scope

Contemporary Research Topics

Scope: Contemporary Research Topics (Health & Wellbeing) 2 Place (November 2017)

The second issue of *Scope: Contemporary Research Topics (Health & Wellbeing) 2 Place*, there after referred to as *Scope (Health & Wellbeing) 2 Place*, provides the opportunity for authors from different disciplines to consider, discuss and debate how "place" is understood in relation to health and wellbeing. The work presented within this journal is drawn from the areas of nursing, occupational therapy, sociology, counselling and geography, health, education and focuses on research and community projects which attempt to (re)build and (re)foster genuine connections with physical location within our communities.

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scope

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CONTENTS

UNIQUENESS OF PLACE AS DEFINED BY IT'S INTERACTIONS

Dr Jean Ross

Place recognition is a component of our everyday practice and equally the lives of the people and clients we engage with as we progress in an array of health and wellbeing activities. How we experience place has an individual as well as a collective perceptive. This edition of Scope offers a space in which to recognise differing disciplines' perspectives of place, wellness and health and to bring about a deeper understanding of the varied relationships and connections we have with place. The overall expectation is to open up local, national and international debate with the prospect of adding to this growing body of knowledge.

Place is typically defined as a geographical location as a physical site indicated on a map with the purpose of specifying a place or site to a location. However there is more to place than a simple location. Place becomes meaningful when a connection with place occurs and can be associated with human and non-human relations, both within and external to the identified location. The theoretical engagement with place is discussed by the authors of the first two papers Jenny Aimers and Jean Ross (respectively) and offers a broad foundation of how place can be engaged with in the process of community development and the practice of nursing. Alternatively, Stephanie Revell has researched how the outdoor places can provide an opportunity for clients to engage with their counsellor as a therapeutic space as they walk and talk. The following three papers reveal place as a meaningful location through individual and collective emotional attachments that establish a strong commitment and a willingness of those people to contribute to the community, demonstrating that when this occurs a sense of belonging is experienced. In the first of those papers James Sunderland engages with local men who are both a contributor and member of the Men's Shed Movement promoting a sense of community and belonging. Alex Andrew highlights the role of a café attached to an aged care facility and exposes a further sense of appreciation and belonging for both the residents and their family members and friends who visit and congregate in the residential café. Josie Crawley engages with narrative through, storytelling, poetry and imagery illustrated through a letterbox connected with a sense of belonging associated with an individual's home.

Home is also a focus of a place where health care in particular is related to long term health conditions in which Anna Askerud promotes as a progressive space, referred to as hospital at home. Place is also represented in the virtual world revealed by James Sutherland and Dave Speden's in a more contemporary research paper dedicated to a school environment, in which communication between children, families and teachers occurs.

There is a myriad of ways which reveal place in a positive light in comparison to the complicated connections between place and difference. Laurie Mahoney's paper focuses on the notion that home is normally considered a safe haven however, this paper questions what is the place of primary health care nurses, when home is not a safe place. The following two papers continue with this theme of place and difference providing an example of two separate international perspectives of how place and cultures are encountered. Linda Robertson and Beatrice Hale's research discuss biculturalism and the preservation of culture in a main stream environment and Mary Butler, Fenja Jones and Susan Ryan's research highlights the place of international internship between an Indian and New Zealand occupational therapists' experience.

Simulation as an educational model of learning within the Bachelor of Nursing programme is the focus of a further two papers. Suzie Bartlett reviews the prospect of introducing The Simulation Model that she developed indicating

there is a place for this within the New Zealand context. And Josie Crawley and Jean Ross review the place of simulation within the speciality area of primary health care, as a particular context of practice. The final paper further explores how place shapes the primary health care nurses' practice in rural New Zealand.

Place is more than considering it as a geographical location, place encourages a sense of belonging, emotion and attachments and can be experienced positively or negatively. Place can be understood as relational and a component of social interactions which are not motionless or frozen in time; they are in process, dynamic and complex.

This edition of Scope is about place, writing about and researching place involves a multi-faceted understanding of the coming together of the physical, social and imaginary worlds and how we engage, understand and embed our practice within this dynamic and complex concept.
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PLACE AND SPACE WITHIN COMMUNITY DEVELOPMENT IN AOTEAROA NEW ZEALAND: A THEORETICAL DISCUSSION.

Jenny Aimers

INTRODUCTION

Communities are shaped by interactions within a variety of spaces and places. Theories of place and space are complex, they show that space and place can on the one hand, provide safety and support, while on the other may divide and exclude. Community development theorists and practitioners have focused on identifying communities by who they include rather than who they might exclude. As a result, discussion has been limited on how communities interact in both physical and social environments at the same time. Other social science disciplines such as geography and psychology have a developed discourse on place and space that could benefit community development practice. In this article I will consider the three methods of community development most commonly used in Aotearoa New Zealand, situating their concepts of community alongside ideas of space and place offered by other social science disciplines.

Background

Community development is viewed either as a place based activity defining its community using geographical boundaries, or alternatively, responding to communities of interest who occupy a marginalised space in society. Community development theorists agree that 'community' is a hotly debated topic (Aimers & Walker, 2013, Shilongonyane, 2009, Shaw, 2006), yet few have delved into the nuances of the place and space, despite these being well developed in other disciplines such as geography and psychology. In this article I will consider three commonly practiced methods of community development and determine how theories around place and space may inform and enrich their practice. These three methods are a structural analysis approach to community development, asset based community development and community-led development. I will begin by discussing place and space as it is commonly articulated by community development theorists, this will be followed by a discussion of place and space derived from other social science disciplines. I will then examine each of the three community development methods and how their current views of place and space might impact on issues of inclusion or exclusion.

The community-a place or a space?

Community development has its genesis in what Shaw (2006, p.26) describes as either "benevolent welfare paternalism" or "working class struggle". Initially community development responded to the power play between the state and civil society either seeking to create social inclusion; or challenging power structures to shift power to those communities who are otherwise marginalised and excluded. While the idea of working class suggests a social space occupied by people who belong to a specific social strata, this can also translate into a place where a social class occupies a geographic area such as a neighbourhood.

Since its emergence in Aotearoa New Zealand some 30 years ago different forms of community development practice have developed and held currency; these practices all recognise communities in a number of different ways. In Community Development literature communities are generally defined in one of three types:

- Communities of place (geographically defined)

- Communities of identity (ethnicity, gender or age)

- Communities of interest (common interests or beliefs)

Some authors suggest that all of these come to play to create a fluid and changeable space (Aimers & Walker, Craig, 2007;,2009; Sihlongonyane, 2009; Shaw, 2007). Kelly and Sewell (1998) state that the process of building community must struggle, "to stay open to the multiple, changing patterns of human lives in different physical and social contexts."(p. 43). They reflect that while a sense of place imparts an identity, this is more than just a physical address. To answer the question where are you from? A place must include the space that is inhabited by culture and sub-culture, language and folklore (ibid). Kelly and Sewell (1998) urge practitioners to consider the words that are used to describe people in transience to illustrate the importance of identity in relation to a physical place, namely 'exile', 'refugee' or 'immigrant'; people moving from, or to, a new place where culture and language must be learned or adapted before it can be thought of as part of their identity. Contrast these names with 'native', 'citizen' and 'local' and we have another picture of where these people sit (ibid).

In Aotearoa we know that tanagata whenua, refers to Māori as the indigenous peoples from this land, but if we look at the literal translations of the phrase it offers a succinct definition of what it means to belong somewhere. Moorfield's (2003-2017) online Māori dictionary has several translations of this phrase to mean, to be natural, to be at home, and being comfortable to be naturalised, acclimatised, or established. Thinking about what it means to be in a community; the idea of being natural, at home and comfortable, to be established or adapted to your place and to have collective authority over that place seems like a worthy aspiration for the work of community development. This suggests that the notion of place in relation to community must incorporate more than a geographic location. However another Maori word, tūrangawaewae that means "domicile, standing, place where one has the right to stand - place where one has rights of residence and belonging through kinship and whakapapa" (Morrfield 2003-2017, n.p.) brings the cultural back to a specific geographic place, illustrating perhaps that the separation of place from identity is problematic. In their study of homelessness, Groot., et al.,(2010, p. 127) argued that "tūrangawaewae is something that is engaged, nurtured and sustained through whanaungatanga (relatedness, the establishing of relationships) and ahi kā (keeping the home-fires burning) connections that are lived in the present " hereby emphasising place as a process that requires sustaining.

