else's shoes. And I've actually been really amazed as to how well some families cope on what little that they have. It's very humbling. (6)*

These types of comments showed that not only were the therapists aware of the struggles facing their clients, but they had also thought deeply about what they had seen and allowed their experiences to change them as individuals and as professionals.

Another important aspect of these stories not discussed during the interviews was that the therapists all described short-term, or temporary experiences of poverty. Each of the therapists had family support, a career to return to, or was engaged in education that would ultimately improve their financial situation. They all had hope for improvement in the future.

Not only do personal experiences of poverty impact on a therapists practice, but experiences of poverty in practice also impact on therapists personal responses to poverty. Several participants spoke about voluntary activities that they engaged in outside of work to address the issues they see their clients experiencing. One therapist spoke of being part of a housing action group, advocating to keep low-income housing available. Another therapist spoke of being an accredited visitor for Age Concern.

> *I have two ladies in the community that I visit fortnightly because they're alone and isolated…both of them, I would say fit into probably into the lower poverty scale of life. I know that one of*

> *them, in particular, will not see anyone other than the lady at the supermarket once a month when she goes to town. If I go and see her once a fortnight, that's three human contacts that she's had in the month. I won't stop going to visit her, even though I'd like to have my Sundays back. (2)*

This therapist also spoke about an awareness of others who don't have a lot, and thus they share excess produce from their garden whenever possible.

> *I'm aware of people who don't have a lot, and when my fruit trees are growing lots of apples, and things like that, or my veggie garden is looking good, I try and share what I have with other people when the opportunity arises. (2)*

4.2.5 Summary

This first theme has described the way that the participants in this research engage their heart in understanding the complexity of poverty and the impact that poverty has on their clients. Personal experiences of poverty sensitised the participants to the challenges facing their clients and triggered an empathetic response. Likewise, a growing understanding of poverty in a professional capacity influences personal responses such as gratitude or engagement in voluntary pursuits that target experiences of poverty.

4.3 Head: Grappling with Poverty

In this next theme, therapists move beyond understanding the issues related to poverty, start to grapple with issues of injustice, and want to push back. Where the first stage of engagement was described as an emotional response characterised by empathy, this second stage of engagement is more of a cognitive response often characterised by a sense of frustration. Sometimes therapists face constraints to acting to remedy a situation, such as solutions falling outside the occupational therapist scope of practice. Some issues are encountered at a system

or societal level. While therapists may be able to bring change to a client's immediate circumstances, this does not change the deeper issues in systems and society that perpetuate injustice. The issues and challenges that therapists grapple with are framed as struggles, concerns, frustrations, and ethical issues.

4.3.1 Stereotypes

A common issue that therapists grapple with is stereotypes about poverty and those living in some form of poverty. These stereotypes were observed by therapists in society, media, and occasionally within themselves. A major frustration regarding societal views and stereotypes was the fact that in many cases the people expressing these judgmental sentiments have never experienced poverty, and they do not understand the realities of living with poverty and dealing with bureaucracy to necessary get supports. This lack of understanding leads to damning judgments about poverty and addictions that are often accompanied by a belief that poverty and addictions are self-inflicted problems that should be changed by the individual.

> *A lot of people make that judgement that you put yourself in that situation. "Why don't you just get off your arse and get a job?" All those kind of...almost stigmatising of people who are in poverty that it's a self-inflicted choice…If you've never been through it or supported somebody through it, people have no idea what it's like…It's easy to judge people who are poor, easy to judge people who are fat, easy to judge. All these judgments that we have in our community about people's choices. (3)*

Therapists struggled with the way these judgements show a lack of understanding of the complexities of poverty and addictions and a denial of societal responsibility. Although these stereotypes are a source of frustration for therapists, stereotypes alone do not directly impact occupational therapy intervention. However, these beliefs, stereotypes, and judgements influence the

development of systemic and societal structures that create and perpetuate disadvantage within the systems that occupational therapists work.

> *I mean, it's just the whole way that society's structured in New Zealand, it just keeps poor, disadvantaged people poor and disadvantaged. It keeps disabled people in a disabled box. (6)*

> *It's that whole kind of mentality, and I see a parallel with that with people that live in poverty and they're only going to get so much help, so that's just going to keep them as a sub-class, because they're just never going to quite be able to get enough money to actually be able to seize an opportunity to actually get a better job because they're just going to be in survival mode. (6)*

Awareness of the development and perpetuation of disadvantage through stereotypes and structures was a source of frustration for therapists. Because occupational therapists work with people who are disadvantaged by the systems and structures that therapists work within, they are able to see both sides of the situation. They see how the stereotypes develop, and the way stereotypes influence structures and processes, and the way in which structural violence perpetuates disadvantage keeping clients on the back foot.

These judgments and stereotypes are experienced not only by those in poverty, with a disability, or battling addictions, but also by those from different cultural backgrounds. One participant spoke about research in which a doctor said they did not refer Maori patients to specialist services because of a belief that Maori are "dole-bludgers" and not deserving of public health services. Unfortunately, these stereotypes are not uncommon, placing many Maori and Pacific people in disadvantaged positions and struggling to get ahead.

> *So they are already on that back foot trying to prove that they can do things, they can look after their moko's…so that all impacts on*

> *their ability to one provide for themselves and provide for their families. (4).*

Examples such as this demonstrate the way disadvantage is perpetuated and compounded by stereotypes and structural inequities. Maori who are already struggling to provide for their families are penalised for their efforts and driven further into poverty. Therapists often face the challenge of trying to help clients get ahead in a system that is structured to maintain stereotypes and disadvantage. While these stereotypes are easily identifiable at a societal level, they also disadvantage people at an individual level. One therapist told a story of a client who had a reputation at the local WINZ office, and because of this, a security guard would often stand behind her during appointments further escalating her behaviour. This situation continued to a point where a formal complaint was made.

> *I had one lady had a bit of a reputation, so the security guard would come and stand behind her during her appointments, which was escalating behaviour and had to do a complaint. It was not okay behaviour. It's all these things that people have to put up with when they're vulnerable anyway. (3)*

This escalation of behaviour and the formal complaint most likely could have been avoided if assumptions about the client had not been made or if appropriate supports had been offered. In this case the therapist was able to work with the client to provide support, but not all WINZ clients have this advantage, and many are likely to miss out on necessary supports. Therapists may also find that they are unable to provide this support to all clients, and then there is a risk that clients are further disadvantaged.

These stereotypes encountered in society were a cause of frustration and concern to all of the therapists in this research. However, it was not only stereotypes in society that were of concern to therapists. At times they were also

troubled by the way their own thinking or actions could be seen to reflect these same stereotypes or judgments. Sometimes the actions or attitudes of clients were described in a way that seemed to fit popular stereotypes, but participants were very clear during the interviews that they did not want to judge their clients. When the stories began with phrases such as, "*I don't want to stereotype, but…*" (1) or "*I know you shouldn't generalise but…*" (6), the internal struggle was evident. As will be seen in the next section about client expectations, often what participants described was the opposite of common stereotypes about people in poverty being a drain on society. The tensions between societal assumptions and participants actual experiences had a profound impact on participants, challenging them to examine their own thinking and changing their perceptions of others.

4.3.2 Client Expectations and Service Criteria

A common stereotype in society is that those who are in poverty and reliant on WINZ benefits for survival is that they have a sense of entitlement to supports and services. At times therapists saw evidence of this mentality from their clients, although the therapists did not want to judge.

> *Not wanting to stereotype but for some folk that are maybe below the poverty line, and relying on the government for financial support, they seem to think they're entitled to…We have to explain to them that we have to apply for funding. It's not an automatic that they're going to be given something… (1)*

At other times, therapists found that clients in poverty did not expect to receive anything, while wealthy clients had much higher expectations regarding the supports they should receive.

> *I know you shouldn't generalise, but sometimes I find the families that are really well off and live in the very poshest suburbs expect the most, fanciest, expensive equipment, with no regard to the fact*

> *that it's a limited budget…whereas you've got people that can be absolutely so poor, and they just expect so little … People think that it's the people living in poverty that are a drain on society when it's so not true. They're often the ones that use the least services (6)*

The contrast between these situations is profound. Both therapists encountered clients with high expectations of receiving support without consideration of budgetary constraints in health care. In one story the clients living in poverty expected everything, whereas in the other story clients in poverty expected so little. It is in this tension that therapists must work, on the one hand, they see behaviour and attitudes that perpetuate stereotypes while at the same time they regularly encounter behaviour that disproves those same stereotypes.

In addition to managing client expectations about service provision, therapists also have to manage their organisation's criteria and restrictions regarding service provision. A significant challenge facing many participants, especially those working in physical health settings, was the role of gate-keeper that therapists are often expected to take on. There is a limited budget available for supports and equipment, and therapists have to make decisions about who will receive these services. When a therapist identifies that a client needs support such as equipment or housing modifications, they apply for Ministry of Health funding through the appropriate equipment and modification services (EMS) provider (Enable or Accessable depending on geographic location in New Zealand). Because health budget is limited, the EMS providers set strict eligibility criteria regarding service provision, and they require therapists to select the most cost-effective options to maximise service provision. These criteria are used in conjunction with the therapist's assessment to determine eligibility for funding.

> *They divvy it out based on what we assess as a need. They have what they call a prioritisation tool to help determine who has the highest need and who is eligible for funding. (1)*

While this sounds like a fairly straightforward system, in theory, a challenge frequently facing therapists is that clients do not always fit into the criteria set out by the funding bodies.

> *It can be quite hard trying to get funding for these people because they don't always fit into neat little boxes that the Ministry of Health would have us use. (1)*

> *We've got clients that would like to get a job, but because they're not working, they might not qualify for the same level of wheelchair…but then you think, well, surely if you give them the better chair, then they're going to be more likely to be able to work. (6)*

One of the biggest challenges for therapists regarding the funding criteria is the Ministry of Health (MoH) definition of disability.

> *If you have somebody that is under 65-years of age, is deemed to be say morbidly obese and potentially has some respiratory issues, then that would be deemed as not a disability. That would be deemed a chronic health condition…I guess for somebody that potentially is living in a social housing situation, that's where we would more often see these sort of things come up. Especially when it comes to obesity. It tends to be more like poverty-related…That's quite common for Pacific Island families…Over 65, they tend to be a wee bit more lenient and to be honest, by the time you're over 65 there's usually multiple co-morbidities involved." (1)*

This is only one example of the service disparities that therapists encounter on a daily basis in practice. Another significant source of disparity is the differences

in funding available to ACC clients compared to MoH clients. Most therapists agree that it is much easier to get support and services for ACC clients than for MoH clients with equivalent needs.

> *I mean, I've seen a real disparity between ACC clients and Ministry of Health clients. I can get power assist without any questions for an ACC client, but it's a struggle for a Ministry of Health client, so it's definitely a two-tier system for sure. (6)*

These disparities in the availability of supports and services for their clients were a significant source of concern and frustration for many participants. They identify client needs, and they can see a solution, but they are unable to provide the ideal solution, or sometimes any solution at all, because of the eligibility criteria set by external agencies. At the same time, therapists are the ones who are assessing clients, identifying needs with their clients, and then having to tell their clients that they will not receive the needed services, which can place therapists in a difficult position.

4.3.3 Service Poverty

Another concern for participants that is closely related to funding criteria is service poverty. Because service providers have limited budgets, they often focus on providing the cheapest option to the largest number of people rather than being able to provide the best options for individuals.

> *The focus is more on cost-effectiveness, reissuability, rather than specifically what is this person's needs and the best solutions for that person's needs. (6)*

Another way that some services try to maximise their funds is by taking funding received for a range of clients under different contracts and spreading that money out evenly amongst their clients. One participant told a story about a residential service that was doing this, and then some clients were not receiving the services they were entitled to because the money had been spent elsewhere.

> *The NGOs take that money and if they're not filled up…there's funding gaps so the money that our clients should get sort of gets flattened out through the rest of the service and maybe they don't see it. (9)*

Not only were clients not receiving services, but in one case a client was paying several hundred dollars each month for medication that should have been covered by the care provider.

> *So he's having to pay for his own medication that he's been told he has to have. So there's a certain unfairness to it. (9)*

This was described as a significant issue as the client could not afford to pay for the medication and was thus facing increased financial poverty.

When discussing service poverty, participants described many of their services as underfunded, resource-poor, and constantly facing cutbacks. This service poverty impacts on the quality of service provided.

> *There's a certain shabbiness to a lot of our services. (9)*

Poverty within services directly impacts what occupational therapists can do with or provide for their clients. One participant spoke of the difficulty of accessing resources from the DHB to use with clients, including being unable to access food to use for meal preparation assessments.

> *I suppose I've learnt that you can't get any resources from the hospital….so I just don't even ask, because I know. Gone are the days that you can order food from the kitchen…you have to ask the patients to bring the ingredients for the meal. It's not right (2)*

Another way in which service poverty is evident is when there is a loss of services. Participants frequently spoke of the challenges in their practice with limited funding and resources, and a diminishing number of services that they can provide to their clients or refer their clients to.

> *We did have a programme going here for a little while, but the money ran out, unfortunately. That was helping whanau to plant gardens and teach them how to plant a garden, and how to look after it, and what to plant…But unfortunately, the funding stopped. (4)*

There was also concern expressed by some participants about the future of their services with funding cuts and budgetary restrictions. These concerns were felt more strongly when participants had personal or family connections to the types of services that were at risk of cutbacks.

> *I think potentially services like ours do face an uncertain future, and I've got real concerns about that, both as an OT and as a person with family/whanau affected by mental health problems. (7)*

The funding cuts and loss of services described were not limited to the health sector or the services employing occupational therapists. There were also reports of funding cuts in local government and council services, and even in within charitable organisations, the very organisations that are intended to help those in poverty.

> *Years ago, food banks were fairly flourishing, very generous, especially at Christmas…but it got to the point that all the charities are pulled together, and there's only a maximum of 300 families that will get a Christmas food parcel, and it's nowhere near as generous as it used to be…, and families are prioritised…so people who are childless, or whatever, who are struggling, don't access that stuff anymore. All the resources are getting depleted really for various reasons. (3)*

For therapists engaged in contract work, the lack of funding impacts their ability to get contracts for ongoing work, placing not only the clients but also the

therapists themselves in positions of uncertainty. While the loss of services may not lead to further poverty for clients, it does place therapists at risk of financial hardship.

> *The DHB, unfortunately, has got less funding. I'm sure you're aware of this, that they're cutting back on everything…It's obviously my opinion, but the fact that I didn't get any more contracts...I think it's a money matter as well, to be honest. (8)*

In contrast to this, one participant spoke about their service being resource-rich compared to other services in the area. While this is an advantage to the clients of this service, the inequity created by this disparity in funding was a concern for this participant.

> *You know, there's another community peer-led day service in [a nearby town], but we are resource-rich as a service compared to them…There is occupational inequity in that not everyone can access our service. (7)*

Grappling with the challenges of service poverty is not unique to therapists working in resource-poor services. Therapists working in resource-rich services grapple with the inequity created by funding disparities.

Another significant issue in many services is the financial poverty experienced by the employees of the services. Caregivers in New Zealand have typically been paid low-wages, and this was an issue of concern for participants in this research.

> *I see a lot of carers who they're obviously on the minimum wage, doing an amazing job, but you can see the health impact of people not being able to afford just regular working hours, people working too many hours to make ends meet, and people not being able to afford really healthy, nutritious food, so I think there's a lot of poverty in a lot of frontline caregivers as well. (6)*

When the people paid to care for vulnerable clients are struggling financially, and their work is not valued, the work suffers, the health of the carers is impacted, and vulnerable clients are put at risk.

> *One example of that is that because some of these caregivers, they go out to homes, they won't turn up. I've been to see clients, and the client hasn't been got out of bed because the caregiver hasn't turned up, because they're hardly making any money because they might have to travel quite far to do the job. (6)*

The inadequate pay rates for carers also impacts the quality of staff employed by some services.

> *Well, I think because they're not very well paid it means you don't attract particularly high skill level of staff…they just don't know what they're doing. They don't know how to talk to clients...It's quite an amateurish feel too much of the interventions that the clients receive…So I suppose you get what you pay for. (9)*

> *The NGOs don't seem to employ professionals…so there's a lack of professional knowledge, there's a lack of evidence-based interventions within those environments. Partly because of the nature of the staffing. (9)*

This was a challenge for participants who were writing treatment plans for their clients but could not be sure that the plans would be carried appropriately or effectively, leading to compromised client outcomes. Participants wanted the best outcomes for their clients and were often frustrated when financial restrictions in the service undermined these outcomes.

4.3.4 Compromised Client Outcomes

Client poverty and service poverty are significant concerns for occupational therapists, and when these two types of poverty intersect, the impact on client outcomes is compounded. Sometimes clients are not eligible for

funded services and other times service providers do not have an adequate budget to meet their obligation. While some clients are able and willing to pay for additional support or services, clients who do not have financial resources miss out on required supports and remain at risk.

Several participants described situations where they identified supports or services that would be beneficial for clients but were unsure if they should recommend the service as they did not know if it would be funded.

> *We can refer these people on to what we think they'd get some benefit from. Them actually having the financial means to be able to follow through with it…They'll be declining it because they'll say, "I can't afford to get the taxi to get that" …If somebody's declined for funding through the Ministry of Health and they don't have the means to pay upfront themselves, they basically remain at risk because we can't follow through with the intervention. (1)*

When a therapist identifies a need for supports or services such as equipment and these are not provided due to funding restrictions, then clients are at risk of physical harm. At other times the services recommended by a therapist relate more to wellbeing. When a client is unable to join a social group, for example, their recovery or wellbeing may be compromised.

> *[finance] always affects whether people join a group…I try and work with people to join a social group or learn a new skill or something like that…often, there isn't the money for transport…or the fee to join the group…I know that they won't go back because they just haven't got the money to go back, or they feel intimidated that everyone else there's got more money than them. (2)*

At other times, participants were able to provide supports and clients could contribute financially to some services, but participants were are aware that this

is not always enough. Or even if it is enough for now, there may come a time when no amount of services will be enough.

> *I've got a case [in a rural area] a 140-kilometre return trip to the local shops…There are no supports. There is no home help to do the vacuuming; there is no one to do the shopping. Once this particular man can't drive anymore, he and his wife will have to move into care…He's going to end up in care, but I suppose that's inevitable…they've sold their house, reverse mortgaged, and they've spent every penny…it's an old bach held together with gaffa tape and tarpaulins, and they spent all the money…He's got all the mod cons, but even that's not going to help… (2)*

This story highlights the impact of living in isolated rural areas where there are very few services. Clients that live in urban centres have a better chance of accessing support services, but when there are no services available in the area, then no amount of money is enough to reduce risk and improve client outcomes.

Client outcomes can also be compromised by other factors in their environments. One participant spoke of clients living in overcrowded housing and the challenge this poses to carrying out community-based interventions. The participant identified a need for relaxation and sleep training for a client, but this could not be carried out due to the home environment

> *I can't sit down and spend time with her in the house and help her relax, do mindfulness or even have an environment to sleep in, because she hasn't got her own room. (2)*

Although a need was identified and the therapist was able to do some work with the client, the outcome of the intervention was compromised due to the clients living situation. In this situation, the therapist continued working with this client and providing as much support as able, but this was all done with a knowledge

that the impact of poverty would continue to undermine the effectiveness of the interventions being provided.

4.3.5 Considering a different way

Another important feature of grappling with poverty at a cognitive level is the way that participants expressed a desire for change as they wondered about how things could be different. There was a sense of frustration and dissatisfaction with the status quo. Participants asked questions about how life could be different for their clients, what they as therapists could do differently in their practice to improve the lives of their clients, and how services or even entire communities could be restructured to mitigate the impact of poverty. One thing that therapists considered was how they could practice in a client-centred way to give control to their clients.