These ideas suggest that for community development practitioners the notion of place must be seen as more than a geographic boundary or unitary social identities. The community is obviously a complex and slippery beast that shifts and ebbs according to the identities of the people in place.

Theories of place and space across social science disciplines

The US National Research Council (NRC), a body that advises on public policy, defines place as a territorial domain bounded by the natural environment or as social constructs shaped by human interactions (National Research Council 2002, p. 56). They go on to describe this notion of place as one that moves both horizontally, within the environment, and vertically, at different scales, leading individuals to occupy a variety of places at any one moment. For example an individual can be in a home, neighbourhood, town, state or country or socially constructed spaces of associations, clubs and networks all at the same time. The NRC (2002) conclude that the character of a place therefore is based on "its peoples' sense of rootedness" which in turn are "shaped by interactions within the place and other place" (p. 56).

Space however is seen as a more abstract concept where it considers people's spatial feelings and how they form attachments to home, neighbourhood or nation (Tuan, 1977). Humanistic geographer, Tuan (1977) talks of place as something people are attached to in order to seek security, whereas space is something that is longed for and represents freedom. Space in this sense is non-physical, infinite and unknown. Place may be physical or mythical but unlike space it is finite and familiar and as such place acts to bound space (Tuan, 1977). How unknown spaces become familiar by defining the boundaries of a place is explained thus,

> *We are in a strange part of town: unknown space stretches ahead of us. In time we know a few landmarks and the routes connecting them. Eventually what was strange town and unknown space becomes familiar place. Abstract space, lacking significance other than strangeness, becomes concrete place filled with meaning.*

(Tuan 1977, p.199)

This goes someway to explaining the logic of place based community development as it creates an argument for creating a place that is familiar, known and safe for those that live there. Geographer John Agnew (1987) argues that to be a place, a space must have three components, a location (that distinguishes this place from other places), a locale (a shape or boundary) and a sense of place (personal attachment). A complicating factor for community development is that people do not confine their social relationships to a specific locale, their interests go beyond their street or neighbourhood and therefore so does their personal attachment (Green & Haines, 2015). In addition Gieseking, et al., (2014) argue that issues of power and subjectivity are critical to any understanding of space and place. They maintain that wealth and decision making define our physical environment and regulations, while social norms limit our social experiences; therefore our experience of subjectivity is heavily influenced by the power exerted by social, political and economic forces. Power can become imbued in geographic or spatial arrangements as veils or tools for oppression and inequity (Blomley, 2006). Such political and social boundaries can be incorporated into physical infrastructure and town planning to work for or against individuals leading to either inclusion or exclusion from the communities they inhabit.

Psychology offers another view of identity and place as the origin of conflict and even war. Environmental psychologists refer to place attachment, a phenomena that is also linked to place identity experienced more as a social identity such as class. In this case there is a strong emotional bond between a person and a place (Florek, 2011; Proshansky, 1978). While the status quo is retained this presents as a positive and caring relationship, however this phenomena is also thought to be the catalyst for NIMBYism[1], whereby communities are overly protective of

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1   Acronym for "Not In My Back Yard." A term for a person who resists unwanted development (Tajefel and Turner, 1979)

their environment and are not open to change or new developments. Social identity is a person's sense of who they are in relation to their membership of a particular social group. Similar to place identity there is a distinction between members of this group and outsiders, in its extreme genocide and war can be waged based on differences in social identity (Tajefel & Turner, 1979).

What all these perspectives offer is an understanding that place and space are complex notions that can on the one hand provide a community with familiarity and security, freedom and possibilities for engagement, while at the same time being divisive and excluding.

Locating communities in practice

In this section I consider three methods of community development practice popular in Aotearoa New Zealand and consider how they view the notion of space and place.

Structural analysis community development

Community development work first became recognised in Aotearoa during the 1960s and 1970s as a response to the rights-based grass-roots movements such as feminism, the Māori renaissance, Pacific peoples diaspora and developing youth cultures (Aimers & Walker, 2013). Structural analysis grew out of these movements but is based on the work of Paulo Freire and his pedagogy of the oppressed. The goal of structural analysis is to develop an understanding of, and challenge the nature of power relations. Structural analysis acknowledges that people have different realities and knowledge. This approach maintains that power was gained through ideologic, political or economic means and the analysis of problems can only be defined by those who have lived that problem (AWEA, n.d). The National Council of Churches brought activist Father Filipe Fanchette to Aotearoa in 1980 and many community workers attended his structural analysis workshops at that time. Structural analysis took a political analysis that sought to identify and challenge the institutional power structures that put social justice at the heart of community development. The process was informed by Marxism and had a clear economic focus. Franchette was quoted in the Auckland Star in 1983 as saying, "You must find out where you are. Get to your roots. We've all been conditioned. Unless we look at the conditioning and distance ourselves from our situation we can't see where to go" (AWEA, n.d. p. 2-3) Structural analysis was later developed to draw on Bourdieu's (1984) idea of habitus that recognises that culture has an impact on oppression in subtle yet powerful ways. This is expressed via the everyday subjectivity of the clothing that is worn, the way people talk or other ways of being that seem natural. This method of community development focuses strongly on communities of interest or exclusion and to that extent frames the idea of place as a convergence of the social, political and economic spaces rather than physical places. The role of both spaces and places in constructing systems of power is a strong theme.

The goal of this form of development was to create a space for freedom or liberation from traditional constraints that could be linked to Blomley's (2006) notion of subjectivity. This is achieved by encouraging the powerless to use their innate knowledge to challenge the boundaries that protect the status quo in order to achieve equity of resources. As such structural analysis resonates strongly with Tuan's (1977) notion of space that represents freedom and infinite possibilities. It could be argued therefore, that this method rejected the strong associations and institutions often valued in place based community development as subjective positions that may contribute to maintaining the status quo rather than lead to liberation of the oppressed.

Asset Based Community Development

Asset Based Community Development (ABCD) was introduced to New Zealand by the Department of Labour's Community Employment Group (CEG) in the early 1990s (Aimers & Walker 2013). It is known colloquially by its practitioners simply as ABCD. CEG brought international experts in ABCD to engage with small towns and rural communities throughout Aotearoa New Zealand. This was supported on the ground by CEGs Bootstraps programme that aimed to re-vitalise communities. ABCD eschews the notion of 'needs' preferring instead to focus on the assets or gifts already available in a community. ABCD practitioners then facilitate the process whereby community members can take charge of the development process by mapping and mobilizing both economic and social assets to create local economic and social opportunities through bridging and networking (Winther, 2015; Mathe & Cunningham, 2002; ABCD Institute, n.d.). Although essentially place based, ABCD maintains that productive communities are held together by creating a unique culture based on high trust relationships and it is these relationships they seek to develop (McKnight, n.d.). McKnight suggests this can be achieved by developing strong associations within a community. These associations may be focused on specific interests but if they have strong interconnected networks then this combines to develop a strong cohesive community. McKnight notes that while each of these groups may have a boundary that inherently creates outsiders, this can be ameliorated by associations that are welcoming rather than exclusive. By recognising that everyone has something to contribute this form of community development looks to build relationships through positive interactions. Associations with dominant norms are however at risk of excluding those with minority groups such as displayed in NYMBism as described by Tajefel and Turner (1979). Overall though, this method seeks to develop the emotional connection communities have with a physical place suggesting this method reflects the environmental psychologists (Florek, 2011; Proshanksy, 1978) viewing of place.

Community led-development

Community-led Development (CLD) characterises itself as a place-based practice that seeks to develop local resources and strengths by nurturing a whole of community shared vision (Inspiring Communities, 2010). Introduced to Aotearoa New Zealand in the mid-2000s this form of development was adopted by the Ministry for Social Development and has formed the basis for their support of community development since this time (Aimers & Walker, 2013). Similar to ABCD, CLD seeks to maximise assets and skills, connecting groups and associations, building local leadership to developing a shared vision that drives action for change and work adaptively (Inspiring Communities, n.d.) In addition CLD considers the development of relationships at multiple levels to be the key to the community change process thereby linking the geographic place with the social and cultural. Where CLD differs from ABCD is that it considers power relations in its processes and this is acknowledged in all levels of the change process be it personal, structural, relational or cultural. The practice promotes whole of community decision making which requires skilled facilitation and well developed process (Department of Internal Affairs, 2013). Of all three community development methods discussed, CLD takes the middle ground between place and space, succinctly representing Agnew's (1987) viewing of place as location, locale and sense of place.

DISCUSSION

The three methods of community development discussed in the previous section represent different positions in relation the community as space and/or place. ABCD relies strongly on place based connections and while they acknowledged the cross cutting nature of social bonds and identity, this was not fully developed with regard to those people in the community who may feel excluded. The CLD approach appears similar to ABCD in that it focused on capitalising on strengths and building networks. CLD works in social and cultural spaces that requires extensive discussion in order to avoid individuals or groups being excluded. This does however lead to a more

process orientated approach. Ultimately both ABCD and CLD could be described as essentially place based. Methods of place based community development involving the whole of community argue that by separating out communities of interest or exclusion we risk working in isolation and do not take into account the wider ecology of the community as a whole and how it interacts (Clarke et al., 2002). As such commonality must be sought using the tools of consciousness raising, negotiation and problem solving (Clarke et al., 2002). I would argue however, that the risk of isolation is still high unless place based practitioners also consider the view of Green and Haines (2015) who maintain that social interests and attachments go beyond a specific locale that may move horizontally, vertically and at different scales, leading to individuals occupying various places and spaces concurrently (National Research Council, 2002).

The structural analysis approach was very different to ABCD or CLD, focusing on an entirely space based approach to community while rejecting the notion of place as a barrier to the freedom of their communities who are oppressed and on the margins of society. There was little consideration for the effects of developmental change on those outside their communities of the oppressed, as this method is unapologetically about shifting power to those without power. Whether this can cause an overcorrection in power relations is not really considered. Physical boundaries were almost irrelevant unless they were used to exert or veil some form of power.

Commonalities between the three methods of community development do exist as they all value the inherent knowledge of their community members. In addition the application of that knowledge was critical to all three methods. However given the very different ways each method defined their community I would suggest that viewing community knowledge under the lens of Gieseking, et al.'s (2014) notion of subjectivity would be of benefit to practitioners of all three methods in order to extend their view of community and limit any divisive effects of their practice.

CONCLUSION

A nuanced understanding of place and space as it relates to communities is critical for community development theorists and practitioners. As such community development has much to learn about place and space from disciplines such as environmental psychology and critical geography. Without exception theories of place and space are about inclusion and exclusion and as the ultimate goal of community development is aimed at including rather than excluding this must be a primary consideration. Rigid boundary setting whether it be physical or social is problematic for community developers. Whether the goal is for a livable community, or a place to feel comfortable, established or have authority over your own place, these notions are not simple and require careful thought by community developers. Community development practice should be wary that creating strong associations can also create further inequality by excluding people as a result of creating a boundary. I conclude that all forms of community development can benefit from further analysis of what it means to belong to a social/cultural space and live in a physical place. There is considerable risk for community development practice to inadvertently build divisions as well as connections as a by-product of their development activities by being blind to those they exclude. By applying the perspectives of disciplines such as psychology and geography to incorporate such concepts as subjectivity, the parallel and horizontal movements in social space and divisive potential of any form of social or physical boundary; community development practitioners can develop a stronger analysis that can ultimately improve understanding and practice.

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Review

'PLACE' IS MORE THAN A PHYSICAL LOCATION: A BROADER ENGAGEMENT OF 'PLACE' TO FURTHER UNDERSTAND NURSING PRACTICE

Dr Jean Ross

INTRODUCTION

The aim of this paper is to embrace the concept 'place' and to progress the international and national discussion about 'place', health and nursing. 'Place' is a familiar term, associated with a location and assumed by the user and recipient that it has a meaning that is understood by both. In this paper, I argue that 'place' is more than a geographical location or site where health care can be accessed and practised. Indeed, 'place' for the purposes of this paper builds on the traditional conceptualisation of 'place', as a geographical 'location' and further extends the social and human to non-human relationships representative in 'place', as 'locale' and a 'sense of place. Further, focus on the relationship between 'place' and space, is discussed in relation to social geography. In contrast, consideration is provided as to how the discipline of nursing has employed the concept 'place' throughout the previous thirty years. The relationship between space and 'place' from both social geography and nursing suggests they are connected despite their different perspectives and in so doing can enhance both disciplines' contributions to the growing body of health and nursing practice. It is in this paper that the concept, 'place' resurfaces along with its relationship with nursing.

Background

'Place' is everywhere. There is little understanding of the word 'place' and the interactions it can have with people (Cresswell, 2004). The English word "place is used in everyday life, while being associated with a number of meanings" (Cresswell, 2004, p.1). In general terms 'place' is considered a location or physical site, for example "this is my place, is not your place, you and I come from different places" (Cresswell, 2004, p.2). 'Place' is important because it is central to the social world. 'Place' occurs when meaning, naming or the feeling of connection occurs with that 'place'. 'Places' are what are made of spaces when linking the human interaction with the environment (Cresswell, 2004). The concept of space is not fixed and it undergoes constant dynamic and political change. Neither is it a receptacle to be filled, rather space has the ability to enhance change (Massey, 1999). Space and place can be considered meaningful for as Thrift (1999) explains they weave together in order to maintain each other. Social geography's conception of the weaving of space and 'place' and nursing's engagement with 'place' are further revealed in this paper.

The meaningful relationship between 'place' and space

When space and place work together, they are more dynamic than working separately. Reflecting back to the seventeenth-century, concepts related to Newtonian and Leibnizian thinking assists in understanding these two concepts (Agnew, 2004). 'Space and place' are relational; space cannot exist without 'place' (Agnew 2011). Space can be viewed as abstract; modern and global, space is representative of movement, in opposition to the rootedness

associated with place, which is understood as specific; local or traditional (Agnew, 2004 Escobar, 2001). Space is associated with a location, for example, having an address, while 'place' is about living at that address. 'Place' therefore conjures up a sense as nostalgia, in contrast to space, which is progressive and radical (Agnew, 2004) which is where a Newtonian view of space becomes active. In opposition to this opinion is the Leibnizian view, which considers the power of what occurs in place, and it is this that makes space appears active, space is always in motion and constantly being made, space is were change occurs.

To further add to the growing debate about 'place' Agnew (1987) a political geographer developed a 'place framework', which I have engaged with to situate nursing practice.

'Place framework'

Agnew (1987) outlined three fundamental elements of 'place' as a meaningful location and he developed a framework (referred to as a 'place framework') in which to improve a deeper understanding of 'place'. Agnew's (1987) three fundamental elements of 'place' include 'location', 'locale' and a 'sense of place' and are further elaborated on.

'Location'

'Location' from Agnew's (1987) perspective includes physical settings or structures. Cresswell (2004) has indicated that the most understandable and "common definition of a place [is as] a meaningful location" (p.7). Meanings associated with 'place' become part of an individuals' understanding of who they are and identify with. 'Location' can also be viewed similarly to 'landscape'. Landscape, is referred to a section of the surface of the earth as viewed from a particular position (Cresswell, 2004). Defining landscape in this way "refers to the shape – the material topography – of a piece of land" (Cresswell, 2004, p.11). Landscape is a way of looking at the land and dates back to the Renaissance when landscapes were painted and viewed from a distance (Cresswell, 2004). Landscape is generally observed from the outside and is not a place where people reside; landscapes are a viewed experience and not a lived one. In this sense, this is how place and landscape are presented as being different.

'Locale'

'Locale' is associated with the development and maintenance of social relationships in which 'place', as 'locale' makes up the second aspect of Agnew's (1987) 'place framework'. 'Place' as 'locale' is where social relations and the meaning of 'place' are made or developed both within and beyond the 'location'. According to Agnew (1987) social relations are more complex than considering them only as interactions between people and which he terms human interaction. These relations are effectively between people and their relationship to a specific geographical context. Relationships between geographical contexts and 'locale' demonstrate how identities are constructed, where human activities occur in 'place' and where meaning is made. Meaningful places assist people to make connections and to develop a sense of who they are in relation to a geographical location. As Hollaway and Hubbard (2001) explain "[t]hese meaningful relationships associate the formation or make up our identities"(p.71). Meaningful relationships can be further extended to encompass a 'sense of place' as represented by Agnew's (1987) third element of his 'place framework', a 'sense of place'.

'Sense of place'

According to Agnew (2004), 'sense of place' is about understanding meaning through subjectivity, belonging and attachments, which are identified and established as an emotional association that people have to 'place' as 'location' where attachments are being established alongside feelings and emotions (McKinnon, 2011; Cresswell, 2002, 2008; Massey, 1995;). An attachment to 'place' establishes a strong commitment to the physical location and a 'sense of place' may develop (Nagel, 2011). A 'sense of place' usually involves or is associated with a community, which, according to Vanclay (2008) is termed 'homeogeneality' and refers to as belonging and cohesion. Individuals have an emotional need to identify with often personal and intimate places and hence 'construct' these places for themselves on the basis of repeated experiences. 'Sense of place', also includes the particular sounds, smells and sights related to specific locations that are represented as a nostalgic experience (McClinchey & Carmichael, 2010). Places are known and cared for from within 'location' as what Tuan (1974) calls 'fields of care' in which people demonstrate a love of place and an emotional attachment develops (England, 2011).