> *It would be nice to be able to try and give these people more control back in their court…Because they don't have the means or the money to make decisions for themselves, they're always relying on support from…the health system or the government…It almost makes them beggars in a way…Rather than having the financial means that they can just do what they want to when they want, within a time frame that they want. (1)*

Some of the deliberations about change were quite general, while other participants thought about how life could be different for specific clients. A story was told of a client whose life was significantly impacted by domestic violence, and the therapist could see this impacting the client's engagement with occupations and contributing to poverty and social isolation.

> *I was thinking about her and just how even her occupations are so limited because of the domestic violence…she's not even allowed to go out and see friends unless he goes as well…And I was just*

> *thinking if she was free of domestic violence, what occupations would she do. And one of them is work. (4)*

In addition to thinking about specific clients, participants also considered specific areas of their practice or service that could be changed or improved.

> *A lot of our folks are disadvantaged when it comes to gaining and holding employment…I'm very keen to address the employment part of our service and get that working a bit better. (7)*

Participants also identified gaps in service provision, either in their own services or in community services that they utilise with and for their clients.

> *As part of one of my e-portfolio competencies, I'm trying to put together a list of social groups with a Maori/Marae type theme for anyone over 65. I've been to about seven Marae's, and there is very little available…I just find that really, really sad, that there isn't even a coffee group for the local kaumatua…there's just such an opportunity. (2)*

In other areas, participants noted that there were multiple services providing similar things and that it could be more cost-effective and potentially improve client outcomes if services were combined.

> *I think that we could do a lot better at joining services up and working smarter…There's too many people doing too similar things, and we're not probably looking at outcomes as well as we should. (7)*

When specific issues are identified, participants reported that more money wouldn't necessarily solve the issues. Rather, work needed to be done to understand the cause of the issues and tackle these underlying societal causes rather than focusing on the symptoms.

> *I'm not sure necessarily that throwing more money at it is the answer. (7)*
>
> *There's just been probably too much of just little fish being handed out, and not enough really looking at the root causes of the inequality and injustices in society. (6)*

In order to address the causes of issues such as poverty and injustice in society, participants stated that work needs to be done at a community level rather than just an individual level. Communities have the best understanding of the specific issues that they face, and as such, they also have knowledge of changes that would be most appropriate and effective.

> *It's really important that systems change the way they operate with communities that have experiences of poverty, and that their ability to make decisions, their ability to run their communities, their ability to find new solutions must be put first. Because I believe people know what they need, and that, actually if systems sat down and listened to what people thought they needed they'd probably think that we can do that so let's do it. (4)*

Another participant also proposed working with communities rather than individuals as a way to bring about effective and lasting change.

> *I have thought sometimes that it would be more useful to be working in a wider social way. So engaging more with whole communities and to think about how communities can support poverty…setting communities up a little bit differently…I think OT could bridge that, working that way more rather than just with individuals…I suppose getting involved in policy as well. And local community activism, stuff like that…If you're thinking about occupational deprivation, the human right to have occupation, it becomes more than just a one-to-one intervention issue. It means*

> *we need to be seeing a different sort of strata of society…What that would actually look like, I don't know. (9)*

There was a sense of frustration in knowing that things could be better, but being uncertain how to undertake these improvements. This participant went on to reflect on the fact that occupational therapists in New Zealand are working in the paradigm of a capitalist society, and that a majority of interventions aim to help people be successful within that paradigm. There was a sense of wondering if this was the best way for occupational therapists to be working, or if there was another way.

> *So it's all about, getting jobs and earning money and being productive and being able to buy stuff. Free things aren't so…they are socially acceptable, but people buy stuff. That's what people do. And that's a lot of what we do, we're trying to get people to be like the norm, maybe we need to be working with people to have alternative lifestyles. (9)*

Throughout these discussions about working with communities and addressing issues at a societal level rather than just at an individual level, therapists proposed some strategies for this. However, they were not currently doing the things they suggested, but there was definitely a sense of wondering if there could be different or better ways of addressing issues such as poverty that impact their clients and their practice in such significant ways.

4.3.6 Supervision and support structures

Because participants in this research revealed grappling with numerous issues related to the poverty experienced by their clients and within their services, it is important to consider how this grappling and frustration can be managed to avoid burnout. Supervision was described as an essential part of practice when faced with issues of poverty. Because of the complexity of the issues facing some clients and the ethical nature of addressing issues of poverty,

participants reported that they frequently discuss concerns with supervisors. In supervision, participants seek reassurance that they have done the right thing, ask for guidance on what else they could do, or look to someone else to place boundaries around what they are doing so decision-making does not rest solely on their shoulders.

> *Certainly gives a lot to take to supervision. It's a pretty hard slog working day in and day out, seeing these folk in their own homes and the struggles and things they have to go through…That's where supervision comes in because it's quite good to debrief…Just reassuring yourself that you've done as much as you can. (1)*

> *I think I will go the extra mile for the people that I feel that are really struggling and need that extra support. Which is a little bit of a concern, because ethically, can I offer an extended supported service to every one of my patients, every one of my clients. I query that every day…It's something I'm particularly aware of and often talk to my supervisor about why and what I've done and make sure that I feel that I can justify it…I'm not good at saying no. My supervisor's particularly good…he just brings me back to reality…Can't save the world. (2)*

Formal supervision was not the only strategy employed by therapists for debriefing or discussing ethical concerns. Informal supervision or discussions with colleagues were also frequently used.

> *I go back, talk to my colleagues, and I talk to my team leader when I'm really concerned, and maybe these things just have to be escalated a bit more. (6)*

Whether therapists use formal or informal supervisory arrangements, these relationships are a valuable way for therapists to discuss their concerns and share the challenges they face on a daily basis.

4.3.7 Summary

Whereas the first stage of engaging with poverty was described as a heart response, this second stage of engagement with poverty has been described as a cognitive response that is characterised by a sense of frustration as participant grappled with the difficult realities of poverty for their clients. Within this grappling, there was often a sense of wanting things to be different for clients, within society, and within specific services, but there was also some uncertainty regarding how to effect the desired change.

4.4 Hands: A Practical Response to Poverty

The final stage of engaging with poverty is where participants take specific actions to address identified needs for clients. At times participants were consciously and deliberately addressing poverty in their practice. At other times standard occupational therapy practice secondarily addressed poverty-related needs. Through conversation, participants began to identify and articulate ways their everyday practice addresses issues such as poverty. The stories told about practical responses also demonstrate that understanding and grappling with issues of poverty is part of the reasoning process.

4.4.1 Occupational Engagement

Participants frequently spoke about the importance of providing opportunities for occupational engagement for all clients. Occupational engagement was described as essential for wellbeing, and compromised by illness, disability, or poverty. This belief in the importance of occupation for wellbeing inspired participants to provide opportunities for occupational engagement.

> *There's a huge need, a huge occupational need that human beings have, especially people with experience of mental health difficulties who are often really occupationally disadvantaged through their life experience. (7)*

Participants spoke about the impact of poverty on the choices people make regarding occupational engagement, and how financial poverty restricts the occupations people can engage in.

> *I see people having very few options. They've got very little discretionary spend, so their opportunity to take a holiday, for example, is greatly reduced…people don't have the discretionary spend to go to the movies and can't go on holiday, can't go and watch the rugby game on Friday night. (7)*

> *It's occupational deprivation due to lack of funds, and people don't have access to the internet, people don't have access to…social media and stuff like that. (9)*

Participants reflected on how engaging in occupations gives control back to people in certain areas of their lives, and once they have control and success in one area, they begin to have hope that they can be successful in other areas as well. One participant spoke specifically of engaging young people in sport, and how success in sport provided a way to engage and belong in society.

> *Sports gives them success and shows them a different pathway in life. If they are successful at sport then…"actually I do belong to this world", whereas if they can't even engage in sport…That's when you start seeing them starting to disengage from society and then start engaging with gangs and those kinds of communities…they make them feel like they belong and they can be successful here. (4)*

This participant understood the importance of engaging in sport, was able to access funding to support a young person to engage in sport and saw the positive outcome in this clients life.

> *He's done really well at sports and wants to be in a sports club…What we can do through our programme, is we can identify*

> *that obviously for this kid, getting some sports equipment, would be something that really could make a difference for this boy and push him into the sports line instead of the gang-line…It's a hand-up, not a hand-out. (4)*

Another example of providing opportunities for occupational engagement was when a participant who described a community mental health service that takes clients camping and fishing in a nearby area.

> *…some of the most powerful experiences I've had as an OT is taking people away for a few days…People say, "That's the best holiday I've had for five years…We've been running that same trip for over 20 years now. And every year at least one or two people have an "Aha!" moment, which I think is like something of a turning point for them. They go, "Oh my God, I can have a life. Oh my God, there is a chance to not be caught up in this terrible drudge of mental illness and poverty." (7)*

This participant spoke at length about the impact of these experiences. When clients get away from their everyday life, they see that there is more to life than what they have experienced, and they feel empowered to change.

> *"Oh, man, maybe if I made a few changes I could actually be doing a bit more of that in my life." (7)*

This participant explained that their service is able to continue providing these opportunities for engagement to clients who have moved on.

> *A number of people do successfully migrate on out of our service and start doing those things for themselves, and we try to also facilitate that process…We've got a big store of camping and fishing equipment that we will loan to people who want to take that on themselves. (7)*

Accessing funding or directly providing resources for clients is not the only way that therapists are able to enable opportunities for occupational engagement. Participants spoke of the importance of liaising with community organisations and knowing the supports and services available in the local community. Some community groups provide financial support to enable engagement in activities such as sport.

> *We've got lots of whanau that would like their kids to be involved with sports…but they haven't got the money to pay for uniforms, they haven't got the money to buy sports equipment for them, they haven't got the money to get them down to the sports grounds…often [the club will say] get the kid there and get them a mouth guard, and we will sort the rest…particularly where Maori are running the club, there's a lot of support given to kids, poor kids, so they can access those things. (4)*

Another participant spoke about connecting clients into local community groups, such as community gardens, as part of a wellness plan.

> *I like to connect people. We've got two fantastic community gardens, and as an OT, I try and get them to go along to the community gardens when the weather's nice. Not so much go and work in the gardens, but offer their support and help the young kids…and we find out what day the primary school kids are going to be there and we go and help. It just gets them known, and in return, they can go home with half a cauliflower and some carrots and things like that…That's one practical thing that I've tried to involve people in. …Because you've got the social stuff, absolutely, and they've still got a bit of nice, fresh food. (2)*

Connecting clients with a community garden was a common part of this therapists practice. It met a variety of occupational and social needs, and directly addressed food insecurity by providing clients with fresh fruit and vegetables.

Another example of one intervention addressing a number of needs was a participant who engaged a client in a cooking course. The occupational therapist believed that if the client was successful with the cooking course, there would be a reduction in domestic violence.

> *We think that her doing this cooking course is going to reduce the domestic violence events dramatically, because she is actually being successful in something, and she has got something outside of the home that she's passionate about. (4)*

Several therapists spoke about work they do to engage people in education or employment opportunities. This included helping clients with putting together a CV, teaching work skills, or the occupational therapist becoming a work broker.

> *The one that I probably facilitate the most is helping whanau to move toward returning to work or returning to education…I honestly believe education and employment are the two biggest pathways out of poverty for everybody really. (4)*

While a return to paid employment was often a goal, engaging clients in voluntary work was also viewed as an important option for people who had limited work history or work skills.

4.4.2 Advocacy and being a witness

Advocacy was frequently described as a way participants actively supported clients who were struggling with poverty. Participants who had personal experience with WINZ had a greater appreciation of how difficult it is to get support from WINZ, and this prompted participants to attend appointments with clients.

> *It does help to advocate and understand how intimidating they are and appreciate that for people…It does make a huge difference when you have somebody who's got a professional hat on and a hospital ID…It's actually disgusting, but the person you're with is treated far more respectfully than they are when they're by themselves. It's actually terrible. (3)*

At times the simple fact that a therapist attended an appointment with a client was enough to change the outcome for the client. The therapist could simply provide support and be a witness to the proceedings. At other times participants took a more active role in educating clients about eligibility and supporting them to ensure needs were met.

> *I'd always attend, or else people wouldn't get what they needed …because you don't know what even to ask for…they don't let you know what you're entitled to. Because of the role we're in, we know, so I could go there and support people and get what they need to have a reasonable quality of life. (3)*

It was important for participants to develop a relationship with agencies such as WINZ as this enabled them to support their clients to access necessary supports.

Building relationships of mutual respect with the staff of other agencies can assist with ensuring clients receive support. One participant told a story of a client who had a particularly bad experience with Child Youth and Family Services (CYFS) (renamed Oranga Tamariki in mid-2017), and through this experience, the client had stopped engaging with CYFS. The therapist had a good relationship with CYFS and was able to support the client to reengage positively.

> *Fortunately, she's got a social worker that realises it's the system that's been a problem for her, and so now, I make sure I'm with her every time she sees CYFS, and CYFS also do the same, they ring me or talk to me and say, we need to see her, when can we do it. (4)*

This same therapist told another story about another client who had a particularly bad experience with WINZ. The client was consistently denied financial support and lost all hope of getting any help.

> *And my client just bowed her head and started crying. And I said to the WINZ worker, "Look, we have been through this, we have investigated…She is going to lose her house because she can't pay her rent. Is that really what you want? Somebody coming to you next week because they are homeless?" And you know, it was that kind of advocacy. Whereas if she had actually sat there and listened to my client, she would have heard the state she was in. As it turned out they did give her the benefit, because of what we had done. But my client, if I hadn't been there, would have got up and walked out because she thought this person was saying "no" again. (4)*

Because the therapist had been involved with supporting the client for some time, they knew the details of the situation and previous attempts at securing support. With this knowledge, the therapist was able to speak up and bring about change for this client.

Sometimes advocacy involves educating clients about the supports available and encouraging them to ask for help.

> *You don't know what you don't know, so a lot of people think you need to go buy equipment…so it's being able to educate people as things change and things that we can help access for them, so they don't need to panic. Ask us first, because we can help source that sort of thing for people. If in doubt, ask. (3)*

If the therapist is not able to meet the clients need, they may know where to go to access supports. Or the therapist may be able to support clients to apply for funding or in appealing funding decisions. One participant spoke of the struggle

to get equipment that would improve a clients quality of life and enable them to maintain independence but did not meet usual funding criteria.

> *I have had to have a really big battle with Accessable to get them some power assist…they're emancipated people that are just wanting to maintain their independence and not become more reliant on people…because power-assist devices are a little bit out of the box, basically giving them a dual mobility option…that doesn't quite fit the criteria or the way the criteria is interpreted by the funding body…with the second person, I just said, "Look, you're just going to have to write a letter in your own words to Accessable" (6)*

Another practical thing that some therapists advocate for with their clients is access to housing. A story was told about a client whose children had been removed from her care by CYFS. The client had done everything needed to be able to care for her children, but she needed to find a house before her children could be returned to her care.

> *Another thing we help advocate for as well is access to housing…And so she came to me because she needed a house in order to be able to have her children back in her care. And so we went through the process of getting a state house…So she is now going to be able to rebuild her family and get her children back…So, it's the whole, you know, you talk about poverty, but if her family is not even in the same house she can't look after them…I think that it's fundamental to the family, and then once you've got your house, then you can build your other things. (4)*

Not all occupational therapists work in environments where they are able to provide this level of support or advocacy to their clients, but for those that can, the results are rewarding.

4.4.3 Taking time to listen

Therapists who desire to provide practical support or advocate for their clients, first need to know and understand what the client is experiencing. This is not always easy in a clinical role, but it is imperative that therapists take the time to listen to their clients. Sometimes listening is the most important task.

> *I do really try and find out what resources and what kind of help there is out there, and a lot of times I just try and listen to people and try and listen and understand. (6)*

When a therapist builds a relationship of trust with their clients, they can ascertain the specific challenges facing their clients. This knowledge opens the door for a practical intervention. As discussed earlier, some families do not access healthcare in a timely manner due to owing money to the Doctor.

> *So what we try to do if we know that's happening is we try to get them to set-up an automatic payment…we try to do that because then it means they can access the health services they need. (4)*

If therapists are aware of specific challenges, they are able to work with their clients to find a solution, but without this knowledge, a therapist is unable to address a client's most significant needs. Making the time to listen to clients can be difficult, especially when clients are reluctant to talk about their struggles. As seen in the stories about advocacy, some clients are so used to hearing "no" from professionals they may be unwilling to risk being told no again. Clients may be reluctant to talk about their difficulties if others might overhear.

> *I can't spend time and support her at her home. She doesn't feel comfortable with that, so we meet in a public place and have coffee or talk in my car because she doesn't want other people to know all of her concerns…If you sit in a café, she won't say too much because it's a small community she lives in…and she just wants to try and eliminate gossip. (2)*

While it is important for therapists to make time to listen to their clients, it is also important that therapists do not push clients to talk if they are not comfortable doing so. Clients maintain a sense of control or dignity in their lives by choosing what they disclose or what they keep hidden.

> *I think there's a lot of hidden poverty and struggle because people want to be respected by other people, and they want to have that self-respect, they're not going to reveal that necessarily to health professionals and other people in their lives. (6)*

It is a difficult balance for therapists making time to listen to their client's needs, while also respecting the clients right to respect and privacy.

4.4.4 Record Keeping and Referrals

Not all practical responses to poverty directly impact a clients situation. Documentation is a way of safeguarding therapists as they report and record issues they have seen. When a therapist is unable to directly address an issue, documenting it helps build a picture of what is going on for a client and can ensure that referrals or other follow-up are actioned.

> *Aside from that, just document what you can. (1)*
>
> *I am always really careful to document in my notes if I've seen issues of needs not being met…and I will follow it up, and I'm always saying, "We should we get a referral to a social worker." (6)*

Documenting issues for clients over time can show if specific patterns are emerging. One participant spoke numerous situations where the family were not providing adequate care for an elderly parent or grandparent but also refused rest home care. This participant also spoke of clients putting family first, giving money to family, and then having nothing left to meet their own needs thus exacerbating financial poverty. This participant described significant concerns

regarding elder abuse with many vulnerable clients, and that these situations needed monitoring and further support.

> *I know many situations that are borderline elder abuse, and you just haven't got the proof to do a damn thing about it…But, you alert people like age concern and social workers and that, but unless you've got the proof, you can't do anything about it. (2)*

Although these situations can feel helpless at the time, continued documentation over time may contribute to the evidence required.

When certain issues are outside of the occupational therapist's specific role or scope of practice, referring on to other professionals or other agencies is a legitimate way of meeting a client's needs.

> *If it's not something that I can see that's within my scope of practice, then I usually make a really good effort to try and refer on to somebody that it is. (1)*

An example of identifying a specific issue, refusing to ignore the issue, and referring on to another agency for support, was given by a participant who identified that a wheelchair-bound client required medical attention. The client was confined to bed due to leg spasms. The therapist also believed that the client was staying in bed to keep warm as the house was cold and damp, and the client could not afford heating. In addition, the client did not have transport to get to a doctor, and could not afford to pay for medical treatment.

> *So then I thought, "Okay, what can I do?" So I sent an email back to the referrers…But the reality is, it is a medical problem that needs medical follow-up, but can the man actually afford that, or even afford to access that? (6)*

While the outcome for this client was not described, the therapist demonstrated an awareness of poverty-related issues compromising the client's health and wellbeing. The therapist acknowledged that this issue was outside their scope of

practice, but they did not ignore it, rather they took all possible steps to find a solution for the client's needs.

Another example of therapists referring on to other agencies for support, was a therapist that spoke of referring clients to budgeting services.

> *I don't try and do any of that stuff myself. I try and get the budgeter to do it because they're the specialist in that area...Because the thing is if I start providing it [food parcels] regularly the whanau become dependent on it, and food parcels aren't the answer. They've got to work out their debts and how they can get enough food on their tables for their children. (4)*

Although this participant had scope within their role to provide occasional food-parcels to clients and had the skills to teach budgeting, it was more appropriate for the therapist to refer clients on to a specialist budgeting service. Just because a therapist has the ability to address a specific issue, does not mean that they should always do so.

This same participant spoke of working with clients to access education or employment opportunities as a way to address financial poverty.

> *And so that's where pathways to working or pathways to doing education or something like that are…And that's often what they want. They know they need more money to buy more food for their children, but they're not sure that they can do the training, they're not sure that they can, that they'll be allowed, they don't know how to access the tertiary providers, or how to access work. And so we refer them, we have a great agency here…that takes people and gives them jobs. (4)*

Again, while the therapist could have done a lot of the work of finding employment or education opportunities, there was an existing service in the local

area that provided these services to clients. Thus referring clients on to other services was an effective use of the therapist's time and resources.

4.4.5 Finding a way

Throughout the research, participants described creative approaches that they would use in order to find a solution to poverty-related challenges and enable interventions to take place. The need for creative approaches is not unique to situations of poverty, but when client poverty and service poverty are encountered simultaneously, the need for creative approaches is more likely.

Several participants described challenges encountered when attempting to contact clients, especially new clients. Clients in poverty may struggle to pay a monthly phone bill, phones get disconnected, and client contact details on referrals becomes outdated. After several unsuccessful attempts to contact a client, a therapist must decide to either continue pursuing the referral or to direct their time and resources elsewhere.

> *I guess an example is that we get all these referrals, our contract is we have to contact them within five working days, so we do that by text. Then nobody's responded to the text. So today I called everybody up, and everybody told me that they didn't respond to my text because they didn't have any credit. That's got at least some elements of poverty-driven. If you don't have even enough credit to text people, that's limiting. (8)*

For this participant, the usual practice in the organisation was to contact clients by text message, but the therapist recognised that not all clients could afford to respond via text message. The approach of calling clients rather than sending text messages was successful in contacting some of the clients.

This participant spoke about another time when even a phone call was not enough to contact the client.

> *There's this referral that we've had, and we've had it for like six weeks. We couldn't get through to reach anybody. None of the phone numbers work, we did all this clinical-reasoning, try and find another number…Anyway, I just walk up there this afternoon…So we've got a new number for her…Sometimes you actually do have to go there and just walk in. (8)*

There were some safety concerns raised by the participant regarding the use of this approach. Community-based occupational therapists do not always know what they will encounter when visiting a client's home, and this uncertainty is heightened when no prior contact has been made with the client. While this approach may not be possible or acceptable in all practice areas, for this participant it was an effective solution to ensure referrals were actioned and clients received the intervention required.

Another example of this 'just do it' approach was described by participants who used their own time or resources to meet a client's needs. One participant spoke about the difficulty of getting resources for craft activities, so rather than applying for funding and having those applications rejected, they simply acquired resources from other places such as second-hand shops.

> *I suppose I've learnt that you can't get any resources from the hospital. If I want to talk to people about doing crafts and things to distract their anxious mind, I go to the op shop, and I buy needles and knitting wool...I just have a great heap of resources that I acquire from the op shop and things like that, which is what I refer to as being donated...I try to always see opportunities to reuse things…I try and be a bit resourceful. (2)*

Another participant spoke about gifting items to clients when it was clear they could not afford to pay for it.

> *I guess the one thing I would say that I really have been reflecting on of late, there's been a couple of scenarios where I've just brought something for clients because they need it. I've sometimes said "just have it, don't worry about it" because I know that I've got more money coming. (8)*

When it comes to funding for services, therapists may look to community groups or charitable funding options for clients who do not meet traditional funding criteria. One participant described a situation where a client was denied equipment due to a rental property being inaccessible, yet there was no funding for housing modifications. The participant then considered alternative funding to meet the client's needs.

> *It was a real ethical thing because you could see it from the funders' point-of-view as well, and that's where you start thinking about, oh, is there any kind of philanthropists out there? Like the Men's Shed, because they just build, like, knock up a ramp. (6)*

There were times when participants found alternative ways to meet the client's needs, that did not cost the client, the therapist or the service. One participant described the struggle that some older clients have with medications.

> *Not affording to have the choice of blister packs, that's something we really battle because it costs…so they just battle on trying to work it out themselves. If there's medication adjustments, that gets messy…I spend quite a bit of time when I'm key working, writing in big marker pen on pieces of paper, the right weekly pills because what the doctor gives them is little and they can't see it. (2)*

Although blister packs for medication are a common solution for many people, they are an expensive option that not everyone can afford. By taking the time to write out the medication instructions for clients, this participant was able to improve the independence and wellbeing of their clients.

Adapting interventions or arranging the timing of interventions to suit the client was also discussed as a way of balancing the need for intervention with the clients' situation. As described earlier, participants reported being unable to access food from the hospital for meal preparation assessments. For community-based therapists, it is important to discuss the assessment with clients in advance and schedule the assessment for a day when the client is able to purchase food.

> *When I'm doing a meal prep assessment, we'll talk to the patient and see when it's appropriate, so whether it's pension day, and we talk about them making things that they would normally make to eat. There should be no added expense. (2)*

This participant explained that shopping with the client was part of the assessment process, so it was important that the shopping experience would not place additional stress on the client.

At other times, therapists identify needs that are slightly outside of their role, yet they find a way to ensure their clients receive the necessary support. One participant working in a non-OT specific role spoke about a client who was unable to attend a doctor appointment as she did not have childcare.

> *The mum had to go to the doctors…She said she couldn't go because she had the kids and the dad was at work…So I said, "I'll take your three kids out for an hour if that makes you go to your GP appointment." (8)*

In many roles, providing childcare would be outside a therapist's scope of practice. This participant believed that it was in the best interests of the client and the family to provide childcare and then went on to describe buying food for the children who had not eaten that day.

4.4.6 Summary

The final stage of engaging with poverty has been described as using the hands to enact a practical response. Many of the examples given of the practical

responses to poverty are part of the usual occupational therapy role, and indeed many interventions were not directly aimed at poverty reduction, but this was an additional outcome. There are also times when therapists appear to stretch the boundaries of what is acceptable practice, and the ethical implications of this will be discussed in the next chapter.

4.5 Conclusion

These findings demonstrate the occupational therapists in New Zealand can and do engage with poverty in a variety of practice areas. Occupational therapists engage their hearts in understanding their clients lived experiences of poverty; they engage with their heads as they grapple with the complexity of the issues of poverty and the ethical dilemmas these issues produce. They also engage their hands as they take practical steps to reduce or eliminate barriers to occupational engagement that are caused by poverty. These three themes – heart, head, and hands – demonstrate the holistic and complex ways that occupational therapists engage with and respond to poverty. There is no one right way of engaging with poverty, and the ways that a therapist responds to or addresses poverty is usually specific their particular role or practice setting.

Throughout the interviews, participants frequently spoke of the complexity of poverty and the issues it creates. They also described the realities of living with poverty in New Zealand. These additional themes will be explored in the discussion in the next chapter, along with a further examination of the understanding, grappling, and responding processes that therapists use when engaging with poverty.

I was told that research like this would be a transformative process, but I never imagined just how this work would transform me.

My parents were given 3-months' notice to move from the home they have rented for 26 years – the home that I spent some of my childhood and all of my adolescence in – although the news was expected, it was heart-breaking. My parents are shell-shocked, and I am feeling their pain with them.

My attempts to help have shown me just how difficult the housing market here is right now, and it is devastating. How is anyone supposed to find somewhere to live and still be able to afford to have any quality of life with rents so high and houses in such high demand?

Chapter Five. Discussion

5.1 Introduction

This research aimed to explore how occupational therapists engage with poverty in their practice. There are numerous definitions of poverty available in a range of literature, and thus developing a definition of poverty was not the aim of this research. A definition of poverty was not given to participants, nor were they asked to define poverty. Instead, participants were asked to describe poverty and the impact of poverty on both their clients and their practice. The data analysis process included comparing participant's descriptions of poverty with the descriptions of poverty in the literature. The similarities and differences between the descriptions of poverty in the literature and from the research participants will be further discussed later in this chapter.

The most important finding from this research is that poverty is part of everyday occupational therapy practice. Engagement with poverty is not limited to specific practice areas, geographical locations, or populations. Engaging with issues of poverty is not a role for a small group of occupational therapists or therapists working in specialist services. All occupational therapists can and do, engage with issues of poverty in whatever practice setting they find themselves, although some therapists may be more conscious of the way they do this. There is no one right way to engage with poverty in occupational therapy practice.

Rather, engaging with poverty occurs in a variety of ways. Therapists who consciously engage with poverty in their practice appear to do so on several different levels. In the findings chapter, these three elements of engagement are described as heart, head, and hands. In Figure these stages of engagement are depicted as a pyramid to demonstrate that each stage builds on the other stages. Understanding poverty is foundational to engaging in poverty, and the practical response to poverty is a smaller and more focused response. In Figure 3, the

stages of engagement are depicted as a series of interlocking circles to reveal the interconnected nature of each of these stages of engagement.

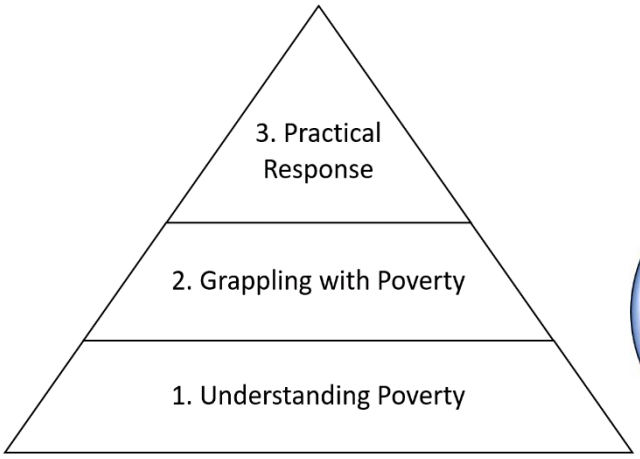

Figure 2: Stages of engagement depicted as a pyramid

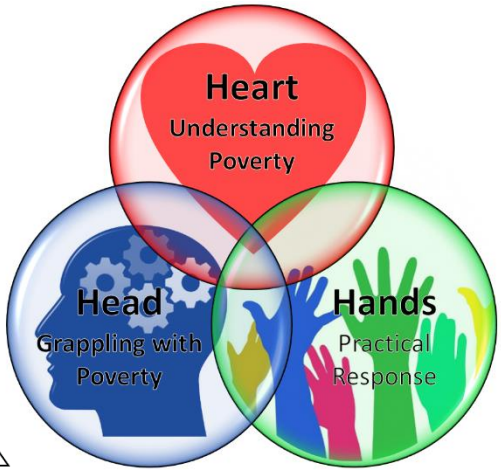

Figure 2: Stages of engagement depicted as interlocking circles.

Each of these stages described are legitimate ways of engaging with poverty-related issues. As portrayed in Figure and Figure 3 above, at times these types of engagement occur independently, at other times they may occur concurrently, or even sequentially. The first stage of engaging with poverty is understanding the issues facing clients and their lived experiences of poverty. This understanding is likely to involve some level of emotional response, hence the description of this as engaging with the heart. This emotional response may then trigger a cognitive, or head, response in which therapists grapple with the issues that they see, identify specific injustices, and experience frustration when they encounter barriers to practising in a way they desire. While these stages of engagement are not a linear process, they may occur in a seemingly linear way. For example, grappling with an issue of poverty may result in the identification of a way to address a specific need. Likewise, the process of addressing one need may increase a therapists' knowledge of a situation or highlight further issues that need to be addressed, leading to increased understanding and a continuation of the grappling process. This series of stages are similar to the four stages in Tronto's approach to care ethics, which include attentiveness, responsibility,

competence, and responsiveness (Tronto, 1998). Attentiveness involves becoming aware of and paying attention to a specific need, which is an important component of engaging with the heart. Taking responsibility includes a process of determining who should be responsible, and through this grappling coming to realise that it within your area of responsibility. Competence further extends the concept of engaging with the hands, by ensuring that the actions taken to meet needs are done well. The final stage in Tronto's care ethic is responsiveness, which includes both the response of the person receiving the care and requires the caregiver to listen to ensure that the actions taken have actually addressed the needs they were supposed to address. This final stage is currently not well demonstrated in the findings of this research. Some of the stories provided in the findings implied that therapists were responsive to the needs of clients, but there is insufficient evidence to make this claim. The need for responsiveness and evaluating the effectiveness of occupational therapy responses to poverty is an area that requires further investigation and will be discussed in the recommendations at the end of this chapter.

This discussion chapter examines some specific ways in which New Zealand occupational therapists understand and engage with issues of poverty. Similarities and differences between the findings and relevant literature are identified. The complexity of poverty and the reality of poverty in New Zealand is explored in greater detail. The everyday nature of engaging with poverty in occupational therapy is examined in relation to specific values espoused in the occupational therapy literature. The ethical tensions faced by occupational therapists as they engage with issues of poverty are explored. An ethical framework is presented as an alternative way to conceptualise and address issues of poverty previously described as occupational or social justice concerns. This chapter ends by addressing further recommendations and implications for practice.

5.2 Poverty is a complex issue

The complexity of poverty and the numerous forms of poverty that can be experienced is important to consider at the outset of this discussion. Without an understanding of the complexity of poverty and the interconnected factors that contribute to it, it would not be possible to determine how occupational therapists can and do, engage with poverty. The literature review revealed that poverty is a complex, multifaceted issue that is defined in many ways. While the most common understanding of poverty relates to a lack of financial resources or material deprivation, poverty is much more than this. As stated by Johnston et al. (2009), "it may be more useful to perceive and articulate poverty as an interdependent cause and outcome that has multi-directional relationships with a variety of social factors that operate together and simultaneously to compound, and intensify the experience of poverty" (p. 51). Because of the numerous factors that contribute to poverty, there is not one simple solution to poverty. Rittel and Webber, (1973) proposed the term 'wicked problems' for issues, such as poverty, that are not easily defined or solved. This idea of poverty as a wicked problem is useful to keep in mind throughout this discussion.

During the interviews, several participants asked what definition of poverty was being used in this research. It was explained to those participants that the purpose of the research was not to define poverty but to understand what it means in practice for occupational therapists. Thus therapists were asked to describe rather than to define poverty. The descriptions of poverty provided were rich and varied. Most significantly, descriptions of poverty extended far beyond financial hardship and also encompassed issues such as social isolation, loss of connection to culture and meaningful cultural practices, limited access to valued occupations, financial hardship and injustice that has persisted through generations, inadequate nutrition, and exclusion from education. These descriptions highlight the social, political, and economic elements that contribute to poverty. The richness and variations in these descriptions of poverty further

demonstrate the complexity of poverty and the challenge that arises when attempting to define poverty. If a definition of poverty were limited to a lack of finances, giving more money to people would appear to be a simple solution to poverty, and thus there would be limited scope for occupational therapists to be involved with addressing poverty. However, poverty is not that simple. It is this complexity inherent in the issue of poverty that creates opportunities for occupational therapists to engage with poverty in meaningful ways. This complexity also makes poverty both challenging yet simple to engage with, in everyday practice.

5.2.1 Intersections between Poverty and Disability

One of the significant challenges facing occupational therapists and their clients is the similarities and interactions between poverty and disability. As discussed earlier in this thesis, there is a strong correlation between poverty and disability, with an over-representation of people with disabilities in the statistics about poverty. In addition to this, when poverty is understood to be more than a lack of finances, then the similarities between poverty and disability become more apparent. Like disability, poverty comprises a matrix of factors including exclusion from or limited access to social resources such as education, employment, healthcare, housing, and transportation. "This understanding of poverty mirrors the situation of many disabled people and those with mental illnesses who experience devalued social statuses and limited access to social resources due to inadequate structural and social responses to their impairments" (Hammell, 2016, p. 283). That is not to say that all people with physical impairments are poor, or that all people who are poor have a disability, but rather demonstrates that "when disability intersects with other devalued social statuses, the likelihood of diminished occupational opportunities and reduced well-being is magnified" (Hammell, 2013, p. 229).

Gerlach (2015) used the term intersectionality, to describe the way social or structural factors and individual characteristics work together in complex

ways to create or sustain marginalisation. Both financial poverty and disability can lead to experiences of isolation and marginalisation, and for people encountering poverty and disability concurrently, the effects of both are heightened. While disability and poverty are separate issues, they are not experienced as separate phenomena. Rather they are experienced simultaneously, and they interact in ways that can make it impossible to determine which phenomenon cause a specific outcome

One example of intersectionality from this research is the way several research participants spoke about the social isolation experienced by their clients. Social isolation was reported to be caused by factors including: age, physical disability, ability or inability to drive, cost of transport, cost of running a vehicle, availability of public transport, accessibility of available transport, accessibility of public spaces, cost of social activities, pressure to conform to social norms, and a myriad of other factors. For an elderly client who is unable to drive, has limited mobility, and is unable to afford private transport, the social isolation they experience cannot be attributed to only one factor, but rather the combination and interaction of factors. For other clients for whom transport is available and accessible, there may be other financial costs involved in social interactions. Clients may have to choose between paying for transport to get to an activity, or paying for the activity when they get there, and thus they may choose, or feel forced, to forgo an activity or social event entirely. Likewise, for a client who is reliant on a wheelchair for mobility, it is not the wheelchair that causes social isolation, but the way in which the built environment impacts community mobility and interacts with other factors such as the cost of specialist transport or the cost of participating in social events, that creates and sustains social isolation.

The interactions and similarities between disability and poverty were frequently discussed during this research. One research participant spoke of the similarities between the way society treats people with disabilities and that way

society treats those in poverty. For people with disabilities, it is not uncommon for society to define them by their disability, expecting them to act in a certain way, often described as the 'sick role'. Agner (2017) described the 'sick role' as a structural barrier that disempowers clients by expecting them to conform to social norms of passivity, compliance, obedience, and adherence to advice from medical professionals. Most people do not choose a sick role; rather they feel pressured to conform to these norms defined by the medical culture that is seemingly in power. These social norms of the 'sick role' are similar to the social expectations often placed on people in poverty. As described in the literature review, there have been major reforms to welfare systems in neoliberal countries around the world, with poverty increasingly viewed as a personal deficit rather than a social issue, and the receipt of welfare viewed as 'dependency'. These changes have also included punitive, stigmatising, and discriminatory approaches to welfare that are harmful, degrading and isolating (Hodgetts et al., 2014). As with the sick role, people who require welfare support are expected to act in certain ways, to be compliant and obedient, and to accept the violence enacted against them. Although there is an expectation of dependency, people in poverty are blamed for their situations and expected to get themselves out of the situation, all while having their behaviour monitored and regulated. It is these very experiences of ongoing marginalisation and disadvantage that compound the challenges faced by people and keep them stuck with little hope for a better future.

Likewise, several research participants spoke of the stigma associated with mental health and the way this marginalises people from mainstream society. This stigma intersects with financial poverty when clients are unable to afford 'typical' activities such as going to the movies, going to a café for coffee, or watching a sports game. This inability to afford activities that are considered social norms can lead to increased marginalisation for many clients. Another participant spoke about the way the outward presentation of clients with

intellectual disabilities can vary depending on socioeconomic background, with a client with a mild disability from a deprived background presenting with a greater level of disability than a client with a moderate disability from a more privileged background. Again, disability interacts with poverty to create different outcomes for different people.

While it would be possible to provide numerous examples from both literature and findings to demonstrate the complexity of the interactions between poverty and disability, that would not fit within the scope of this research. The examples given were used to highlight the complexity of poverty, the intersections between poverty and disability, and the way these intersections intensify the experiences of both poverty and disability.