'Sense of place' helps explain how identities are established, which occurs through the attachments, performance and emotions, associated with place (Cresswell, 2008, 2004; Butz & Eyles, 1997; Agnew, 1987). According to Tuan (1974), to develop a 'sense of place' requires the ability to know the place personally and which the individual responds to emotionally. This intimate knowledge is gained over a long period of time through extended encounters with the 'location'. These extended time periods invest the individual with a deep 'sense of place', which makes place an extension of the individual (Holloway & Hubbard, 2001). The following section elaborates on 'place' in comparison to nursing conceptualisation of 'place' as nurses engage in the provision of health care.

'Place' as constructed in nursing

The literature associating 'place' and nursing practice was initially identified as far back as Florence Nightingale (Andrews, 2002, 2003). In 1859 Nightingale published the Notes on Nursing: What it is and what it is not (Nightingale, 1969) in which she discussed the requirements necessary to improve patient health care. Nightingale discussed the merits of cleanliness, the environmental necessities of clean air, effective ventilation, warmth and light, together with the nurses' proximity to patients. She brought to our attention the potential for the environment to be a contributing factor to a person's health and was one of the first nurses in the world to take notes on patient's health issues and then to discern links between health and environment (Nightingale, 1969).

Further research undertaken by Liaschenko (1996a) has explained the importance of understanding 'place' in nursing. Liaschenko's (1996a) argument revolves around the fact that nursing practice occurs in numerous sites and locations for example, the hospital setting, or the client's home, workplace, schools, long-term facilities, health centres, local shops and sporting events. Amongst these sites of practice there is generally no differentiation in the literature as to whether these sites are urban or rural locations, which is an important aspect to consider in the provision of health care. Thomas (2013) has demonstrated the importance of 'place' knowing, in which health and illness can be understood in relation to 'location' and sites of practice. Understanding 'place' from Thomas's perspective focuses on the knowledge generated by community residents about their own interpretation of factors that could affect their own health. This engagement builds on the work by health geographers Kearns and Moon (2002) who consider the importance of understanding 'place' in relation to health, illness and the availability of health care services in local regional communities in New Zealand.

There are four categories emerging from the nursing literature associated with the dual concept of 'place' and nursing practice (Carolan, et al., 2006). The first refers to situatedness representing the connection and feeling in 'place'. The second links situatedness with creating a healing environment in which relationships between clients and the nurse develops. The third is extended to conceptualise the nurses' practice as disembodied or displaced and linked to proximity. This in turn reflects the fourth category, which focuses on involving issues of workplace, power and gender and the connection these have with 'place'. The principal nursing categories representative of 'place', include, situatedness; creating a healing place and proximity as mentioned above connect with social geography's engagement of 'place' in which 'place' and situatedness and 'place' and proximity are further expanded on. Jones and Ross (2003) have studied the context in which nursing practice in rural locations occurs, and express that:

> [r]ural nursing practice is shaped by its situatedness. Distinctive settings determine nursing roles and responses-which differ according to the health needs and health service provision in particular rural communities…

(p. 18)

Therefore it is implied that 'place' can be identified as location; site; context, or 'situatedness' and can impact on the nurses' ability or the way in which the nurse identifies and performs their practice. Lee and McDonagh (2010) have also connected the concept of situatedness to the shaping of nursing practice in rural locations, and have expanded Malone's (2003) study on the nurses' personal and professional proximity of the nurse-patient relationship in 'place' or location.

Malone (2003) proposes that there are four areas to consider in relation to nurses' proximity and these include, the physical proximity, the narrative proximity, the personal proximity and the moral proximity. The physical proximity, is associated with the nurse practising in physical nearness to the client, including the concepts of touch and physical caring (Peter & Liaschenko, 2004; Malone, 2003). Physical presence benefits the development of the nurse-client relationship. Relationships associated with nursing are twofold. Firstly, nursing occurs in a physical location, and secondly, the development of a professional relationship is a necessary component of the work of nursing (Liaschenko, 1997; Christensen, 1993). The nurse-client relationship is a fundamental component of nursing and necessitates a nurse's full, psychological and spiritual presence as explained by Osterman and Schwartz-Barcott (1996), whilst creating a specific 'place' of caring. Indeed, for the nurse-client relationship to be effective the nurse is positioned physically to understand the client's needs and to act on those needs. Proximity associated with the nurse-client/patient relationship, relates to nurses understanding of their moral responsibilities and how they enact their moral selves towards the patient/client (Peter & Liaschenko, 2004). Narrative proximity engages the nurse and client together through effective communication in which social relationships are further developed and the facilitation of health care is provided. Personal proximity focuses on understanding the client, and moral proximity refers to advocating on behalf of the client.

Proximity with patients can also be extended to the concept of nursing presence with patients or clients and extends the caring elements so important in nursing. Peter (2002) states that the presence of nurses has a profound effect on the experiences clients relate to, in conjunction with establishing 'place' as the therapeutic essence of healing as comprising presence, co-presence, moral agency, and the therapeutic and interpersonal relationships with clients, families/whanau, work colleagues and communities.

DISCUSSION

Traditionally, the profession of nursing has not routinely engaged with social geographers' concept, 'place'. By engaging with Agnew's (1987) 'place framework' and the nursing literature promotes different but complementary piecing together of this concept to further understand nursing and the provision of health care. Agnew's (1987) 'place framework' is the pivotal aspect in which to unite nursing's and social geography's engagement with 'place' aligned with 'location', 'locale' and 'sense of place'. The notion of place and nursing practice was initially recognised by Nightingale in 1859 (Nightingale, 1969) with reference to nursing sites of practice as the 'environment' in which patients' experienced and received health care. 'Place' associated with nursing has generally focused on the site or location of practice, which bears a resemblance to either a hospital setting, or the client's home (Liaschenko, 1996). Sites of practice or the environment can be aligned with the first element of Agnew's (1987) 'place framework', 'location'. The environment has continued to be of interest in nursing and was initially expressed by Jones and Ross (2003) and more recently by (Lee & McDonagh, 2010), as situatedness.

Situatedness extends the nurse's relationship and partnership between the patient, client or community and can be considered as the nurse/client proximity as suggested by Peter and Liaschenko (2004). The development and continuing relationship between the nurse and patient/client that is an essential component of nursing practice further aligns with the second element of Agnew's (1987) 'place framework', 'locale' where social relations develop both within and beyond the 'location' or sites of practice. For example, situatedness has been associated with the shaping of rural nursing practice, and is associated with the notion of creating a healing environment that is a specific 'place' of caring the client/patient associates with and feels a sense of belonging. Creating a healing environment has a profound effect on the experiences clients relate to, in conjunction with establishing 'place' as the therapeutic essence of healing (Peter, 2002) through subjectivity, belonging and attachments. These identifying features, establish an emotional association that people have with 'place' as 'location' and where attachments are being established alongside feelings and emotions (McKinnon, 2011, Cresswell, 2002, 2008; Massey, 1995). An attachment to 'place' establishes a strong commitment to the physical location and a 'sense of place' may develop (Nagel, 2011). A 'sense of place' aligns with the third element of Agnew's 'place framework', in which the nurse takes into consideration the clients' 'sense of place' as the therapeutic relationship and partnership develops between the nurse and client in 'place' (Ross, 2016).

'Place' therefore, becomes a meaningful and dynamic attribute in nursing practice. The concept of 'place' is a central component of geography, which Liaschenko, considers as the geography of nursing. Liaschenko (1997; 1996a; 1996b; 1994) has considered geography as a useful way through which to talk about the depth of the nurse-patient relationship in location and to which this author concurs in this paper. 'Place' therefore, is necessary to re-engage with, understand and respond to in relation to nursing practice as discussed within the nursing literature over the past thirty years.

CONCLUSION

In this paper I have engaged with the concept 'place' as progressed by nursing and social geography which has proved to be a valuable asset. The conceptualisation of 'place' is everywhere, and according to Cresswell (2004) there is little understanding of the word 'place' and the interactions it can have with people. However, 'place' is important because it is central to the social world, and 'place' occurs when meaning, naming or the feeling of a connection occurs with that location. When space and place work together, they are more dynamic than working separately and therefore the weaving of space and 'place' and nursing's engagement with 'place' have been revealed in this paper, and will in future discussions, enhance this dialogue.