5.2.2 Culture

Another factor that has significant interaction with poverty is culture. Although culture can be defined in many ways, for the purpose of this part of the discussion, culture refers primarily to ethnicity and ways of being related to ethnic background. As with the interactions between poverty and disability, culture intersects with poverty in unique and varying ways that can both create and sustain marginalisation. In order to understand intersectionality as it relates to culture, it is necessary to remember that "people's experiences of marginalization and health inequities are rooted in broader structures within society" (Gerlach, 2015, p. 251). That is to say that it is important for occupational therapists in New Zealand to understand the broader historical, social and structural contexts in which we live and the way these factors impact on lived experiences and life choices. New Zealand is a country with a history of colonisation, and the impacts of this cannot be ignored when considering current social and political issues such as poverty.

During this research, the effects of colonisation on Maori were poignantly described by research participants. One outcome of colonial practices was that

many Maori had tribal land, and thus their very livelihoods, stolen from them, plunging whole families and tribal groups into poverty. Many Maori had no choice but to relocate to cities in order to find paid employment and support themselves and their families. Not only did the injustice of these colonial practices cause immediate poverty for large numbers of Maori, but many families affected are still battling the impact of colonisation and subsequent poverty several generations later. One injustice (colonisation) led to another injustice (poverty) which leads to or contributes to numerous further injustices including generational poverty, loss of culture and cultural practices, and isolation from family and whanau.

This thesis is not intended to be a thorough discussion about culture and cultural safety. Nonetheless, it is evident that occupational therapists critically reflect on the intersectionality of factors such as poverty and culture, and are aware of the way these intersections contribute to the lived experience of each phenomenon. Although this discussion has highlighted the experiences of Maori in New Zealand, this snapshot barely scratches the surface of the complexity of these issues. Moreover, this focus on the experiences of Maori is also not meant to detract from the multitude of other cultural and ethnic backgrounds in New Zealand and the unique experiences of each person and group.

5.3 Poverty is a reality in New Zealand

The fact that poverty is a reality in New Zealand is not a surprising finding from this research. Much has been written about poverty in New Zealand, and media reports abound regarding poverty in general and detailing the lives of people who are significantly impacted by financial hardship or material deprivation. The purpose of this discussion is not to describe in detail the realities and lived experiences of poverty. Rather the aim is to highlight the similarities between what has been reported in the literature and what was

reported by participants in this research regarding poverty and to demonstrate why and how these specific issues are of significance for occupational therapists in New Zealand. The implications of these issues will also be discussed briefly as a foundation for the recommendations made at the end of this chapter.

5.3.1 Housing

> *…once you've got your house, then you can build your other things. (4)*

According to Maslow's hierarchy of needs, the need for shelter is a basic physiological need. That is, shelter, along with food, water, and rest, are foundational needs that must be met before the higher needs can be considered (Maslow, 1943). The second level of basic needs in Maslow's hierarchy includes the need for safety and security, needs that many would assume could be met through adequate shelter and housing. It may also be assumed that in a country such as New Zealand, all people should be able to have these very basic needs met. Sadly, for many people around the world, including New Zealand, this is not always the case.

Homelessness is an extreme example of ones need for shelter being unmet and is an issue that is addressed by occupational therapists in some areas. Occupational therapy literature about homelessness highlights the importance of safe and secure housing for health and wellbeing and the way homelessness contributes to occupational deprivation, further undermining a person's wellbeing (Chard, Faulkner, & Chugg, 2009; Marshall et al., 2017; Thomas et al., 2017). The literature also discusses the role that occupational therapists can play in addressing issues of homelessness (Finlayson et al., 2002; Roy et al., 2017a; Thomas et al., 2011; Tryssenaar et al., 1999). Although not a primary role for any of the participants in this research, several participants spoke of clients who have experienced homelessness or who were at risk of homelessness. In some practice settings, the research participants were able to work directly with clients to

support them in finding and retaining affordable accommodation, whereas other participants spoke of referring clients on to other services for this support. Consistent with the occupational therapy literature, participants in this study reiterated the importance of housing for health and wellbeing, and the impact of homelessness on occupational participation.

While homelessness is an extreme example of a person not having their need for adequate shelter met, it is not the only manifestation of a lack of shelter or security. One of the most significant poverty-related concerns discussed by participants in this research was the state of housing in New Zealand. If media reports are believed, housing prices in New Zealand have reached an all-time high, there is a shortage of houses available for purchase in New Zealand, and home ownership is out of reach for a large portion of people (Grimes, 2017). Because of the rising house prices, the cost of rentals has also increased significantly leaving many families struggling to afford a place to live. There are also numerous reports about properties in New Zealand, especially rentals, being cold, damp, inaccessible, overcrowded, and unhealthy (Rangiwhetu, Pierse, Viggers, & Howden-Chapman, 2018). As one research participant stated:

> *People's rehabilitation and health outcomes are being compromised in New Zealand…because they don't have adequate housing and shelter, because these houses are cold, damp and unhealthy. (6)*

The physical state of many houses was not the only area of concern for participants in this study. Participants also frequently reported that people's housing situations were not secure and that many clients struggle to find affordable accommodation. At times clients were described as reliant on having several generations of one family living in a single home to cover rental costs. Other participants reported that clients were forced to move out of homes they had lived in and raised their families in for many years as the home was deemed more suitable for a larger family. The transience of some clients was described as a challenge for many participants, as clients could not always be located to

initiate occupational therapy input or to provide necessary follow-up. Because occupational therapists frequently work with clients in their homes or work with clients to return home, the impact of these poverty-related housing issues cannot be ignored.

Inadequate or insecure housing has a multitude of effects on occupational therapy services and the clients receiving those services. When a person is living in an overcrowded environment, and there is limited space available, occupational therapists may have to think of creative ways to engage safely with a client. When a housing situation is unstable, and the client is required to move frequently, the provision of necessary services or equipment becomes challenging. Several therapists spoke of times when locating clients has been difficult due to changing addresses or changing phone numbers. One therapist reported simply turning up at a client's home to action a referral, and another participant reported times of having to return specialised equipment to the provider as the client had relocated as was no longer in the therapist's service area. These are just some of many examples that could be provided of times when the provision of occupational therapy services to clients are compromised by the impact of poverty on housing or living arrangements.

In addition to understanding the practical implications of poor quality housing or transience, occupational therapists should also be aware of potential social and emotional implications. Occupational therapists who are mindful of the emotional and social impacts of an unsuitable or a changing housing situation may be able to better support or assist clients with managing the practical tasks associated with relocation. Therapists may also be able to advocate with and for their clients in finding or retaining suitable housing. In physical health settings, a client may need adaptive equipment needs reevaluated to ensure they are suitable for the new environment. If a client moves to a new area, they may also require support with establishing social networks and navigating the physical community, including accessing public transport options.

5.3.2 Cost of transport

In order to access employment, education, healthcare, food, and many social activities, some form of transportation is required. However, transportation is not always available or affordable for many people. Transport issues may include a loss of drivers licence, lack of public transport, inaccessible public transport, or the financial cost of private transport options. The cost and availability of transport was an issue frequently discussed by research participants. As described earlier in the discussion, poverty and disability can interact with transport issues creating or sustaining social isolation, particularly for older adults who are no longer able to drive. Limited access to transport significantly impacts health and wellbeing outcomes for many people affected by poverty. Limited access to transport can also be a barrier that prevents people from moving out of poverty.

Employment is frequently cited as a pathway out of poverty, but job seeking requires access to resources including transportation (Laliberte Rudman & Aldrich, 2017), and finding work becomes increasingly difficult for people who do not own a car when the available jobs are outside of the areas covered by public transport (Laliberte Rudman & Aldrich, 2016). In New Zealand, Hodgetts, Chamberlain, Tankel, and Groot, (2013) reported that in a sprawling city like Auckland with limited public transport, owning a vehicle is essential, but it is also a significant financial burden. Many people struggle with the costs associated with vehicle ownership, but without a vehicle, many would be unable to retain employment. Similar challenges are faced in rural areas, as there is often no public transport available, and people need to balance the costs of running a vehicle with other necessary expenses (Aldrich & Callanan, 2011).

The cost of transport also contributes to the cost of accessing healthcare. If a person is reliant on public transport for accessing healthcare services, then in addition to the cost of healthcare, they also have to factor in the cost of transport and the time required for using public transport. In a discussion about health

disparities, (Ford, Waring, & Boggis, 2007) spoke about clients delaying healthcare due to the time required to access health services via public transport and the potential loss of income faced when taking time away from work. Likewise, Watson and Duncan (2010) reported that a client referred to rehabilitation services was unable to get there due to having no money for transport and being unable to walk to the clinic. Reports from participants in this research also reflected this. Participants told stories of clients not accessing essential healthcare as they could not afford to get there, or of clients declining services as they could not afford them. While there are many social activities and support groups that occupational therapists may believe would be beneficial to their clients, it can be a challenge for therapists to know if or when to recommended these services if they know that their clients will not be able to afford to pay for them. One therapist spoke about encouraging clients to participate in social groups as part of their wellness plan. The therapist was able to assist with the cost (often minimal costs, such as a gold coin donation) for the first 1 or 2 visits. After this, they were left debating the appropriateness of encouraging these activities when they knew their client would not continue to engage because of the cost, either of the activity itself or the transport to get there on a regular basis.

This ethical dilemma of the impact of funding limitations facing therapists is not unique to this therapist, to this study, or even to therapists in New Zealand. In a study of occupational therapy values held by occupational therapists in Quebec, Drolet and Désormeaux-Moreau (2016) reported that "several participants felt that the current context of limited resources in Quebec does nothing to facilitate compliance with these practice ideas, which reflect their professional values" (p279). The challenge of the availability of resources will be explored in greater depth later in this discussion.

There have been several suggestions made in occupational therapy literature regarding addressing transportation concerns. Hammell (2013, 2015b)

suggests that access to transportation and car ownership is an unrecognised advantage of those from a privileged economic status and social class and that a continued focus on car ownership, driving, and driver retraining perpetuates adherence to an individualistic focus within occupational therapy. Hammell (2015b) proposes that transportation concerns should be addressed at a political and policy level, a sentiment also echoed by Reitz and Scaffa (2013) who suggest consulting with local authorities to advocate for accessible and affordable public transport.

5.3.3 Structural Violence

As described in the literature review, structural violence "denotes methodical and often subtle processes through which social structures disadvantage and harm certain groups of people (Galtung, 1969)" (Hodgetts et al., 2014, p. 3). It is dynamic and multifaceted, occurring at an individual level during face-to-face interactions, and at a systemic level with policies, procedures and report documents. The presence of structural violence in New Zealand has been well documented. Hodgetts, Chamberlain, Groot, and Tankel (2014) provide a thorough description of the state of the welfare system in New Zealand, specifically looking at the changes to the welfare system that occurred between 2007-2013. The descriptions of this period reflect a greater move in New Zealand toward neoliberalism, with welfare structures becoming more punitive and discriminatory, with a focus on personal deficits rather than societal or structural responsibility. The stories told in this research reflect these societal changes. Throughout this research, participants frequently spoke of the challenges many of their clients face when trying to access support services from government organisations such as Work and Income New Zealand (WINZ), Housing New Zealand (HNZ), and Oranga Tamariki (formerly Child, Youth and Family - CYFS). Incidents reported by therapists include services being repeatedly denied, clients not being informed of the supports they were entitled to, an overt security presence targeting specific clients, and clients forced to

relocate to smaller houses to free up a rental house for a larger or younger family. These and other behaviours and organisational structures make it difficult for clients to access the services and supports they require. All the participants in this research reported these types of incidents; they are not isolated occurrences. Likewise, a study by Drolet and Désormeaux-Moreau (2016) reported that "most of the participants believed themselves to be at the service of individuals who at some time were victims of injustice" (p. 277).

The issue this raises for occupational therapists is about where they fit within these systems and structures. While it can be easy to point the finger at other professionals or organisations that take this punitive approach to welfare and support services, it is vital that occupational therapists take the time to consider their place in this system. Are occupational therapists contributing to their client's experiences of structural violence, or do they actively work to combat this in their practice? While it is not possible to change the behaviour of someone else, it is possible for therapists to support and advocate for their clients when they are encountering structural violence. It is also important for occupational therapists to reflect on personal attitudes and values, and consider how these could contribute to an experience of structural violence. One situation where occupational therapists may inadvertently contribute to a client's experience of structural violence is when the occupational therapist is in a position of being a gatekeeper for a limited resource. The ethical nature of the gatekeeper role will be explored in greater detail later in this discussion.

5.4 Poverty is part of everyday occupational therapy practice

As stated at the beginning of this discussion, one of the most significant findings from this research is that occupational therapists are engaging with poverty in a variety of ways in a wide range of practice settings, not through new and novel approaches to occupational therapy practice, but simply as part of

what they do every day. In fact, it could be said that engaging with poverty is what occupational therapists do. For the participants in this research, and, for therapists in most practice areas, it would be rare for financial poverty to be the primary reason for referral to occupational therapy services. Nonetheless, poverty is a significant concern for many recipients of occupational therapy services.

Occupational therapists largely work with people who lack the resources required to enable engagement in purposeful and meaningful occupations. This means that as part of the assessment process, occupational therapists want to know what resources, both intrinsic and extrinsic resources, a person has available, or what specific barriers they are encountering. Thus poverty, including financial poverty, is simply one of many factors that are considered as part of occupational therapy assessment and intervention.

> *"So it is something that I've always assessed…I've always thought about what the person's resources are and tried to think of interventions that will work with that." (9)*

Likewise, the strategies or interventions used with clients whose lives are impacted by sometimes extreme financial poverty are the same strategies used in the absence of poverty. Although the strategies used may require some adaptation to suit the situations of clients impacted by extreme financial poverty, the basic strategies remain the same. As demonstrated in the findings, occupational therapists use a range of strategies when engaging with poverty. For the purpose of this discussion, four main strategies will be explored: occupational performance skill training or life-skills training; therapeutic use of self; partnership; and advocacy.

5.4.1 Occupational Performance Skills Training

According to the World Federation of Occupational Therapy (WFOT), "The primary goal of occupational therapy is to enable people to participate in

the activities of everyday life" (World Federation of Occupational Therapy, 2011). Thus it is not surprising that participants in this research frequently spoke about working with clients to teach and re-learn skills required for participation in life. The skills discussed were many and varied depending on the practice area of the therapists, and included cooking and nutrition, budgeting and financial management, using an EFTPOS card, job seeking, work readiness, assertiveness training, sleep training, use of adaptive equipment, navigating social services, symptom management, and numerous other skills. These are not new, or novel approaches to occupational therapy practice, nor are these approaches used only with those clients experiencing poverty. They are simply part of the occupational therapy role. Nevertheless, these approaches can have a significant impact on individual experiences of poverty and may be effective responses for poverty reduction in some situations.

In a systematic review of occupational therapy interventions with homeless people, Thomas, Gray, and McGinty (2011) "demonstrated the effectiveness of occupational therapy in providing interventions that increase employment and education prospects, money management, coping skills, and leisure activities" (p. 38). Likewise, the findings of a scoping review of occupation based practices for homelessness "indicate that health and social service providers, in particular, occupational therapists, have implemented a variety of practices that aim to enable and support the occupations of persons experiencing or at risk of homelessness" (Roy et al., 2017b, p. 105). Strategies aimed at occupational performance skills training, or life-skills training, included financial management, pre-vocational training, food and nutrition management, health and safety management, home management, social skills, and community participation. This review also highlighted the need for occupation-based assessments and goal setting with clients to ensure that interventions target the needs and goals identified by individuals (Roy et al., 2017b). Not all homeless people have the same experiences or the same needs, and the same is true for

those experiencing poverty. For clients who have identified needs regarding life-skills training, then these strategies are appropriate and may be effective for reducing homelessness or experiences of poverty.

While occupational performance or life-skills training is a necessary and effective strategy for individuals with identified needs, an individual approach does not address the social or structural barriers that create and sustain poverty. Therefore, life-skills training is simply one tool, not the only tool, that occupational therapists can and should use when engaging with poverty.

5.4.2 Therapeutic Use of Self

One of the most powerful and accessible tools an occupational therapist has is themselves. When interacting with clients, it is not possible to leave self behind. For this reason, it is important that occupational therapists learn to use themselves and their experiences in a way that maximises the therapeutic relationship. According to the New Zealand Occupational Therapy Board Code of Ethics, occupational therapists must "ensure that people receiving their services feel safe, accepted, and are not threatened by actions or attitudes of the therapist" (p .4). In order to do this, occupational therapists need to be aware of their own attitudes and actions and how they may be perceived by others.

Throughout this research, participants frequently spoke about the importance of listening to their clients in order to build trust in the relationship so that the clients could feel safe to share the issues that were of most concern to them. It was acknowledged that developing this level of trust takes time. Whakawhanaungatanga, the process of building relationships, was identified as an especially important part of any interaction with Maori clients, and also clients from Pasifika backgrounds. This time spent building relationships provides a foundation upon which assessments and interventions can then take place. This is not a process that is unique to Maori and Pacific cultures, or to New Zealand occupational therapists. In a study about occupational therapy values, Drolet

and Désormeaux-Moreau (2016) reported that "participants favour active listening and are attentive to clients' and families' discourses" (p. 276), as a way of upholding human dignity. When using active listening strategies with clients impacted by poverty, occupational therapists not only uphold human dignity, but they also provide a safe environment for clients to reveal concerns that they might otherwise have been unwilling to talk about. The true extent of a client's poverty may remain hidden from occupational therapists and other health professionals if this atmosphere is trust is not well established.

In addition to using active listening skills, occupational therapists also bring their personal beliefs, values, and experiences into the therapeutic environment. In this research, participants frequently spoke of personal or family experiences of poverty and other hardships, and they reported that their experiences often gave them greater empathy for their clients. The occupational therapist who has been on the receiving end of the structural violence imposed by social services such as WINZ is far more likely to advocate for their clients who are being victimised by these systems. The therapist who has experienced periods of unemployment and financial hardship may be more understanding of the challenges faced by those desperately looking for and unable to find work. Those who have grown up in families that have been impacted by financial poverty and hardship for generations understand how difficult it can be to overcome the multitude of barriers that perpetuate the poverty cycle. Yet, it is vital that occupational therapists reflect on their own experiences and values, that they consider how their experiences and values differ from the values and experiences of their clients and begin to articulate the way in which these differences can positively or negatively impact the therapeutic relationship.

The influence of personal experiences and the impact they have on a therapist's engagement with social issues such as poverty is an important finding from this research. The existing literature regarding poverty and related issues such as homelessness and unemployment appears to focus primarily on what

occupational therapists do, that is the specific strategies and interventions used. The personal motivation of therapists has been relatively unexamined. When exploring the relationship between occupation and social class, Beagan (2007) reviewed and analysed essays from occupational therapy students who identified as being from low-income families or having lived in poverty prior to entering university. This research is a great reminder of the importance of recognising and reflecting on class-based values in health and educational settings. It also highlights some of the diversity of experiences present in the occupational therapy profession. What was not explored was the way in which experiences of social class impacts on professional practice. One of the recommendations made was to explore "the practice patterns of therapists from working-class backgrounds" (Beagan, 2007, p. 133), but to date, it does not appear that research of this nature has taken place.

5.4.3 Advocacy

In the literature review, advocacy was described as one of many strategies that occupational therapists can use to address issues of poverty. Likewise, participants in this research frequently spoke of instances in which they have advocated with and for their clients, and advocacy was described as an important part of the clinical role. Because advocacy has been highlighted as such a significant part of the occupational therapy role in both previous research and this current research, it is important to examine what advocacy is, and how occupational therapists can use advocacy to engage with issues of poverty. Although advocacy was discussed in the literature about poverty, it was primarily referred to as one of the many tools that occupational therapists use when engaging with poverty; thus specific literature about advocacy was not included in the literature review. Subsequently, to explore what advocacy means for occupational therapists, additional literature is required to further this discussion.