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Original Research

WALK AND TALK THERAPY: POTENTIAL CLIENT PERCEPTIONS

Stephanie Revell

INTRODUCTION

Walk and talk is an emergent therapeutic activity within counselling/psychotherapy practice. The activity of 'walk and talk' is pan-theoretical and can be utilised as the foundation for all therapeutic work, or as a periodic activity in conjunction with office based sessions. Research exploring the benefits and utility of walk and talk is in its infancy despite the growing number of therapists choosing to integrate this activity into their professional practice. This study explored general perceptions of walk and talk as a therapeutic activity, generating qualitative data gained from short answer responses that sought to elicit perceptions of appealing and least appealing aspects of walk and talk therapy. Thematic analysis identified the following three themes: 'being outdoors'; 'engaging in movement' and the 'aspects affecting the context of therapy'. Taking therapy into an outdoor context and walking while talking was perceived to both support and hinder the therapeutic intent. This highlights complex and multi-layered relationships people have with 'place' as well as the importance of the provision of a professional framework in offering this therapeutic activity. Understanding potential clients' perceptions of therapeutic interventions, can serve to inform professional practice, leading to a client led and informed approach.

Background

'Walk and talk' is a general term that is used to describe a therapeutic activity where the counsellor and client walk together in outdoor settings during therapy sessions (Revell & McLeod, 2016; Doucette, 2004; Hays, 1999). The activity of 'walk and talk' is pan theoretical and can be utilised as the foundation for all therapeutic work, or as a periodic activity in conjunction with office based sessions (Revell & McLeod, 2017). Research exploring the benefits of walk and talk is in its infancy despite the growing popularity of integrating this activity into therapeutic encounters (Revell & McLeod, 2017, 2016; McKinney, 2011).

Previous research has highlighted a discrepancy between therapists seeking to accommodate walk and talk within their professional practice and the number of clients who wish to try it (Revell & McLeod, 2017; McKinney, 2011). It is generally assumed that clients enter therapy with ideas about what could be useful for them in dealing with and managing their difficulties (McLeod, 2012; Sandell, et al., 2011). Within the literature, various terms are used interchangeably to explore client focussed concepts such as attitudes, beliefs, expectations, treatment credibility, acceptability and helpfulness beliefs (McLeod, 2012; Sandell et al., 2011; Bragesjö, Clinton & Sandell, 2004; Iselin & Addis, 2003; Duncan & Miller, 2000; Joyce & Piper, 1998; Kazdin, 1980).

Of particular relevance to the present study, are the concepts of helpfulness beliefs and acceptability. Helpfulness beliefs are influenced by how well pre-existing ideas about the nature of the issue(s) and the potential ways of

addressing it are matched (Duncan & Millar, 2000; Iselin & Addis, 2003). Helpfulness beliefs are further shaped by the degree of existing knowledge or familiarity about a certain intervention; the type of issue that help is being sought for; and past experiences of a particular intervention (Sandell et al., 2011; Frovenholt et al., 2007). Interventions for particular issues are judged as acceptable when they are perceived as being fair, reasonable, appropriate and non-intrusive (Kazdin, 1980). Therefore, interventions that are perceived as potentially being helpful and deemed acceptable are more likely to be implemented, engaged with and ultimately successful (Iselin & Addis, 2003; Kazdin, 1980).

Walk and talk is an emergent therapeutic practice and little is known about how this is perceived by potential clients in terms of offering a 'fit' between activity and desired therapeutic outcome. Therefore, understanding how helpful and/or acceptable the idea of walk and talk is, can serve to inform the development, provision and potential success of this emergent therapeutic activity.

Historically, the physical setting in counselling/psychotherapy has received relatively scant attention in psychotherapeutic literature (Fenner, 2011; Backhaus, 2008; Berger, 2007). Of the studies that have been conducted, the focus has been largely on client and therapist components, thus overlooking how the physical environment might influence various processes within the therapeutic encounter (Jordan, 2015; Backhaus, 2008; Fenner, 2011; Pressly & Heesacker, 2001). Despite this, the awareness that therapy processes and outcomes are subject to influences by the setting of the therapy, is not new (Pressly & Heesacker, 2001; Gross et al., 1998). Recent studies have sought to promote the interconnectedness between therapist-client-physical environment factors as dynamic influences within the therapy encounter, thus challenging the privileging of human influences on the therapeutic process (Jordan, 2015; Backhaus, 2008; Berger, 2007). Backhaus (2008) argues that investigations of the therapeutic process need to explicitly acknowledge the potential influence of the physical environment as it is an interconnected part of the overall therapeutic encounter.

Taking the view that therapy occurs between two people in the context of 'somewhere', literature on 'place' offers a useful framework for exploring this further. 'Place' is a term used to describe meanings that are attached to locations (Vanclay, 2008). Creswell (2004) describes place as ''…a way of seeing, knowing and understanding the world. When we look at the world as a world of places we see different things. We see attachments and connections between people and place. We see worlds of meaning and experience'' (p.11). Place is approached from various positions that are both distinct and interconnected. A humanistic view of place emphasises human experiences in the world (Creswell, 2008). Experiences, therefore, are informed by both feeling and thought from which meaning can be made from past experiences and projections into the future (Tuan, 1977). From within a humanistic position, a phenomenological interpretation focuses on subjective experiences gained through 'being in the world' (Creswell, 2004). The 'essence' of a phenomenological view on place is the recognition that being human and being in place are inextricably linked, therefore place is understood through the way we experience the world (Relph, 1976). This stance promotes 'place' as a construct that goes beyond location, and argue that human experience of place is influenced by a conscious relationship between the self and the world (Creswell, 2004).

Health geographers have examined the ways certain places and wellbeing are connected (Philips, Evans & Muirhead, 2015). Recently, the focus has been shifting from identifying characteristics within a setting that contribute to wellbeing and moving toward an understanding of wellbeing and place that emphasises the role of relationships (Conradson, 2005). Atkinson (2013) promotes conceptualising wellbeing as a process and not an outcome.

Therefore, situating wellbeing within the broader context of relationships between people and places, as something fluid and subject to change over time and experiences. This view has particular relevance for the practice of walk and talk, as the therapeutic relationship underpins what takes place within the therapy. Therefore, it is the complex and multi-dimensional relational interactions that occur in a particular setting from which meaning is made (Conradson, 2005). It is from this relational stance that explores processes and practices that the realisation of place to support wellbeing can be achieved (Philips, Evans & Muirhead, 2015). Understanding the altered dynamics associated with taking therapy into outdoor places therefore, calls for the acknowledgement of context and subjective experience, which includes all aspects of place.

The focus of this study was to explore potential client's perceptions of walk and talk as a therapeutic activity. The full survey utilised a mixed methods approach (Hanson et al., 2005). Only data from the qualitative short answer questions will be presented in this current article.

METHOD

The full survey contained both qualitative and quantitative items, thus employing a mixed methods approach (Hanson et al., 2005). Quantitative measures sought to identify predictive factors associated with the likelihood of choosing to participate in walk and talk. Qualitative data reported in this present article relates to short answer responses that sought to elicit participants' perceptions of appealing and least appealing aspects of a written description of walk and talk therapy. This survey was administered on-line via the survey platform Qualtrics. An on-line survey was considered the most effective way of accessing a large number of potential respondents from various locations throughout the UK.

A convenience sampling approach was employed. Participation was sought from current students aged 18 years and over who were students at UK based Universities/Colleges. An email introducing the study and inviting participation was sent to academic staff known to the first author, requesting distribution of the survey link to their students. Additionally, information was placed on research forums and other informal networks.

Ethical permission was granted by Canterbury Christ Church University (UK) research ethics committee. All participants were requested to read the information pages prior to gaining access to the survey. Participants indicated their explicit consent by selecting the 'I agree' option, which once ticked, would grant access to the survey. No sensitive information was sought and all responses were anonymous. 147 participants responded to the qualitative questions with 79% (n=117) female and 21% (n=29) male. 74% (n=109) of participants were aged between 18-35 years old, with the majority (n=80) aged 18-25. The majority of participants indicated they were studying Psychology or Counselling related courses with both undergraduate and postgraduate levels represented. In line with other studies seeking perceptions of counselling/psychotherapy interventions (Sandell et al., 2011) a written description of walk and talk was given. Respondents were asked to imagine they were about to enter counselling/psychotherapy sessions. In addition to indoor based counselling, they would also be offered the opportunity to try 'walk and talk therapy'. A description of walk and talk was given as described in Figure 1.

A type of counselling that takes place in an outdoor setting. You and your counsellor/psychotherapist walk outdoors together during the session while you discuss your issues. Sessions are usually around 50-60 minutes long. Common locations that are used include parks, woodlands, beaches and riverside paths. Walk and talk therapy is not be intended to be a workout or a physically strenuous exercise session and is adapted to suit individual physical needs. Some people find the combination of movement and being outdoors helpful for reasons such as: becoming 'unstuck' when exploring difficult issues; improvement in mood due to physical activity; feeling more relaxed; and being in a natural setting can have the effect of increasing overall well-being.

Figure 1. A description of walk and talk
Source: Author

Respondents were then asked to describe in the text box provided, those aspects of walk and talk they considered appealing and which aspects were considered least appealing. Qualitative data were analysed using a six phase thematic analysis process, as described by Braun and Clarke (2006). The intention of utilising thematic analysis was to provide an overall account of the themes, reflecting the data in full. Adopting this approach inevitably results in a level of depth and complexity being lost (Braun & Clarke, 2006). However, given this inquiry is investigating an under-researched area and seeking views that are not known, this approach was considered appropriate and sufficient (Braun & Clarke, 2006). The phases of analysis involved familiarisation with the data; producing preliminary codes; identifying themes; re-evaluation of themes; refining core themes and identifying core narratives; generating an account of themes overall (Braun & Clarke, 2006). The data analysis was independently checked by a colleague of the author and no major discrepancies were found.

FINDINGS

Three main themes; 'being outdoors'; 'engaging in movement'; and 'therapy processes' were identified through analysis. Appealing and less appealing aspects were integrated within each theme, in order to present a fuller account of how walk and talk as a therapeutic activity is perceived. A summary of the full analysis is presented below. Figure 2 shows the overall analysis.

BEING OUTDOORS		ENGAGING IN MOVEMENT		ASPECTS AFFECTING THE CONTEXT OF THERAPY	
The open space	Lacks therapeutic containment	*Being in motion*	Supports engagement with therapeutic process	*Effects on therapy processes*	Having a shared experience
	Feels emotionally unsafe		Encourages overall wellbeing		Having flexibility and choice
	Opportunity to be overheard		Increases integration of mind/body processes		Challenging ideas of professionalism
	Enhances affect		Limits use of other therapeutic activities		
	Adds therapeutic benefits		Impractical when physically limited		
Varying weather conditions	Negatively impacting upon mood	*Walking side by side*	Lowering intensity of therapy session	*Having distractions*	As a helpful therapeutic tool
	Disruptive to focus of session		Creating barriers to developing therapeutic connection		As something that gets in the way
	Invigorating				
A different setting	Offers contrast to being indoors				
	Allows for different connections				

Figure 2. Thematic Analysis
Source: Author

In the main theme 'being outdoors' participants identified that being in an open space would offer an opportunity for enhanced positive affect through an improvement in mood, and the development of an overall 'feel good' factor. There were also associations made between personal relaxation and outdoor settings. One participant expressed this as: *"Feeling an increase in overall well-being; an uplift in mood; a general relaxation in tension and anxieties"*. Therapeutic benefits to being in open space was articulated as: being outside can help me to clear things I have on my mind" and where *"being able to be outdoors in a relaxing setting and just talk…* would be considered helpful.

However, open space was not always conceptualised in such positive ways. A lack of containment in the physical environment highlighted the ways privacy could be compromised through *"the fact that you are out in the open with other people"*. The potential for being overheard was related to feeling inhibited and uncomfortable: *"Perhaps the feeling that other individuals can hear private conversation and may make me feel uneasy about who is around listening and making judgements about my experiences and thoughts."* These factors appeared to evoke feelings of being 'exposed'. This seemed to stem from not being in a specifically identified place for the therapy. This could be understood as linked to a sense of being emotionally unsafe. For example, *"If you're outdoors I wouldn't feel completely safe talking about certain things"* and *"I would find it difficult to talk about deep things in an open space"*.

Varying weather conditions was also identified as potentially impacting upon the therapy. References to weather highlighted the ways it could impact upon mood and the tone of the session. For example, *"the fact that one would be subjected to mood swings due to changing weather"* and *"it would feel moderately uncomfortable of the weather wasn't great, it may make me tense up and not want to talk about anything"*. However, the weather was also identified as a factor that could be experienced as *"refreshing and stimulating positive emotions"*. References to *"being in the fresh air, being able to breathe deeply, feeling the wind"* were associated with clarity of thought and facilitative of therapeutic exploration.

Being outdoors fundamentally alters the setting of the therapy. This contrast was perceived as offering 'something else', for example *"more positive than looking at four walls, less formal, more comfortable sharing feelings"*. An outdoor setting was also seen to be helpful as *"the problem wouldn't be so concentrated, and I would feel more free if the session was outdoors"*, similarly expressed as *"not being stuck in a small room with difficult feelings"*. A reduction in stigma associated with being a client in therapy was also commented on as well as less *"…rigidity involved with clinic based working"*. Being in an out-of-doors setting presented possible connections from *"being able to use nature as an avenue through which to talk about myself"* to *"being outside, … being able to see a bigger picture [and] foster greater connectedness with the world"*.

The second main theme identified, was 'engaging in movement'. Being in motion through walking was described as supporting overall wellbeing. For example *"I really like the moving around aspect. I find energy levels drop when I am sat still, I also like the feeling of my body moving, and it gives me a much better sense of wellbeing."*

Walking was also identified as being *"good for stress"* and having *"positive physical and emotional effects"*. There were strong links made between walking and thinking/problem solving that indicated this being supportive of strategies, such as, *"I will often go for a walk when feeling overwhelmed or upset as I find it helpful for thinking and problem solving"*. Being able to move during a therapy session was seen as facilitative of therapeutic engagement as *"…struggling to ask for help or talk about something very painful… going for a walk could be a good way of engaging me"*. Walking could also make talking easier, as *"sitting down talking about difficult issues can be hard at times. Talking usually comes easier to me when walking outside anyway"*.

However, walking was also identified as a potentially limiting factor in therapy. Constraints were linked to not being able to meet spontaneous needs, such as not having the option to sit if desired or access to creative materials. For example *"I also feel that walking at the same time wouldn't allow for drawing and mapping things out"*. Walking during therapy is not always possible or desirable when managing physical limitations. Particularly, the physical effort was described as being counterproductive to therapeutic aims, such as *"it could be physically draining, considering my physical health is poor..."* While, existing medical conditions could make walking and talking challenging. *"I have cerebral palsy so walking and talking would be potentially difficult"*.

Walking side by side with a therapist was viewed as both potentially beneficial and problematic. The change in dynamic of being physically alongside as opposed to 'face to face' was thought to be *"much easier for sharing difficult things when you're not also having to maintain eye contact"*. This also could offer the opportunity for *"avoiding eye contact if I wanted to without it being awkward or obvious, lifting the 'pressure' of the situation"*. However, not being able

to see a therapist's face could also be a limiting factor, *"I would miss the face-to-face nature of a traditional therapy paradigm… I might feel that my therapist wasn't 'seeing' me if we were walking and talking"*

'Therapy processes' was the third theme identified. Having a shared experience of client and therapist walking together was identified as potentially fostering a collaborative therapeutic relationship and facilitative of rapport building. *"It would also create a sense of trust… much faster"*. The neutrality of the place (i.e. not 'owned' by either party) was also identified as being useful in building a therapeutic relationship. Flexibility and choice could be gained through choice on location, pace and direction the walk could take. *"The fact that I can choose when to walk and when to stop, and perhaps even where to go"*. Choice also referred to having *"the opportunity to try something new"* and *"liking the creativity of the idea"*.

The concept of 'walk and talk' was also identified as challenging notions of professionalism, representing unclear boundaries *"I would feel worried about going for a walk with a therapist I didn't know and would feel… that the boundaries of the session would be less clear"*. The informality associated with walk and talk *"would not feel like it was professional. Would just be like talking to a friend and if I went to a session I would want a client/counsellor relationship"*. Experiencing distractions through the activity of walk and talk had the potential to bring something useful to the therapy by *"feel[ing] like there is more flow to the session and you could talk and walk for a long time to work out solutions or express emotions as the…environment distracts you"*. Distractions were also seen to offer physical representation of psychological space from difficult material *"being able to talk openly and frankly whilst being engaged in a task of 'walking' to provide a slight distance between the things being discussed"*

On the other hand, the potential for distraction through the environment and walking was identified as something that could be experienced adversely *"having to focus on taking in my surroundings and on the walking, rather than being able to think solely on problems – too much multi-tasking."* The variation inherent in outdoor settings – through sight or sounds - was identified as potentially increasing the potential for attention being drawn away from the focus of the therapy. A consequence of this could be *"allowing avoidance of more direct immediate contact"* or result in *"not discussing all of your feelings"*.