Advocacy has been identified as a way that occupational therapists can put their values into action, and as such is described as a professional imperative (Kirsh, 2015). Drolet and Désormeaux-Moreau (2016) expand on this by explaining that not only is advocacy important, it "is part of the daily routine of many occupational therapists" (p. 278). While advocacy is now commonplace in occupational therapy practice, it has not always been this way. Tannous (2000) argued that occupational therapists could not be true advocates for their clients due to a conflict of interests between client needs and organisations that employ occupational therapists. It was suggested that the term 'spokesperson' be to describe the way occupational therapists can "defend people's rights and promote greater life opportunity" (Tannous, 2000, p. 45), thus allowing advocacy to be a truly independent role.

Despite this early criticism of the place of advocacy in the occupational therapy role, advocacy is more widely accepted, and indeed, expected within occupational therapy practice today. The role of advocate is included as a professional enablement skill in the Canadian Model of Client-Centred Enablement and is identified by the Canadian Association of Occupational Therapists (CAOT) as a competency required for being a change agent (Dhillon, Wilkins, Stewart, & Law, 2016). Likewise in New Zealand being an advocate is included in the professional competencies for registration (Occupational Therapy Board of New Zealand, 2015b). However, there has been a lack of consistency and clarity around defining advocacy within occupational therapy (Dhillon, Wilkins, Law, Stewart, & Tremblay, 2010). Occupational therapists can advocate with and for clients, or for the profession, and they can advocate for individual needs (cases), or advocate to address wider social and structural issues (causes) that prevent occupational engagement (Dhillon et al., 2010, 2016; Kirsh, 2015). From this research, it appears that occupational therapists primarily advocate with and for their clients, often working to give their clients their own voice so they can continue to advocate for themselves when the occupational therapist is

no longer present. One frustration reported by therapists in the study by Dhillon et al., (2016) was that the occupational therapist had more power to advocate for clients' needs than the client themselves. This frustration was evident in the statement that "some clients did not have a voice while others had a voice that was not being heard" (Dhillon et al., 2016, p. 349), and this was a sentiment reflected by participants in this research about poverty. While the participants in this current research encouraged clients to advocate for themselves, they also worked with their clients to ensure their voices were being heard in a way that could be understood and accepted. It seems that there were times when therapists deemed it necessary to step in and advocate for their clients in order to see results, but participants also believed that it should not have to be this way.

When it comes to applying the research about advocacy to the issue of poverty, it is important to recognise the different levels at which advocacy can occur. Case advocacy focuses on the needs of an individual, and like life-skills training, can be effective in addressing specific concerns for individuals or small groups. In order to make a significant difference to the issue of poverty advocacy related to specific causes is likely to be more effective. Rather than occupational therapists advocating with multiple clients about the same system level problem, it may be more effective to advocate for change to occur at a systemic or structural level (Dhillon et al., 2016). As Kirsh (2015) said, "if we want to succeed at the individual level, we will need to find innovative ways to address these fundamental causes" (p. 216).

Although the need for advocacy is generally accepted within occupational therapy, there is less certainty about how to actually be an advocate, and specifically about advocating for causes rather than individuals. Throughout this research on poverty, there was a sense that many participants wanted to make a more significant difference with regards to poverty, but there was uncertainty about how this could be done. In response to the uncertainty expressed by Canadian occupational therapists about how to actually advocate effectively,

Boniface and Anand, (2018) have begun to publish a series of articles in Occupational Therapy Now with specific instruction regarding how to advocate effectively. As of the writing of this thesis in early 2019, no further articles were available in this series, but occupational therapists wanting to develop advocacy skills are encouraged to seek out these articles as they become available.

The first step for occupational therapists wanting to become advocates, it to understand what they are advocating for, and they need to be able to articulate why they should advocate about a specific issue. Occupational therapists "focus on the client's occupations or meaningful activities, and this is the unique contribution they provide on interprofessional teams" (Dhillon et al., 2010, p. 246) with regard to advocacy. Any advocacy that is being done from an occupational therapy perspective should involve advocating for equitable occupational opportunities for all people. Because poverty has been identified as a social construct that inhibits occupational engagement, then issues relating to poverty are worthy of an occupational therapist's advocacy.

5.5 Engaging with poverty is congruent with occupational therapy values

The findings of this research demonstrate that engaging with issues of poverty within occupational therapy is congruent with occupational therapy values. In addition, adherence to espoused occupational therapy values necessitates engagement with poverty and other related social issues. For example, an occupational therapist who truly values occupational engagement will recognise that financial poverty limits opportunities for engagement, and will thus seek ways of addressing or minimising the barriers to engagement. Examples from the findings will be used to demonstrate the relevance of these values, and also some of the challenges that occupational therapists face when attempting to engage with poverty in ways that are congruent with their values

in settings that may not support working in this way. There will also be some discussion about how these values may conflict at times when therapists are engaging with issues of poverty or social justice.

Before a discussion about the congruence of occupational therapy values and engagement with poverty can occur, it is important to establish what is meant by 'values' and to specify which values will be discussed. In this context, values refer to principles or standards of behaviour and more specifically, principles that are related to morals or ethics. A study by Drolet and Désormeaux-Moreau (2016) reported on the values of occupational therapists in Quebec, Canada. This study identified that there are numerous values reported in occupational therapy literature and key documents. It then went on to describe the values reported by French-speaking occupational therapists in Quebec. Although there may be significant disparities between French-speaking occupational therapists in Canada, and English-speaking occupational therapists in Aotearoa/New Zealand, the values reported in this study by Drolet and Désormeaux-Moreau (2016) were chosen to guide this discussion, as they are values reported by occupational therapists themselves, rather than values promoted by key documents or registering bodies. These values included: autonomy; human dignity; occupational participation; social justice and equity; professionalism; holism; partnership; the environment or ecological approach; solicitude; and honesty and integrity.

While the list of values provided by Drolet and Désormeaux-Moreau (2016) is not an all-inclusive list of values for occupational therapists globally, it provides a starting point for considering how occupational therapy values are congruent with engagement with poverty. Not all of these values can be discussed in this research; thus the values most relevant to poverty or the values most often reflected in the research findings have been selected for further discussion here. Those values are occupational participation; client-centred practice; holism; solicitude; and social justice and equity.

5.5.1 Occupational Participation:

Of all the values espoused by occupational therapists, a belief in the benefits of occupational participation or occupational engagement is the most important. A focus on the importance of purposeful and meaningful occupation is the unique contribution of occupational therapy in health and social settings. Therefore, it is not surprising that this value is frequently spoken of in occupational therapy and occupational science literature. "Despite the disparity of opinions in the literature on occupational therapy values, one value stands out as common to most…occupational participation" (Drolet, 2014, p. 8). Likewise, occupational participation, or a lack of occupational participation, was a frequent topic of conversation in this research.

> *There's a huge need, a huge occupational need that human beings have…I see people having very few options…[they] are often really occupationally disadvantaged through their life experience. (7)*

Financial poverty was described as limiting or preventing participation in meaningful occupations for many clients.

> *I suppose it's occupational deprivation due to lack of funds (9)*

A lack of occupational engagement or a lack of opportunities for occupational engagement was considered to be a form of poverty.

> *I'm also absolutely certain that there's occupational poverty as well. (4)*

Occupational engagement, especially engagement in employment and educational activities, was described as a way of overcoming the effects of poverty or even providing a pathway out of poverty.

> *Education and employment are the 2 biggest pathways out of poverty for everybody really. (4)*

It is this belief in the importance of occupational participation and the recognition that poverty creates barriers to participation, that gives emphasis to the importance of poverty in occupational therapy practice. Recent research by Leadley, (2018) highlights the way that financial poverty and material deprivation in families disrupts and impoverishes children's patterns of occupation. Children who grow up in poverty experience restricted participation in social activities, occupational choices and opportunities are constrained, and they experience stigma and social exclusion. Bringing an occupational perspective to the discourse about child poverty, or poverty in general, is one way for occupational therapists to advocate for opportunities for occupational engagement for all people.

Although this unique focus on occupational participation is important, occupational therapists and occupational scientists have been challenged in the literature to examine categorisations of and assumptions about occupation critically. It has been argued that current typological categorisations of occupations are culturally specific and class-bound, and exclude certain occupations, and that experiential categorisation may be a less exclusionary alternative (Aldrich et al., 2014; Hammell, 2009a, 2009b). Examples of occupations that are not addressed in current categorisations of occupation include survival occupations such as resource seeking (Aldrich et al., 2017), food provisioning (Beagan et al., 2018), and occupations that are considered unhealthy, illegal, deviant (Kiepek, Beagan, Laliberte Rudman, & Phelan, 2018). The omission of these types of occupations from current conceptual frameworks is problematic when engaging with issues of poverty. For people with limited incomes, the occupations involved in seeking resources such as financial support, health care, and food are time-consuming and likely to prevent people engaging in other occupations that they consider meaningful or valuable (Aldrich et al., 2017). Likewise, food provisioning and preparation tasks with limited income require planning and creativity in order to overcome significant barriers (Beagan

et al., 2018). It is important that these survival occupations are recognised by occupational therapists when engaging with poverty, as they are likely to impact on a clients ability to engage with therapy.

Occupations that are considered unhealthy, deviant, illegal, or otherwise non-sanctioned are also important to consider in the context of poverty. In the existing literature, these non-sanctioned occupations are often discussed as being in need of remediation (Kiepek et al., 2018). During this research, some occupations or behaviours were discussed that were considered non-sanctioned. It was suggested that providing ways for clients to engage in healthy and socially acceptable occupations, such as sports, may work to reduce the likelihood of disengaging from society and engaging with non-sanctioned activities, such as gang membership. There was also some level of acceptance of unhealthy activities, such as smoking, when it was acknowledged that clients might not have any other forms of enjoyment in their lives. Thus, although occupational therapists value and promote occupational engagement, further thought is needed about the way occupations are categorised and which occupations are considered worth researching. The relationship between occupational participation and poverty is a complex one, and further research about this complexity is likely to assist with an effective occupational therapy response to poverty.

5.5.2 Client-centred practice

While client-centred practice is upheld as an ideal in occupational therapy, the reality is often far more challenging. A frequent topic in this research was participants wanting to give power to their clients. The expressed desire to give power back to their clients implies a realisation that clients do not have the power to make decisions in some aspects of their life. It may be that there is a recognised power imbalance in the therapeutic relationship, or it may be that the therapist recognises that the client has so little control in their life that they want to give them power in something.

In an ideal world "decisions about participating in activities should be made by clients" (Drolet & Désormeaux-Moreau, 2016, p. 276), however, research participants identified that a lack of financial resources constrains the choices a person is able to make.

> *It would be nice to be able to give people more control…Because they don't have the means or the money to make decisions for themselves (1)*

Participants also reported that the recommendations they make to clients regarding therapeutic input could be influenced by a client's financial poverty. One participant spoke about wanting to engage clients in community groups and other social activities as part of their wellness plans but was reluctant to do this when it was clear that the client would not be able to pay even the small entry fee to many of these groups. Although the occupational therapist identified activities that a client would benefit from engaging in, the options were not always presented to the clients. Situations such as this challenge the notion of client-centred practice. It could be assumed that for client-centred practice to occur that a client needs to be presented with all available options so they can make an informed, but it could also be argued that presenting unrealistic options to a client is not client-centred either.

It is not only the financial poverty of clients that constrains occupational therapists attempting to practice in a client-centred manner. Service poverty or funding criteria can be a significant barrier to practice. "Our role is to meet the client and allow them to fulfil the potential they've identified, not the one we or the system want, but what they want" (Drolet & Désormeaux-Moreau, 2016, p. 276). The challenge faced by occupational therapists when attempting to work in a client-centred way when also in the role of gatekeeper to a limited resource will be further explored later in this discussion.

5.5.3 Holism

Holistic occupational therapy practice "takes into account every dimension of the person, including emotional, cognitive, physical, and social considerations" (Drolet & Désormeaux-Moreau, 2016, p. 278). Occupational therapists consider and treat the whole person, and also pay attention to the client's environment. Financial poverty is part of the context and environment of a person's life, and should thus be of concern to occupational therapists. In addition, occupational therapists also need to understand the social and political climate and the impact this has on experiences of poverty. If occupational therapy interventions are to be adapted to "the unique features of each client, and to the meaning clients assign to interventions and daily activities" (Drolet & Désormeaux-Moreau, 2016, p. 277), then consideration needs to be given to the social and structural factors that enable or constrain occupational participation. As has been discussed regarding intersectionality, personal, social, and structural factors intersect in complex ways to create or sustain poverty. Thus these broader systems that are at work in a person's environment need to be considered.

Occupational therapists can also use themselves to practice in a holistic way. This research has highlighted the way that occupational therapists use their heart, head, and hands when engaging with poverty. This could be viewed as a component of the therapeutic use of self discussed earlier, or it could be a way of expanding this idea of the therapeutic use of self. Whereas therapeutic use of self is primarily concerned with the therapeutic relationship and the impact of this relationship on occupational engagement (Taylor, Lee, Kielhofner, & Ketkar, 2009), the process of using the heart, head, and hands when engaging with poverty also implies the inclusion of these processes in clinical reasoning and decision making, not just in interactions with clients.

5.5.4 Solicitude

Solicitude is described as occupational therapists "being touched by clients and placing himself in their place in order to better understand and help

them" (Drolet & Désormeaux-Moreau, 2016, p. 279). This value placed on solicitude could also be said to underpin the use of strategies such as the therapeutic use of self. The importance of solicitude was evident throughout this research, and particularly in the way therapists engage with poverty with their 'heart'. Participants in this research discussed the importance of compassion, and how personal experiences of poverty gives a much greater level of empathy for their clients. Personal experiences with structural violence in social services inspire them to advocate for their clients to ensure their needs are met.

Participants spoke of how these experiences of empathy in their professional roles also impact their personal lives and the way they interact with others. Several participants spoke of being engaged in community activities in their free time, visiting elderly who experience isolation at home, involvement in political rallies regarding the cost of housing, among other things. Participants also spoke of using their own time and resources to benefit their clients, going over and above what is expected to ensure the best care for clients. Several participants also spoke about taking the learning from their experiences at work and using these to teach empathy and acceptance of diversity to their children and other family members.

This focus on solicitude in both their personal and professional lives is consistent with research on values of occupational therapists in Canada. Drolet and Désormeaux-Moreau (2016) reported that "a concern for benevolence, an altruistic inspiration – in short, a great degree of solicitude – drove the participants" (p. 279), and also noted the privilege that occupational therapists have when they establish helping relationships and have meaningful interactions with clients. When engaging with clients, especially those whose lives are impacted by poverty, it is helpful to remember that entering into a therapeutic relationship is a privilege. Otherwise, as Gerlach (2015) said:

> In our genuine intention to ''do good'' in our work with ''marginalized populations,'' there is a risk that our intent and actions are tacitly

> underpinned by a position of superiority as we focus on ''needs'' and ''problems'' rather than people's agency, resistance, and capabilities. (p. 249)

Solicitude is important when engaging with clients impacted by poverty, but as described, it is not without difficulty, and thus occupational therapists should be aware of their own thoughts and attitudes that influence solicitude.

5.5.5 Social Justice and Equity

As was seen in the discussion about advocacy "many participants see themselves as defenders of their clients' rights, especially their occupational rights" and "most of the participants believed themselves to be at the service of individuals who at some time were victims of injustice" (Drolet & Désormeaux-Moreau, 2016, p. 277). It is this belief in justice and equity that inspires occupational therapists to advocate with and for their clients. Participants in this research appeared to be informed by a social justice perspective.

> *I guess the big stuff for us is around this occupational inequality that comes out of poverty. (7)*

While some participants used language that is consistent with social justice and occupational justice not all participants used this language. Yet they all described situations with clients that were examples of injustice, and they all acted in ways that demonstrated a desire to see justice for their clients.

5.6 Poverty creates ethical dilemmas for occupational therapists

There are numerous ways that issues related to poverty can be conceptualised. In the occupational therapy and occupational science literature, issues of poverty are frequently discussed within a framework of occupational justice and occupational rights. This language is useful for occupational

therapists as it situates poverty and its related issues firmly within the occupational therapy role. However, the use of this language is not without difficulty. As already demonstrated in this discussion, the language of social justice and occupational justice is not consistently used by occupational therapists in practice. In addition to this, the language of occupational justice may be viewed as professional jargon, and the terminology may mean different things to people outside of occupational therapy.

Issues of poverty that impact on occupational engagement could also be described as ethical dilemmas. Throughout this research, participants frequently spoke of challenges they grappled with when they worked with clients in poverty. These challenges were included but were not limited to issues such as the financial or material deprivation experienced by clients, limited resources in health services, criteria that excluded clients with needs from necessary services, and professional or role-specific boundaries.

5.6.1 Challenge of being a gatekeeper

Within most roles, occupational therapists have access to resources that their clients need. These resources may be in the form of equipment, time for assessments or intervention, knowledge of other professionals or providers, funding for equipment and services, or other professional skills. However, in most services the supply of time and resources is finite, and therapists are required to make decisions about allocation of resources. At first, it may appear that occupational therapists have an important or privileged role with this ability to make decisions about the allocation of resources; however, with this privileged and powerful position comes great responsibility. Although a majority of occupational therapists do not deliberately choose this gatekeeper role, they have a professional mandate to "provide services in a fair and equitable manner" (Occupational Therapy Board of New Zealand, 2015a). Because there is a finite pool of funding and resources available they face situations where they are forced to decide who will receive services and who will not. Even if they do not have

the final say about the allocation of resources, the information they provide to others may hold great weight in allocation decisions.

For therapists making decisions about allocation of resources, there are many factors to be considered. Because time and resources are finite, the utilitarian ethical ideal of the greatest good for the greatest number is often a guiding principle in decision making. However, this also needs to be balanced with the management of risk. The allocation of resources to one person may mean there are inadequate resources for the next person, leaving them at risk of harm. When a clients safety is compromised due to funding a resources limitation, occupational therapists have an ethical responsibility to "advise key personnel when resources are insufficient to allow for safe, adequate, equitable service provision" and also to "document identified unmet needs and the actions that are taken to address these needs" (Occupational Therapy Board of New Zealand, 2015a).

In many situations, occupational therapists report that eligibility criteria for services and support work to remove decision making power from them. The therapist's job then is to answer questions about eligibility honestly, to advocate for justice, and then allow the funding system to decide who receives services. Participants in this research reported that this is not always easy. There are times when a therapist can see that a client does not meet the eligibility criteria for a specific support or service that would make a significant difference to their health and wellbeing. One example discussed in relation to this was about elderly clients requiring a community services card in order to be eligible for home-help services. While a need for thresholds in place for receiving services is generally accepted, this is difficult for those people whose income may be only a few dollars about the threshold leaving them ineligible for home-help yet unable to pay for it themselves. While clients with limited finances often struggled the most, participants in this study often reported that they were not the ones most demanding of resources. Several therapists reported that clients with the most

resources at their disposal were more likely to demand services and demonstrate a sense of entitlement to receive the services they deem that their tax dollars have paid for in previous years. Likewise, these therapists also reported that clients with the least resources were the least demanding of services, even though they are the ones who would most benefit from then. In contrast, there were reports from some participants of clients with limited resources being very demanding of and reliant on services.