DISCUSSION

Findings from this study show that potential clients can identify a number of benefits that could be gained from participating in walk and talk. Whilst drawbacks were also identified, there was generally a positive response for walk and talk as a potential therapeutic activity. As the first known study to explore potential client's attitudes towards walk and talk, this offers an optimistic start from which further inquiry can be developed. This study further highlights place related issues and concerns that arise when taking counselling into outdoor settings, as the move from indoor to outdoor is perceived to add something and also potentially detract from the therapeutic encounter. This finding lends support to Conradson's (2005) assertion that people can see outdoor settings as both helpful and problematic at the same time, therefore challenging the assumption that natural settings are "intrinsically therapeutic" (p.338). The varied responses to walk and talk are indicative of perceptions based on past experiences, thus supporting Tuan's (1977) assertion that meaning is made from a dynamic interplay between past experiences and anticipations into the future. Furthermore, results from this study show perceptions of walk and talk as being inextricably linked with place, as appraised through responses to the outdoor environment. This further serves to demonstrate the multi-dimensional and complex relationships between people, place and experience and the different meanings that arise from these (Creswell, 2008).

A high degree of similarity between appealing and least appealing aspects suggest a dissonance in how the purpose and intent of walk and talk is perceived to fit therapy in an outdoor setting. Herzog, Maguire and Nebel (2003) report that potentially restorative environments can be both well-suited and ill-suited to the individual's intent and goals. They further suggest it is a degree of compatibility (i.e. to what extent the environment meets the needs of a situation) that is seen to mediate the potential for restoration. These findings support the importance of helpfulness beliefs that clients enter therapy with, thus suggesting those more favourable to walk and talk can see the ways this could be beneficial to them (Iselin & Addis, 2003; Duncan & Millar, 2000).

The maintenance of appropriate professional boundaries was of concern to participants in this study. There is an unpredictability inherent in outdoor environments with limited human control over the setting, therefore therapy will in some way or another be affected by variations in the environment. Jordan (2014) highlights the need for therapists to be accountable for the holding of the 'therapeutic frame' when working in outdoor settings, and attend to professional aspects such as confidentiality and boundaries. In a study of therapists who offer walk and talk within their therapy practice, therapists described how walk and talk was offered in an informed, collaborative and planned manner. They emphasised the importance of a therapeutic rationale for moving from indoors to outdoors, acknowledging unpredictable aspects and involving the client in the decision making process (Revell & McLeod, 2017). This suggests that therapists who offer walk and talk are familiar with managing professional boundaries in an unpredictable environment and have developed the skills to work with these in a way that is constructive for the client's therapeutic benefit.

The participants in this study demonstrated a high level of awareness regarding the physical and emotional benefits to be gained from walking and being in outdoor environments. Walk and talk could therefore provide an opportunity that harnesses existing levels of awareness and at the same time serve to support a wider public health agenda through increasing physical activity levels of clients and beneficial effects of spending time in outdoor environments, enhancing overall wellbeing (Mayer et al., 2009; Pryor et al., 2006).

It is important to acknowledge the limitations of this study. Firstly, the perceptions of walk and talk as a therapeutic activity were not from actual clients of therapy. Therefore, it is possible that perceptions might be different for individuals at the point of accessing therapy, when experiencing a level of distress or seeking particular things from their therapy. Clients of therapy (who are not studying counselling/psychology related courses) may also have different reactions to walk and talk and fewer concerns related to the maintenance of the therapeutic relationship. The majority of participants were young adults, and therefore findings are not generalizable to all age groups.

Short answer responses limit the depth and richness of the data. However, as the practice of walk and talk therapy has not been widely investigated, the findings from this study offer a useful platform from which to base further in-depth qualitative investigations upon. Research exploring client experience of participating in walk and talk is needed in order to broaden understanding of how this therapeutic activity can enhance existing therapy provision for some clients.

CONCLUSION

In conclusion, the findings from this study offer general support for the provision of walk and talk as a therapeutic activity. Useful insight has been gained into the reasons that potential clients may choose or not choose to take part in walk and talk, if offered. Therapists wishing to integrate walk and talk into their therapeutic practice can be informed of various practical aspects that require careful consideration and collaboration with clients that could enhance uptake of this therapeutic activity.

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A PLACE OF BELONGING: REFLECTIONS ON BEING A MEMBER OF THE TAIERI BLOKES SHED

James Sunderland

INTRODUCTION

Occupational therapy recognizes the transactional relationship between person, occupation, and environment (place) as a key determinant of health and well-being. When place affords the occupational wants and needs of individuals, and collectives, subsequent health, and wellbeing benefits result. This paper examines this transactional relationship at the Taieri Blokes Shed, a community that is part of the Men's Shed Movement. The Men's Shed movement originated in Australia as a way of addressing older men's health and well-being issues through engagement in meaningful trade based occupations. Shed Members work shoulder to shoulder on constructive work projects for the benefit of the wider local community, their Shed, and themselves. Research on Men's Sheds indicates a number of benefits related to health, well-being, education, and vocational training for those who are active in these communities. The aim of this study was to understand the culture of The Taieri Blokes Shed as viewed through an occupational lens, in turn capturing the benefits of active membership. An ethnographic methodology was used where the author was a participant observer over a six-month period, after which qualitative theme checking interviews were conducted with six selected Shed members. Cultural records and secondary sources were also used to inform findings. Findings revealed constructive work was the reason individuals joined this community and attended on a regular basis. Constructive work is organized into projects that have identified purpose and meaning, benefiting the wider community, the individual member, and the Shed. The Taieri Blokes Shed is a place, which has been fashioned to afford constructive work and community. Engagement in constructive work projects facilitates occupational identity and satisfaction, social inclusion and community contribution. Findings are discussed in relation to the link between place, occupation, health and well-being. Implications for occupational therapy are acknowledged.

Background

Of all the clubs, I've ever been in my life, and there are quite a few, this is easily the most united in its members and its aims, without doubt'

(Taieri Blokes Shed Member)

Men's Sheds are places centered on occupations of constructive work, where members are male and often retired from full time paid employment. The author was a participant observer at one Men's Shed, The Taieri Blokes Shed, for six months in 2011, and drew additional understandings from qualitative interviews with selected members. Background information is provided on occupational therapies understanding of the transactional relationship between person, occupation, and environment (place), the Men's Shed movement, and the Taieri Blokes Shed. The methodology of this research is outlined and the findings are presented and discussed in relation to occupational therapy's philosophical beliefs about the interconnectedness of person, place, and occupation, and the association to health and well being.

LITERATURE REVIEW

In the last three decades, the occupational therapy profession has focused increasingly on the quality of place as well as how these qualities contribute to health and well-being through the enablement of meaningful and purposeful occupation (Kielhoner, 2008; Ulrich et al., 2008; Dunn, Haney, Brown, & Youngstorm, 2003; Gitlin, 2003; Rowles, 2003; Corcoran & Gitlin, 1997). More specifically occupational therapy research, and practice, has attended to place as a factor in the spatial-temporal patterns of an individuals, or collectives, lifeworld. Where lifeworld is a phenomenological topic that looks at the everyday world, that which is taken for granted, or generally unnoticed (Finlay, 2008; Toombs, 2001; Seamon, 1979).

In the broadest sense, place is a defined area of space, where perceptions are fluid, associated with occupations that have happened, are happening, or will happen in the future. Individual and collective human occupation is central to our attaching meaning to places. What begins, as undifferentiated space becomes 'place' as we get to know it better and endow it with value (Relph, 1976, 2008). Place is an environmental locus, gathering meaning, intention, and action (Casey, 2009; Malpas, 1999; Relph, 2008, 1976). Places allow, or require us, to engage in occupation, realizing who we are, what we can achieve, and how we belong. Places guide our doing, being, becoming, and belonging (Wilcock, 1998). The places we access on a regular and routine basis provide insight into how we are occupied and what we value in life. Alongside this understanding is awareness that loss of place, or barriers and presence in place, have substantial impact on a person's identity and their physical and mental health.

The occupational therapy profession sees enablement of occupational performance and subsequent realization of health and well-being as being dependent on the transactional relationship between person, occupation, and environment (place) (Law, Cooper, Strong, Stewart, Rigby, & Letts, 2016).