5.6.2 Underground Practices

A significant ethical issue that emerged from this research was the use of 'underground practices'. The phrase, underground practice, was first used in occupational therapy by Fleming and Mattingly (1994) to describe the dilemmas that occupational therapists encounter when there is a conflict between their professional values and the medical model in which they work. When attempting to balance a phenomenological approach that treats the person in a holistic manner, and a biomechanical approach that is accepted and funded, the "disjunction between what therapists do and what they report to others can put therapists in a difficult position" (Fleming & Mattingly, 1994, p. 296). Although there has been a shift in occupational therapy since these underground practices were first described, and there is more acceptance of a phenomenological approach to occupational therapy, underground practices still remain, even if they are not described using this terminology.

Dhillon et al., (2010) reported that advocacy may be controversial and that this controversy can lead to advocacy becoming an 'underground practice'. There was mixed evidence regarding this within this current research. Participants frequently spoke about advocating with and for their clients. Although advocacy was described as something they do, there remained a sense of uncertainty regarding the place of advocacy within their role. Regardless of this uncertainty, none of the research participants suggested that they would cease to advocate with and for their clients.

Another example of an underground practice that was a feature in this research was therapists using their own resources, including financial, material, and time resources, to meet client needs when these needs would otherwise be unmet by the service. Participants reported buying and donating second-hand resources to the craft groups they run, loaning technological devices to clients for weekend use, or purchasing small items required to meet clients needs. These practices are not exclusive to occupational therapy, but participants also spoke of other staff within their organisations also doing what they felt was needed to meet the needs of clients. These practices were described as 'going the extra mile' or simply 'doing what I can', yet they remained somewhat hidden as they were often aimed at meeting client needs that were not perceived to be valued by the dominant medical model in many services.

The process of sourcing and donating materials to a service to enable a continuation of group interventions could be described as a creative approach to working around structural barriers in a context of service poverty. Yet these creative approaches are not without risk. If occupational therapists and other staff consistently donate their own time and resources to a service, then the true financial cost of a service may remain hidden from those who provide funding. Thus further funding is unlikely, and services will continue to struggle with limited finances, and staff will continue propping up the services with their own resources. Then again, if therapists approach the funding provider for resources, then there is the risk that those resources will be denied, or services may be opened to scrutiny potentially leading not only to denial of resources but also service cutbacks.

While it is understandable, and perhaps even justifiable, why some practices within occupational therapy remain hidden, a continuation of underground practices limits the ability to bring significant change. As with advocacy, if individual occupational therapists continue personally addressing the needs of individual clients, then structural barriers to service provision are

likely to remain hidden or ignored and thus continue unchanged. Uncovering and verbalising these previously underground practices is likely to cause discomfort as boundaries are challenged and the way things are done is subject to critique. But this discomfort is necessary to bring systemic change to meet the needs of the clients who are disadvantaged by poverty and structural barriers. In discussion with fellow students, the comment was made that if occupational therapy practice is consistently pushing the boundaries, then perhaps the boundaries are in the wrong place. The way these boundaries or barriers that define occupational therapy practice can be changed is by making known that which was previously hidden, being proud of the contribution of occupational therapy, and remembering that temporary professional discomfort will ultimately be for the good of the disadvantaged or marginalised people we serve.

5.6.3 Managing Safety and Risk

During this research, several participants described actions that they have taken in the face of extreme poverty that could be interpreted as significant safety issues for occupational therapists. Stories were told of occupational therapists spending time talking with clients in a vehicle when the home environment was so overcrowded that meaningful conversation was not possible. Other participants told stories of the challenges they face trying to contact clients to action new referrals, and that sometimes they simply turn up at a clients home unannounced when they are unable to access up to date contact information for a client. While these strategies can be effective, they are not without risk. These situations are not unique to working with clients impacted by poverty, but it seems that they are more likely to occur in conjunction with poverty. An overcrowded home environment is more likely to occur in situations of poverty. Transience or lack of a phone is also symptomatic of financial poverty. As with all client interactions, occupational therapists need to be aware of potential safety concerns and take necessary precautions to ensure safety.

5.6.4 Managing conflicting values

Earlier in the discussion, the congruence between occupational therapy values and engagement with poverty was described. This discussion also highlighted the challenges that occupational therapists sometimes face when their values conflict, or where there is a conflict of loyalty to the client, their professional or personal values, and the organisations for which they work.

An example of the need for managing conflicting values was highlighted by the discussion about occupational therapists being gatekeepers. The desire to be a good steward of resources, to ensure equitable distribution of resources and services, and to maximise the benefit of a limited resource may appear to be in incompatible with the value of occupational engagement. This challenge of balancing resources and professional values was also reported by Drolet and Désormeaux-Moreau (2016) who stated that in their research"several participants felt that the current context of limited resources in Quebec does nothing to facilitate compliance with these practice ideas, which reflect their professional values" (p. 279). Maximising allocation of limited resources is likely to mean that some clients miss out on services, or they receive a bare minimum service, which compromises a clients' ability to engage in meaningful occupations. However, if large amounts of resources were given to one client to maximise their occupational potential, then other clients may miss out on services completely. Understanding the values at play in these situations would assist an occupational therapist in making and articulating clinical decisions. An occupational therapist who has made a conscious decision to prioritise a specific value or values will have greater confidence in the decisions they make. The ability to make these decisions consciously and confidently requires occupational therapists to examine the values they uphold and to critically reflect on whether their practice is truly congruent with espoused values. Where there is a mismatch between espoused values and actual practice, further critical

examination is likely needed to determine the cause of this mismatch and to devise possible solutions.

5.6.5 Strategies for managing ethical tensions related to poverty

> *"one way to improve professional practice is to take the time to think about what one is doing and to reflect critically on one's attitudes, decisions, and actions. (Drolet & Désormeaux-Moreau, 2016, p. 278)*

When therapists continuously encounter ethical dilemmas in their practice, strategies are needed for reflecting on and working through these dilemmas. One strategy that was frequently spoken about by the participants in this research was the use of clinical supervision. Participants spoke of using supervision to review clinical decisions to be sure they could justify what they had done, and especially when they questioned whether they could offer the same level of service to all their clients. Supervision was used to gain reassurance regarding decisions made previously, or to seek guidance for decision making. Formal supervision was not the only strategy used. Some participants also reported discussing ethical issues with colleagues or taking issues to management if required. While not a significant finding related to poverty, it was interesting to note that formal supervision was reported as a strategy used by less experienced therapists, whereas more experienced therapists were more likely to discuss issues with colleagues in an informal manner. Participants working in more traditional or mainstream occupational therapy roles also reported more ethical issues that required discussion with others. The reasons for this were not explored, but it is possible that the flexibility of non-traditional roles may have reduced the dilemmas faced by participants.

It is not uncommon for occupational therapists to face barriers in their work environment that prevent them from living up to their professional values and ideals (Drolet, 2018), and this appeared to be particularly true for

occupational therapists engaging with poverty. Thus it is important for occupational therapists to have strategies in place for managing their response to ethical dilemmas or they will be at risk of moral distress and burnout.

5.7 Implications for practice

Poverty is a widespread issue in New Zealand, and it will be encountered by all occupational therapists in all practice areas. The question is not if poverty will be encountered, but what the response will be. First and foremost, occupational therapists need to understand the complexity of poverty and the intersectional nature of poverty, disability, culture. Occupational therapists also need to be aware of and be able to engage meaningfully in the broader societal and political discourse about poverty. Occupational therapy does not hold any type of monopoly when it comes to addressing social issues such as poverty, so it is important that there is an ability to understand other perspectives and work with other professionals in meaningful ways.

Engaging with poverty should be, and is already a part of our practice. It is not something new that is just being discovered within occupational therapy; it has been part of the profession from the beginning. A lot is already being done in relation to poverty in existing occupational therapy roles, yet there is still more that could be done. The need is not for something new, but rather for expansion of what is already being done.

When engaging with poverty, occupational therapists engage with their whole selves and there is a need to understand the implications of this. It will be difficult or painful at times, so processes and supports need to be in place to ensure occupational therapists are not overwhelmed by the enormity of the issue or paralysed by moral distress.

Engaging with poverty will highlight ethical issues regarding service poverty, unjust funding criteria, conflicting values, underground practice, and a

multitude of other issues that cannot be adequately addressed in this thesis. If these issues are to be addressed, it is essential that occupational therapists find ways to articulate these issues clearly and to advocate for the change required to ensure justice for all clients.

If occupational therapists want to enact their values of enabling participation in occupation, then the social and structural barriers to participation cannot be ignored. In order to defend the rights of the disadvantaged and the marginalised occupational therapy needs to be very clear about it has to offer and why the profession is positioned to offer it. This is likely to require ongoing examination of professional and personal beliefs and values.

5.8 Recommendations

Engagement with poverty is a fundamental part of occupational therapy and the effects of poverty influence day to day practice. Acknowledging and accepting the central role of poverty in practice is important if occupational therapy is to be involved in social and political endeavours to eradicate poverty globally. The following recommendations incorporate what has been learnt from the literature and the participants in this research, and propose actions that can be taken by individuals, groups, organisations, and the occupational therapy profession to promote justice for people whose lives are impacted by poverty.

5.8.1 Challenge our thinking about poverty

The first step in bringing change is through challenging our thinking about poverty, about occupation, and about the impacts of poverty on occupational engagement. The need to challenge our thinking is not a new or isolated recommendation within occupational therapy or occupational science. The need for critical thinking about categorisations of occupation has been suggested by several authors (Aldrich et al., 2014, 2017; Hammell, 2009a, 2009b; Kiepek et al., 2018; Laliberte Rudman & Aldrich, 2017). Critical thinking about

culture and cultural diversity has also been promoted (Beagan, 2015; Gerlach, 2012; Hammell, 2011, 2013, 2015c).

This discussion has highlighted the complexity of poverty and some of the ways poverty can be understood and conceptualised to give emphasis to this complexity. Gerlach (2015) proposed integrating intersectional analysis into critical thinking in order to create "an intellectual space for occupational therapists, albeit a more complicated one, to examine and disrupt our normative assumptions and to provoke a more complex, contextualized, and nuanced understanding of people's occupational realities and their lived experiences of marginalization and inequity" (p. 250). This would encourage critical reflection on both personal and professional values and assumptions regarding poverty and deprivation, which is essential if we wish to make progress in this area.

> **Recommendation 1:** Encourage critical reflection about the relationship between occupation, poverty, deprivation, and marginalisation in occupational therapy practice, and challenge personal and professional assumptions and values about these issues.

5.8.2 Strengthen professional discourse about poverty

The next step in bringing change will require challenging not only the way in which we think about specific issues but also challenging the way we talk about and discuss these issues. One way this could begin is through purposefully sharing stories of the challenges we face in practice related to poverty. These stories could be shared informally, through conversations with both occupational therapy colleagues and other professional colleagues. The stories could also be shared formally, in the form of in-service presentations, conference presentations blog posts, articles in professional magazines, or journal articles.

The frameworks that we use to inform our thinking also need to be reflected in the language that we use in our professional discourse. The language used to discuss issues of poverty and deprivation should be chosen intentionally

to reflect the values and assumptions that we hold. Intersectionality has been proposed as one way of complicating and framing our thinking about poverty, and this could also be incorporated into our discourse (Gerlach, 2015). The language of social justice and occupational justices has been an evolving conversation within our professional discourse (Durocher, Gibson, et al., 2014; Durocher, Rappolt, et al., 2014; Hocking, 2017; Townsend & Wilcock, 2004; Wilcock & Townsend, 2000), and should be further strengthened and incorporated into everyday, practice-based discourse.

Another way that our discourse could be shaped regarding poverty is through an ethical framework. Drolet and Hudon (2014) developed and promote the use of the Quadripartite Ethical Tool (QET), to assist the integration of ethical knowledge into ethical analyses and reasoning. The QET combines three ethical theories – utilitarian, deontological and virtue ethics – with professional values. This is a framework that would be of considerable value to occupational therapists who want to articulate issues related to poverty as ethical issues. An increased understanding of ethical theories would assist with communicating how and why poverty creates ethical dilemmas. Framing poverty as an ethical issue may be a way to stimulate and facilitate conversation about poverty and its impacts on occupational therapy, both within occupational therapy and with other professionals that we work with.

Engaging with discourse about poverty outside occupational therapy will be essential for bringing change. Occupational therapists need to be familiar with the language and the discourse about poverty in society and in the local political arena. It is only by knowing the conversations that are occurring around us that we can be prepared and willing to engage with these conversations, to make out professional knowledge and expertise known in a way that can be understood and accepted. Engagement with the social and political discourse about significant social issues such as poverty needs to be modelled by the professional association and regulatory bodies. But this social and political engagement is not

the sole domain of the professional bodies. Every occupational therapist has the ability, and indeed the responsibility, to engage in these conversations for the benefit of their clients and their profession.

> **Recommendation 2**: Sharing or publication of more practice-based stories about engaging with poverty to showcase the tireless work of occupational therapists in addressing significant social and structural barriers to participation.
>
> **Recommendation 3:** Practice an intentional use of language to frame poverty-related issues as ethical issues or as issues related to justice.
>
> **Recommendation 4:** Occupational therapists to seek understanding of the wider social and political discourse surrounding significant issues such as poverty, and then to use this understanding to engage in the political conversation, or to initiate such conversations in their workplaces.

5.8.3 Expand our practice to tackle poverty in a greater way

While critical thinking and intentional use of language regarding issues of poverty are important, these alone will not bring significant change. Throughout this research process, both during the interviews and in casual conversations with occupational therapists at conferences, it seemed that occupational therapists wanted more than a language to explain why poverty is an issue they can take some ownership of; they also wanted some guidance about how to engage with poverty within the constraints of their work environments. While providing a list of specific ways that occupational therapists can or should engage with poverty in practice is outside the scope of this research project, some broad recommendations can be made regarding advocacy and engaging with poverty-related issues at a policy or political level. These ideas are not new or unique to this research but are suggestions that have already been made in the occupational therapy and occupational science literature. These suggestions are not about developing an entirely new skill set or moving into new roles, but

rather expanding the work that is already being done, and utilising existing skills in a wider range of situations.

Advocacy has been a topic that has been explored throughout this research. Participants in this research spoke of times they have acted as advocates for their clients. It is a topic that has received some attention in the professional literature (Dhillon et al., 2010, 2016; Tannous, 2000) and has been labelled as a 'professional imperative' (Kirsh, 2015). In New Zealand, advocacy is included in both the Code of Ethics for occupational therapists and in the Competencies for Registration and continuing practice (Occupational Therapy Board of New Zealand, 2015a, 2015b). Yet there appears to be some uncertainty regarding how to be an advocate and how to advocate effectively for clients and the profession, as is evident by the series of articles being published by the Canadian Occupational Therapy Association to provide practical education regarding advocacy. If advocacy is going to be promoted as a professional imperative and included in key documents regarding ethics and competency, then it is essential that occupational therapists have the skills, or receive the training and support required to achieve this goal. Any training provided regarding advocacy could also be useful for occupational therapists who wish to engage at a political level or influence policy decisions.

Poverty is not an individual issue but comprises a range of individual and structural factors that work together. Thus an individual approach to poverty reduction will be ineffective long-term. To bring about significant change to the state of poverty in New Zealand, structural barriers need to be addressed. One way that occupational therapists can engage with issues of poverty at a political level is by being aware of significant issues or reforms that are occurring around the country, and by making submissions to the appropriate authorities regarding these proposals. Occupational therapists may also choose to be involved in policy development or revision within the organisations they work for. Most large organisations have systems in place for reviewing policies on a regular

basis, and involvement in these processes should be achievable for many occupational therapists.

Another suggestion that was highlighted during this research was about shifting occupational therapy practice from working solely at an individual level to also working at population levels.

> *It's really important that systems change the way they operate with communities that have experiences of poverty, and that their ability to make decisions, their ability to run their communities, their ability to find new solutions must be put first. Because I believe people know what they need, and that, actually if systems sat down and listened to what people thought they needed they'd probably think that we can do that so let's do it. (4)*

While it is not likely that all occupational therapists can, or should, work at a population level in their practice, expanding beyond the individualistic focus that has characterised occupational therapy practice for many years is vital effectively addressing poverty. This need has begun to be addressed in occupational therapy and occupational science literature, but more work is required in this field, and the discourse needs to move beyond ideals and into practical applications of these ideals.

> **Recommendation 5:** Ensure that all occupational therapists have the skills required to be advocates for clients and the profession, and to engage with significant issues at a policy level or a political level. One way this could be achieved is through providing opportunities for learning and practising these skills at both undergraduate and post-graduate levels, and offering training opportunities for practising occupational therapists wishing to expand their skill set. The occupational therapy profession in New Zealand may also choose to learn from our Canadian colleagues,

either by making use of the articles they are writing or by publishing our own series of articles relevant to a New Zealand context.

Recommendation 6: If occupational therapists are to engage at a political level by making submissions to local and national authorities about issues that are significant to occupational therapy, then training about how to write submissions may be of benefit.

Recommendation 7: Occupational therapists are encouraged to seek opportunities to engage at a population level rather than solely with individuals. Occupational therapists who have these opportunities should be encouraged to write about the practical aspects of these undertakings so that other occupational therapists can learn from these experiences, and apply the learning to their own practice areas.

5.8.4 Evaluate our responsiveness to poverty

At the beginning of this discussion, it was acknowledged that there are numerous similarities between the response to poverty demonstrated in this research and Tronto's approach to care ethics (Tronto, 1998). What the findings of this research have been unable to demonstrate is evidence of responsiveness or the effectiveness of occupational therapy approaches to poverty. There is evidence that occupational therapists are engaging with issues of poverty in their practice, but there was limited information provided regarding the response of clients to the interventions provided. In order for occupational therapy to be able to provide competent and effective occupational therapy for people impacted by poverty, some evaluation of services and approaches is required, and the clients perspective must be considered.

Recommendation 8: In order to assess the effectiveness of occupational therapy interventions with people impacted by poverty, outcome measures need to be developed to capture the clients' experience of occupational therapy interventions. Outcome measures may also be used

to monitor change in specific poverty-related indicators, including those directly addressed by occupational therapy, and issues peripheral to occupational therapy interventions.

5.9 Further Research

This research should be replicated with a larger number of participants, with attention paid to the difference between practice areas, age, years of experience, and the impact of culture on poverty. Further research focused on engagement with poverty within specific services or practice areas may also be of benefit. This would enable research findings to be generalised to a wider range of occupational therapy practice areas.

One issue that was identified both before and during this research is a limited amount of information regarding specific strategies that occupational therapists in New Zealand use when engaging with poverty. While this research has provided some information about this, the focus of this research has been more on the how and why of engaging with poverty, than detailing specific approaches. In order to gain a depth of understanding about specific strategies, research about specific services that provide unique occupational therapy services to people impacted by poverty would of great benefit.

This research described a process of occupational therapists engaging with poverty using their hearts, heads, and hands. Because this research was carried out in New Zealand, it cannot be assumed that occupational therapists in other countries also engage with poverty in this way. Testing this theory both with a wider audience in New Zealand and with occupational therapists around the world could add to an understanding of the processes of engaging with significant social issues such as poverty.

Finally, this research looked specifically at occupational therapists and their perceptions of the way in which they engage with poverty in their practice.

Research that explores the client perspective of poverty and the occupational therapy role in managing poverty-related issues would be a particularly valuable addition to the understanding of poverty in New Zealand. Recommendations have been made regarding the development of outcome measures that evaluate the effectiveness of occupational therapy interventions with people living in poverty. The development of outcome measures should be based on research with clients to ensure that the correct indicators are measured, and any outcome measures developed could then form the basis of further research.

5.10 Strengths and Limitations of the Study

There are strengths and limitations inherent in all research, and this study is no exception. The purpose of qualitative research is to understand the participants' experiences of a specific phenomenon, in this case, engagement with poverty in their practice. This research had a small sample size, and because of the sampling techniques used, it is likely that the results show some bias, as the occupational therapists who volunteered to be part of this research were those who are particularly sensitised to poverty in their practice. However, this research has been presented at several times throughout this research process and has seen a high degree of resonance with others in the profession, which indicates that the findings may be transferable within New Zealand.

Another feature of this research project that is both a strength and a limitation is that participants in this research came from a wide range of practice areas and geographical locations in New Zealand. This was a strength of the study as it provided a broad overview of the issues facing the occupational therapy profession in New Zealand. It was also a limitation as the findings included a range of topics leading to breadth rather than depth in the analysis. The participants in this research also had significant differences in years of practice experience, and the impact of years of practice was not directly

investigated in this research. Although two of the research participants were relatively recent graduates, all of the participants were older than the researcher, so all had more life experience than many new-graduate therapists. It is unknown if younger therapists would report different reactions to issues of poverty, or why no younger occupational therapists volunteered to participate in this research. The perspective of younger, new graduate therapists or even occupational therapy students would be valuable in the future.

This research was completed within a masters programme, and thus by a novice researcher, which may have impacted on the research process and analysis of findings. The timeframe for the research was significantly longer than initially planned, which can be both a strength and a limitation. The longer timeframe meant that there were approximately 18-months between data collection and final write up of this thesis, which created some distance between the researcher and the initial findings, but has allowed a lot more time for immersion in the data and reflection on the implications of the findings. As described briefly in the literature review, there were some limitations in the literature review process. The literature review was not a systematic review, and the literature sourced was based on what was available through the Robertson Library service. Because of the researchers limited but continually growing knowledge of the breadth of poverty-related literature, it is possible that some relevant works were not included in this research. Because of the timeframes over which the research occurred, new literature relevant to the topic was published during this time, and the literature review required some revisions to accommodate findings from the new literature.

5.11 Conclusion

This chapter has explored the research findings in greater depth and linked these findings with existing occupational therapy and

occupational science literature. The claim was made at the beginning of the discussion that engagement with issues of poverty is congruent with occupational therapy values and thus part of the occupational therapy scope of practice. The discussion focused on analysing these claims and linking the research results with relevant occupational therapy and occupational science literature. Recommendations have been made regarding the need to critically evaluate occupational therapy beliefs about poverty, to use this critical thinking to strengthen the occupational therapy discourse regarding poverty both within and outside of the profession. Further work is needed to expand occupational therapy practice to address poverty in a comprehensive way, and then research is necessary to determine the effectiveness of the approaches implemented.

The final chapter will summarise and conclude this thesis.

Homelessness is not an option for my parents; I will not allow it.

After much discussion, we have been able to purchase a home to rent to my parents. It is such a relief to know that they have somewhere safe and secure to live and that they have a home for the future.

This makes me wonder about others in the community who do not have such support. I want to be able to help others too, but it's not possible right now.

I guess my parents aren't really so poor after all. They may not have much money, but they have so much else, including family who loves them and is willing to make sacrifices for them.

Chapter Six. Conclusion

This research has explored how occupational therapists engage with poverty in their practice. It was not an exploration of specialist practice areas relating to poverty, but instead, looked at occupational therapists from a range of generalist and more specialised practice areas. The research question developed from my own enquiring about the roles that occupational therapists can, and do, play in addressing poverty, a significant social issue in New Zealand. Initially, there was a temptation to try to imagine a new occupational therapy service to address the issues in my local community. After searching the occupational therapy and occupational science literature for answers, it became apparent that before something new could be done, it was necessary first to understand what is already being done. It was also decided that the research would not focus on occupational therapists working with specific populations or age-groups, but would be a cross-section of therapists from a variety of settings. While a focus on one specific practice area would likely have given depth to the understanding of poverty in that area, the aim of this research was to provide a broad understanding from a range of practice areas and perspectives; thus a diverse sample was sought and included in this research.

An Interpretive Description method for qualitative research was selected for this research. Interpretive description developed in the field of Nursing and is a method that is suited to research questions based on clinical practice. The applied nature of Interpretive descriptive research was well suited to the research question which sought to understand not only what occupational therapists do in relation to poverty, but also the how and the why behind their actions. Ethics approval for this research was received from the Otago Polytechnic Ethics Committee and from ethical approval was also received by OTNZ-WNA through which recruitment occurred.

The findings of this research confirm that occupational therapists in a range of practice areas around New Zealand can and do engage with issues of poverty in their everyday practice. Poverty is not a specialist issue but is simply part of the daily role of therapists. Occupational therapists engage with poverty using their hearts, heads, and hands – that is they engage by understanding and empathising with clients, they grapple with the ethical and moral issues they see caused by poverty, and they use their hands to act in practical ways to address individual, social, and structural barriers to occupational participation. Each of these facets of engagement is indispensable; they may manifest individually, sequentially. or simultaneously. There is not one right way to engage with poverty; instead, it is an ongoing process that engages the whole person and changes and develops over time. These findings formed the basis of the discussion about the everyday nature of engagement with poverty, the specific skills that occupational therapists employ when engaging with poverty, and the ethical nature of poverty. Engaging with poverty is congruent with occupational therapy values, although these values can be challenged or appear in conflict at times.

This research celebrates the significant work that occupational therapists are doing in relation to issues of poverty in their existing practice. However, the work cannot stop here. While occupational therapists are doing significant and commendable work across the country, and indeed around the world, there is still much to be done. In order for occupational therapy to have a meaningful role in the eradication of poverty globally

We must critically examine our thinking about poverty and our role in addressing social and structural barriers to occupational engagement. We have a duty to expand our practice to encompass work not only with individuals but with families and whanau, with communities. It is not about doing something entirely new, but rather expanding the things we already do well, and implementing these strategies with more people and in more places. Finally, we

need to be intentional about the language we use when discussing social issues such as poverty. As we strengthen the discourse within our profession, we also need to be aware of the wider discourse happening in society about poverty and ensure that the language we use can be understood and integrated into the broader social and political discourse. Our language needs to demonstrate our unique contribution to the discourse about poverty – that is, we bring an occupational perspective. As we challenge our thinking, expand our practice, and strengthen our discourse, when then need to have the courage to take our contribution to a world that needs what we have to offer.

There is a song that has been going around in my head throughout this research process, and it seems like the perfect way to conclude this thesis.

"Now that I have seen, I am responsible

Faith without deeds is dead

(Albertine, by Brooke Fraser)

My faith is the foundation upon which I build my life. I believe that one way I can work out my faith and my love for God is through loving others and taking practical action to address the needs of those around me.

I saw the plight of my parents, and I took responsibility.

I have seen the struggles facing so many in my community. I have been trying to do what I can, but now it is time to do more.

Through this research, I have seen the challenges facing my OT colleagues as they encounter poverty in their daily practice.

They have taken responsibility, they are doing so much, yet I sense there is a yearning to do more.

I have seen their struggles, and my first responsibility from this research is to support and encourage my colleagues in their endeavours.

Now that I have seen, I am responsible.

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Appendices

Appendices to be included:

1. Ethics approval from Otago
2. Recruitment email
3. Participant information sheet
4. Consent form
5. Interview guide
6. Narrative with preliminary concepts
7. Individual interviews with development of themes
8. Compiled themes from whiteboard exercise
9. Whiteboard photo dated 24.08.2017
10. QUIRKOS screenshots
11. Whiteboard photo dated December 2018 – findings, literature and discussion

Appendix 1. Ethics Approval

3 February 2017

Heidi Cathcart
School of Occupational Therapy
Otago Polytechnic
Forth Street
Private Bag 1910
Dunedin

Dear Heidi

Re: Application for Ethics Consent
Reference Number: 701
Application Title: *Occupational Therapy and Poverty*

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

The review panel has considered your revised application including responses to questions and issues raised. We are pleased to inform you that we are satisfied with the revisions made and confirm ethical approval for the project.

Many thanks for your careful responses to our recommendations.

We wish you well with your work and remind you that at the conclusion of your research you should send a brief report with findings and/or conclusions to the Ethics Committee. All correspondence regarding this application should include the reference number assigned to it.

Regards

Liz Ditzel
Deputy Chair, Ethics Committee
Otago Polytechnic

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Appendix 2. Recruitment email

Recruitment letter

To be emailed via the OTNZ-WNA

Dear occupational therapist

I would like to invite you to participate in a research project about how occupational therapists in New Zealand engage with issues of poverty. Over the past few years the issue of poverty has been gaining increased attention in the media as a rapidly growing social issue in New Zealand. If poverty is a growing problem in New Zealand, then that must mean that a growing number of our clients are also living with the effects of poverty. Yet, there is limited information in the Occupational Therapy and Occupational Science literature about how occupational therapists in New Zealand are engaging with this significant social issue.

We are looking for research participants who are currently working as occupational therapists in New Zealand, and who identify that some, or all, of their clients have been impacted by poverty in some way. If this is an issue that has ever affected you or your clients then we want hear from you. Participation in the project will involve a semi structured interview where you will be asked to reflect on the issue of poverty as it relates to your occupational therapy practice. This can be carried out either face-to-face, or over the phone, depending on your location

This research project is being carried out as part of a Masters in Occupational Therapy though Otago Polytechnic.

If you are interested in taking part in this research project, please email Heidi Cathcart by Monday, 26th June 2017, with details of your area of practice.

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

Heidi Cathcart (researcher) pendeha1@student.op.ac.nz or 027 323 7191

Or

Dr Mary Butler (supervisor) mbutler@op.ac.nz

Otago Polytechnic
School of Occupational Therapy

Appendix 3. Participant information sheet

Occupational Therapy and Poverty

Participant Information Sheet

General Introduction

Poverty is a significant social issue, and one that has been gaining increased attention in the media in New Zealand in recent years. Despite the increased attention on poverty, there is little information about poverty and deprivation in New Zealand within the occupational therapy and occupational science literature. This study aims to better understand the relevance of poverty to occupational therapists in New Zealand, the ways in which occupational therapists are currently engaging with issues of poverty, and explore if there are new ways to engage with issues of poverty within occupational therapy practice.

What is the aim of the project?

- To better understand the issue of poverty from an occupational therapy perspective
- To understand how occupational therapists in New Zealand are engaging with issues of poverty within existing roles.
- To explore new ways for occupational therapists to engage with issues of poverty in New Zealand.

What types of participants are being sought?

I am looking for occupational therapists who are currently registered and working in New Zealand.

What will my participation involve?

If you agree to take part in this project, you will be invited to participate in an interview lasting approximately 60 minutes. Interviews will predominantly take place via phone or Skype or face-to-face (depending on location). Following your interview, you will be provided with a summary of your interview to check for accuracy.

How will confidentiality and/or anonymity be protected?

All personally identifying information will be removed from research findings to ensure confidentiality and anonymity of research participants, clients, and workplaces.

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

Interviews will cover a range of topics, including but not limited to the following:

- Work history and current employment
- Experiences of working with clients in poverty, both past and present
- How poverty affects engagement in therapy
- How poverty affects engagement in occupations
- How awareness of poverty has shaped your practice

Interviews will be digitally recorded, and these recordings will be stored on the researcher's laptop computer which is password protected.

This project is for a Master's Thesis. The final thesis will be available to the public via Otago Polytechnic. Results of this project may also be published in academic journals or conferences 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 in such a way that only those mentioned below (researcher and supervisor) will have access to it. All digital data, including recordings of interviews and interview transcripts, will be stored on the researcher's laptop which is password protected. Any hard copies of transcripts will be stored in locked filing cabinet when not in use. Participants names and any other identifying information will be removed from transcripts, and pseudonyms will be assigned. Once de-identified and member checked, a digital copy of the transcripts will be forwarded to Otago Polytechnic to be kept in secure storage for 5 years from completion of research. Hard copies of transcripts will be shredded following completion of this study.

What if I change my mind and want to withdraw from the project?

You can decline to participate without any disadvantage to yourself of any kind. If you choose to participate, you may withdraw from the project at any time, without giving reasons for your withdrawal. You can refuse to answer any particular question, or ask for the audio recording to be turned off at any stage. Following the interview, you will be sent a summary of the discussion, and at this time you will have the opportunity to review, amend, or remove any of the information you have supplied.

What if I have any questions?

If you have any questions about the project, either now or in the future, please feel free to contact either:
Heidi Cathcart: pendeha1@student.op.ac.nz, 027 323 7191

or: Dr Mary Butler: mbutler@op.ac.nz, 03 4796073/0273077667

Any additional information given or conditions agreed to will be noted on the consent form.

Appendix 4. Consent form

Consent Form

Occupational Therapy and Poverty

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

I know that:

- My participation in this project is entirely voluntary and I am free to refuse to answer any particular question.
- I am free to stop participating at any time without giving reasons and without any disadvantage.
- I will be emailed a summary of the discussion following the interview, and will be provided with the opportunity to review, amend and/or withdraw information at this point if I so choose.
- The data (i.e. digital recording) will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for five years after which it will be destroyed. If it is to be kept longer than five years my permission will be sought.
- The results of the project will be published in the researchers Master's Thesis which will be available via Otago Polytechnic, but my anonymity and confidentiality will be preserved.
- The results of the project may also be published in academic journals or presented at conferences, but again my anonymity and confidentiality will be preserved.

Additional information given or conditions agreed to:

I agree to take part in this project under the conditions set out in this consent form and in the participant information sheet.

..... *(signature of participant)*

..... *(date)*

..... *(signature of researcher)*

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

Appendix 5. Interview guide

INTERVIEW GUIDE

- Name
- Age (specific age, or age range?)
- Years of practice as an OT (specific or range?)
- Current place of employment (public, private, community, not-for profit. Health/education/etc. What about urban/rural settings?)
- Job title/Position (OT or generic role?)
- Years in current position/with current employer (may have worked for same employer for many years, but held a variety of roles in the organisation)
- Description of service you work in
- Description of your role – types of things you do in a typical day
- Description of the types of clients you work with

Questions about poverty

- In what ways do you encounter poverty in your role as an occupational therapist?
- Are there any cases that stand out in your memory?
- How have these experiences shaped your practice?
- How is poverty affecting the people you work with?
- Describe the impact of poverty on the people you work with regarding:
    - Ability to participate in chosen occupations
    - Ability to engage with therapy
    - Impact of poverty on experiences of disability
    - Impact of disability on experiences of poverty

Appendix 6. Narrative interview report examples

Interview1

This interview was carried out with an occupational therapist working in an acute home visit role. This role involves carrying out home visits with clients either in the acute wards or those who had been discharged from the acute wards in the previous 6 weeks. Clients come from anywhere in the district health board area, so includes urban, small town, and rural locations.

This therapist identified that most of her clients are dealing with some form of poverty in their lives, and the poverty is usually financial. She also identified social isolation as a form of poverty for many clients. The social poverty, or social isolation, was identified predominantly with regard to older people and was often made worse by financial poverty. For example, for an elderly person who has lost their drivers licence, and is reliant on a WINZ benefit, they may struggle to get out of the house and use public transport due to frailty, and then often cannot afford to pay for a taxi or other private transport options. This means they are not able to engage in their community, and at times may not engage with suggested support services.

Housing was also identified as a major concern in a lot of cases, and this has been further complicated post-earthquake as houses are even more difficult to come by. There have been significant changes in social housing in the past year or so, which also impacts many clients. This therapist reported that due to the housing shortages, some clients who have been in Housing NZ properties for many years have been told they have to move into a new, smaller property to enable a family to move into the larger property. These housing challenges were identified as a way in which many clients have a loss of control over their situation.

A challenge faced by this OT was the use of the "Impact on life Questionaire" that is used by the Ministry of Health to determine eligibility for funding for equipment and housing modifications. Some clients report managing well and thus do not receive assistance that the OT identified as potentially beneficial. Part of this questionnaire also asks if clients have a community services card, as without a community services card they are not eligible for certain supports. The assumption here is that if a clients income exceeds a certain level then they would be able to pay for supports, but this is not always the case, especially when a client's income may be only $5 over the threshold.

Another challenge faced by this OT with regards to the funding criteria for supports was that some clients, often those reliant on benefits, not understanding the need to apply for funding for supports such as equipment or housing modifications. Some clients assume that they should be entitled to the supports. Challenges with regards to the eligibility criteria were also identified with regard to the MoH definition of disability and that people with chronic health conditions, such as morbid obesity, do not qualify for funding for supports.

This OT expressed frustration that some clients choose to smoke rather than paying to get their prescription medications. She can often see how much a person needs their medication, but also acknowledged that for some clients smoking is the only thing left in life that gives them some enjoyment.

This therapist spoke of using supervision to discuss and debrief difficult cases and to get reassurance that she has done everything possible for her clients. Supervision was seen as very important for this therapist. Clear and thorough documentation was also seen as essential. And this OT spoke of referring on to other professionals and other services to get supports for clients when this was outside of the OT scope of practice.

This OT said that what she would most like to achieve is being able to give control back to the client she works with. In so many ways they have control taken from them, and she would like to be able to put the control back in their court.

Interview 7

This interview was carried out with an Occupational Therapist who is the coordinator for a mental health resource centre which evolved out of a clubhouse model programme. Clients accessing this service are adults who have had contact with mental health services and where mental illness (not addictions or intellectual disability) is a primary concern. This OT is also the professional advisor for mental health occupational therapy in the local DHB.

In this interview the reflections on what is being seen with regards to poverty was woven in with descriptions of how and why the service is addressing some of these needs. The primary concern identified by this therapist was the limited choices available to those living in poverty, and these choices are further limited for those also living with a significant mental illness. To address the issue of limited choice, the service tries to assist people to get opportunities to meet their social, recreational, vocational, and educational goals in more affordable ways. One example was of this was taking clients on an annual fishing holiday to a nearby location. This is a trip that has been part of the service for over 20 years now, and the OT said that *"every year at least one or two people have an "Aha!" moment, which I think is like something of a turning point for them. They go, "Oh my God, I can have a life. Oh my God, there is a chance to not be caught up in this terrible drudge of mental illness and poverty.""*

We all make choices everyday about what we spend our money on, but for people with mental illness and poverty, they have such limited money available that their choices are significantly limited. The occupational injustice of this was highlight, saying that people simply don't have the opportunities that many of us take for granted.

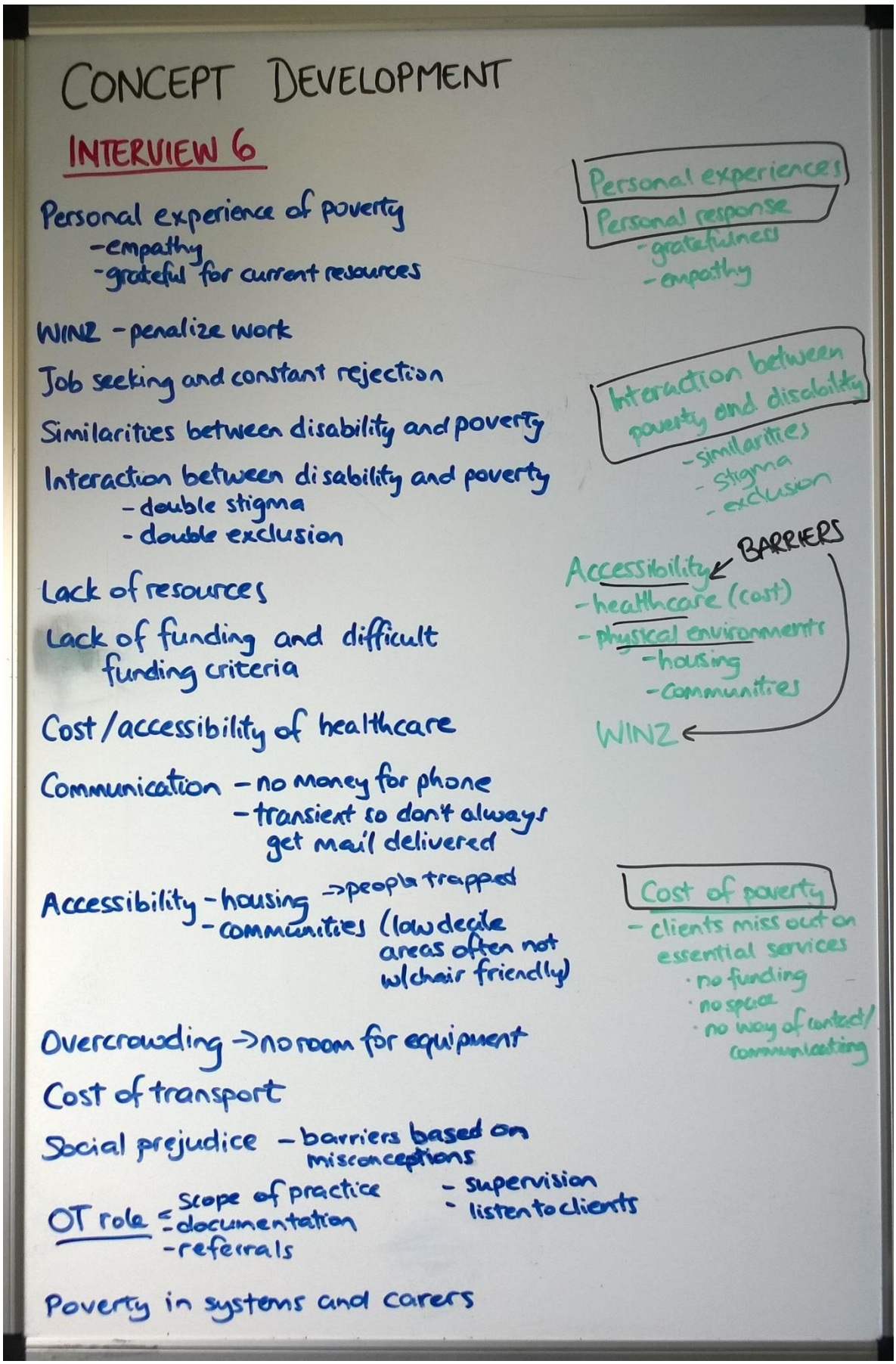
The OT described the service as being resource rich, meaning that they are able to provide transport to enable people to attend the programmes, as public transport in the area is limited and expensive. There was some inequity identified as the service is based in a large geographical region, so this service is not accessible to everyone in the area.

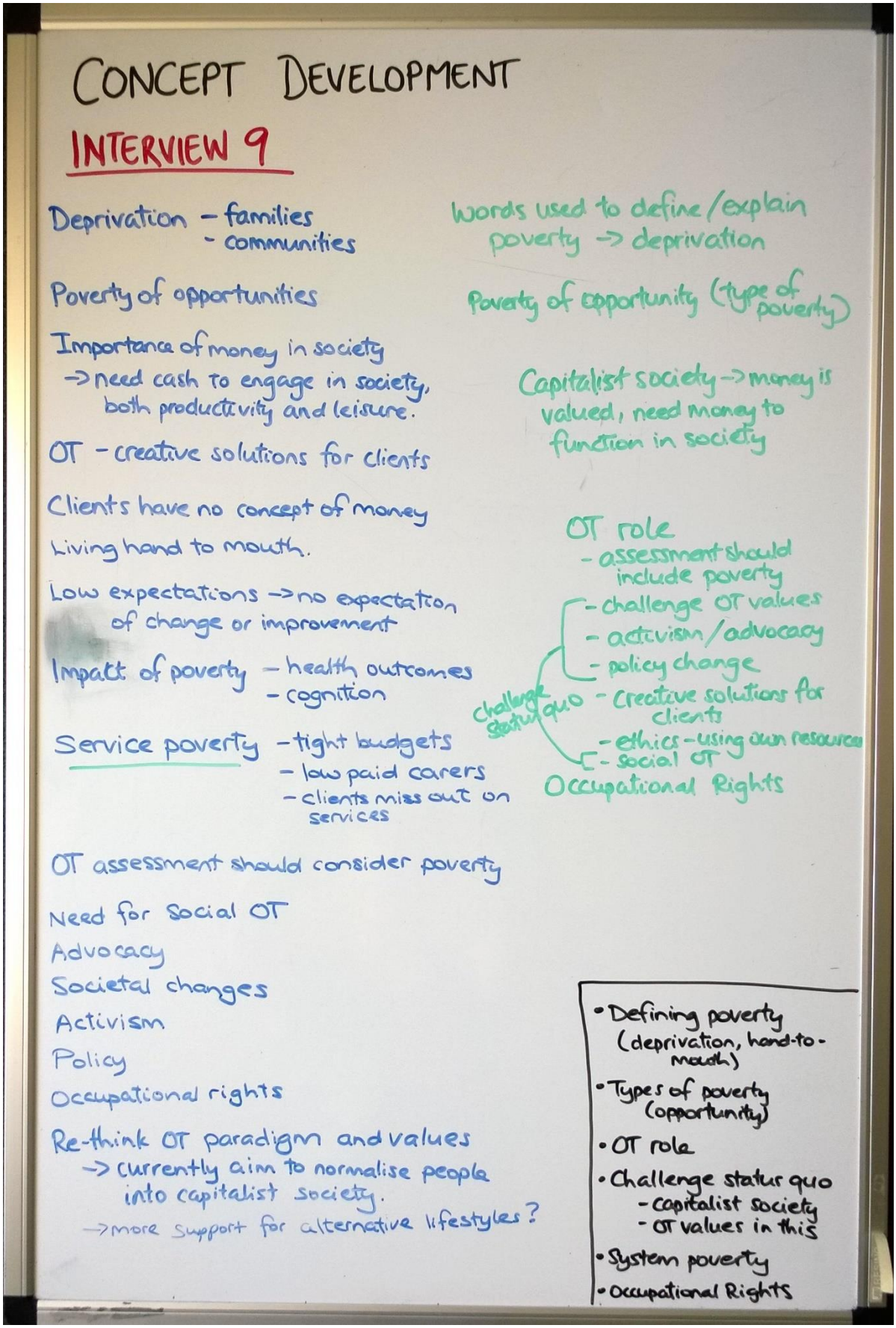
The issue of employment and the difficulty that many mental health clients have in holding down employment was briefly discussed. The OT believed that if the issue of employment was addressed then the issues of poverty would be resolved in many cases.

This OT also expressed an interest in nutrition and the impact of poor nutrition on poor health outcomes. This is a significant issue in mental health where a lot of medications cause increased hunger, and many clients buy cheaper food as they are looking for bulk in food rather than quality. This is an area of concern that is being investigated in the service to see what education can be provided.

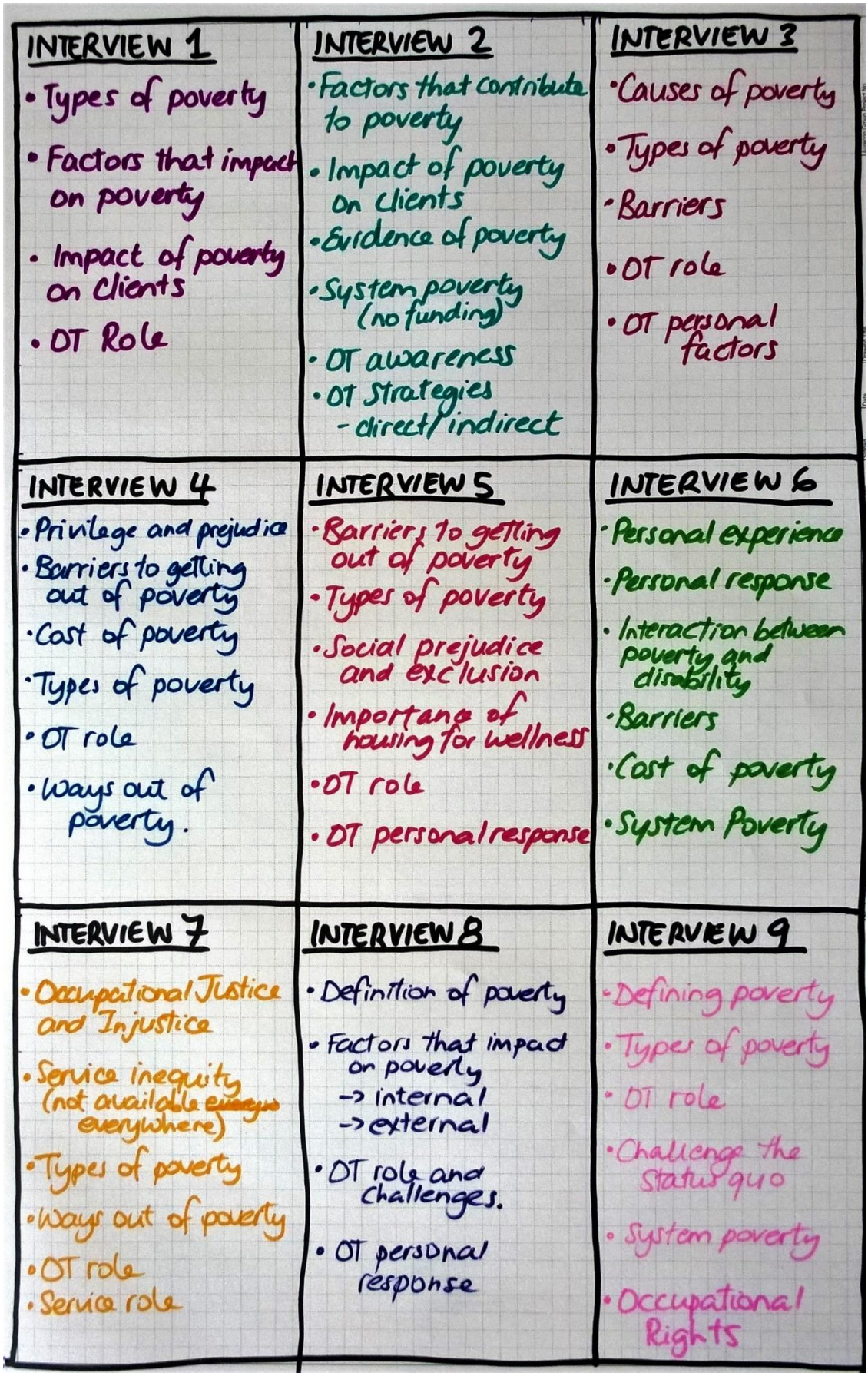
There are no simple answers to addressing the issues of poverty, especially within mental health, and this OT thought that throwing more money at the problem would be unlikely to resolve it.

Appendix 7. Conceptual interview scheme examples

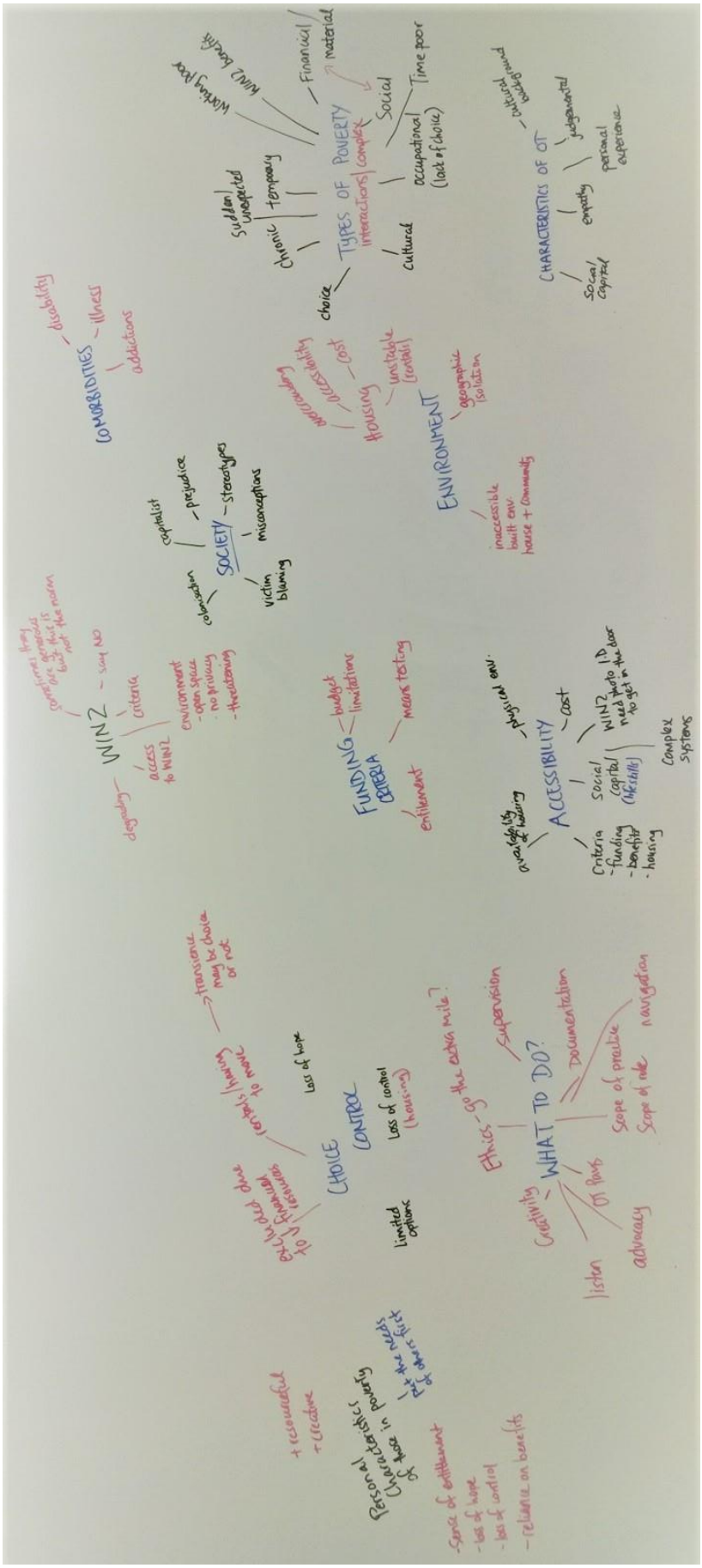



CONCEPT DEVELOPMENT
INTERVIEW 9
Deprivation – families
– communities
Poverty of opportunities
Importance of money in society
→ need cash to engage in society, both productivity and leisure.
OT – creative solutions for clients
Clients have no concept of money
Living hand to mouth.
Low expectations → no expectation of change or improvement
Impact of poverty – health outcomes
– cognition
Service poverty – tight budgets
– low paid carers
– clients miss out on services
OT assessment should consider poverty
Need for Social OT
Advocacy
Societal changes
Activism
Policy
Occupational rights
Re-think OT paradigm and values
→ currently aim to normalise people into capitalist society.
→ more support for alternative lifestyles?
Words used to define/explain poverty → deprivation
Poverty of opportunity (type of poverty)
Capitalist society → money is valued, need money to function in society
OT role
– assessment should include poverty
– challenge OT values
– activism/advocacy
– policy change
challenge status quo
– creative solutions for clients
– ethics – using own resources
– social OT
Occupational Rights
• Defining poverty (deprivation, hand-to-mouth)
• Types of poverty (opportunity)
• OT role
• Challenge status quo
– capitalist society
– OT values in this
• System poverty
• Occupational Rights

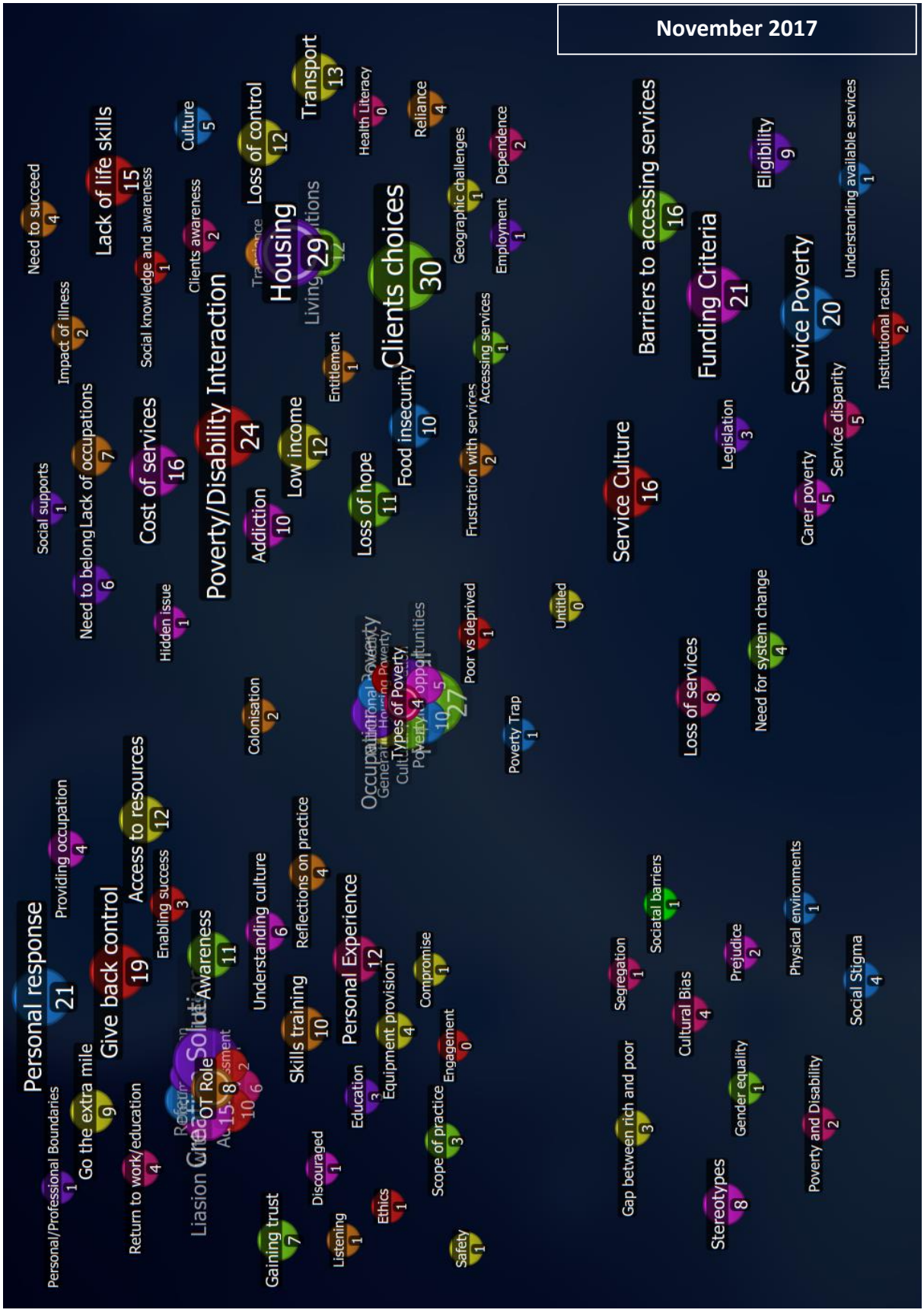
Appendix 8. Compiled themes from whiteboard exercise



Appendix 9. Whiteboard photo dated 24.08.2017



Appendix 10. QUIRKOS screenshots



April 2018
Social knowledge and awareness
1
Social supports
1
Impact of illness
2
Clients awareness
2
Entitlement
1
Frustration with services
2
Need for system change
4
Service Culture
Therapi
Ethical Responsibility
0
Poverty
20
Ethics
1
Contributing factors
Awareness of poverty
0
Need to belong
6
Hidden issue
1
Poverty Trap
1
Creative Solutions
Implications for Practice
Employment
1
Lack of life skills
15
Discouraged
1
Enabling success
3
Safety
1
Prejudice
2
Sociatal barriers
1
Segregation
1
Gender equality
1
Cultural Bias
4
Physical environments
1

Appendix 11. Whiteboard photo dated December 2018