> Occupational situations have three components: places, people (with their attributes, thoughts, feelings, and memories), and the occupations in which the people engage. Thus the link between person, place, and occupation is so strong that one cannot consider occupations without considering they involve people in places.
>
> (Hamilton, 2010, p.252)

Occupational therapy comprises working with individuals, and groups, to enable occupation engagement in place, often following injury, disability or complications arising from ageing or health events. This practice involves analysis and adaptation of occupational tasks or the environment (place) to support engagement. Sometimes the focus is on assisting reengagement in familiar places, at other times it may require supporting individuals, and significant others, to manage transition of place from the familiar to the unfamiliar, while acknowledging what has been lost (occupational transition). Occupational therapists accesses, and advocate for, place orientated communities that provide health, and well-being benefits for those they work with. In this paper an occupational lens is applied to one community, the Taieri Blokes Shed, which provides a number of health and well-being benefits for its members. The Taieri Blokes Shed is a physical defined place that is bestowed with meaning through individual and collective engagement in purposeful constructive occupations. It is a place associated with the wider Men's Shed movement.

The men's shed movement

The Men's Shed movement originated in South Australia in the early 1990s with a subsequent proliferation of Sheds throughout Australia, New Zealand, Ireland and the United Kingdom. Most Sheds have 'grass roots' origins in local communities that contribute to their individual association with the geographic region and its unique profile. Retired elderly males working 'shoulder to shoulder' on construction projects benefiting their local community, their Sheds, and themselves predominantly populate men's Sheds. At the time of writing over 60 Shed communities, exist throughout New Zealand with the majority affiliated with MENZSHED New Zealand (http://menzshed.org.nz) a registered charity that provides national support for Member Sheds, assisting governance structures and facilitating public access. Each Shed community has their own individual flavor based on their membership, the work they undertake, and the wider district in which they are situated.

There is a growing body of research on the Men's Shed Movement, predominantly based in the Australian context. Men's Sheds are viewed in the literature as meaningful community based organisations that offer health and well-being benefits to those who attend. Early research on the movement focused on the quantifiable health, education, and vocation benefits resulting from Shed membership (Golding, 2009; Golding, 2008; Golding, Brown, Foley, Harvey & Gleeson, 2007; Golding, 2006). More recent research conducted by Moylan, Blackburn, Leggat, Robinson, Carey and Hayes (2011) established that the collaborative nature of the Men's Shed contributes to the health and well-being of participants as does the sense of purpose provided by the work and the structure it provides for participants. Additional studies have also provided evidence of the physical, mental and emotional health benefits of the Men's Shed movement and include, Fildes, Fildes, Cass, Wallner and Owen, (2010); Ormsby, Stanley and Jaworski (2010); Morgan (2010) and Ballinger, Talbot and Verrinder (2009).

The Men's Shed Movement: The Company of Men provides a definitive overview of the development of the Men's Shed movement. Golding (2015) acknowledges that Men's Sheds provide social inclusion for men (commonly retired men) because of the multiple benefits derived from men working in a community that does together. What Men's Sheds provide in relation to social inclusion and active participation links to identify requirements for successful retirement and wellness in ageing (Koopman-Boyden & Wadegrave, 2007). What is important is finding the right match between the needs of the individual and the affordances of the Men's Shed community. Men's Sheds, although having recognised benefits, are communities not health care, or therapy facilities. Golding (2015) states "[i]n practice most Men's Sheds welcome and admit men of any age or background, with a range of disabilities, though many are reluctant to take men as regular workshop participants if they require high level care without the support of a regular carer" (p. 379).

There are limited studies of Men's Sheds within occupational therapy. Martin and Wicks (2008) studied the experiences of meaningful occupation of members of one Shed, The Berry Men's Shed. More recently Wicks (2013) has documented a transactional view of Shedding, highlighting its complexity and multidimensional nature, which have associations to the findings of this research.

Figure 1. Exterior of *Taieri Blokes'* Shed. Source: Author

The Taieri blokes' shed- a brief overview

The Taieri Blokes Shed is located in Mosgiel, Dunedin, and is part of the wider Men's Shed movement. The Taieri Blokes Shed is a community that has assisted a group of men to cope with the transition from paid employment to retirement. For the majority of members this transition has meant the loss of routine engagement in familiar work places, farms, or rural communities. Many members have moved to Mosgiel after retirement. This move posed unforeseen barriers to engagement in chosen occupations and social interaction. Mosgiel is a small town of 10,000 persons situated fifteen kilometers southwest of Dunedin (Figure 2).

All members of The Taieri Blokes Shed, from here on referred to as The Shed, are male with an average age of 75 years. Roughly half of the members have trades-based employment backgrounds; with others having work, home and community construction histories, as well as this, a number of members are retired farmers. Over 70% live with wives and partners while the remainder live alone. The members of The Shed are, in general, mobile and independent. Many manage health issues common to their age group including, hearing impairments, vision loss, and reduced mobility.
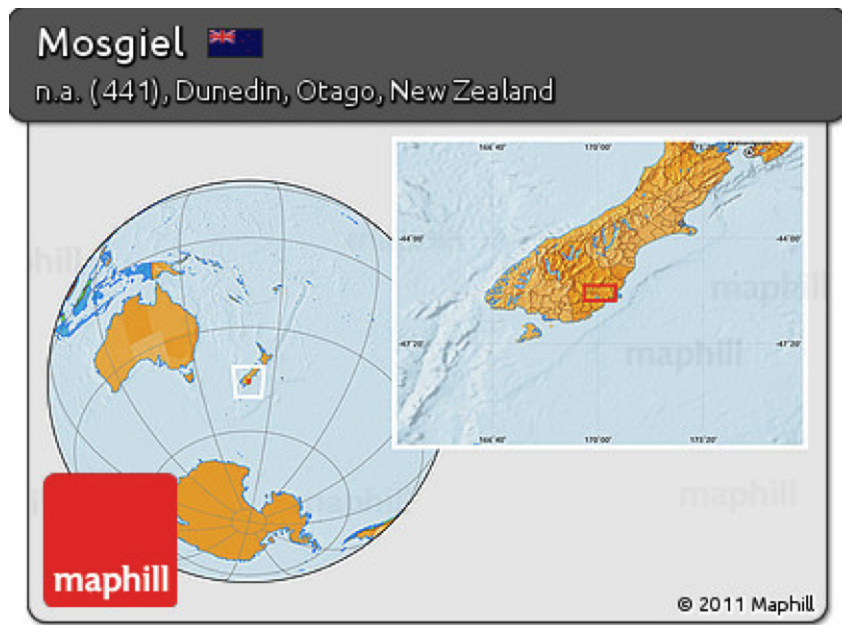
Figure 2. Mosgiel, Otago, New Zealand. Source: Maphill (2017)

Research aim

The primary aim of this study was to understand the culture of the Taieri Blokes Shed viewed through an occupational lens. This viewpoint directed focus on comprehending the following areas:

• Occupations that are attributed meaning and purpose by Shed Members.

• The structuring of occupation in relation to members (persons), and the environment (place)

• Health and well-being benefits derive from active occupational engagement

• The Sheds connection to the wider Otago community

Through understanding these areas subsequent links can be made to the wider Men's Shed movement and occupational therapy

METHOLOGY

This research used an ethnographic methodology. Ethnographical research aims to represent the nature of people within social collectives and demands the researcher's immersion within a community of interest, which involves enactment of social roles and relationships, which places the self (researcher) at the heart of the enterprise (Coffey, 1999, p. 23). Although an ethnographic methodology was used, this is not a traditional anthropologic study. This research is underpinned by key philosophies and concepts from the fields of occupational therapy and occupational science.

This research documents and interprets the culture of the Taieri Blokes Shed. An analysis of the Shed community from an insider (emic) and outsider (etic) perspective is provided. An emic approach is an insider's view and captures how people think within a community or culture (Kottak, 2006), how they perceive the world, categorise, imagine and explain events and proceedings. An etic approach recognises that members of a culture are so involved in what they are doing that cannot be impartial in interpreting their culture. An etic approach shifts the viewpoint from the member of the culture to the researcher and what they consider to be important (Kottak, 2006). An occupational perspective informed the etic view.

Data collection

Data (empirical material) were collected in this research by employing three primary methods: participant observation, qualitative interviewing, and analysis of cultural artifacts. Secondary data sources were examined to broaden understanding of the wider context of the research and the Men's Shed movement. The researcher was a participant observer at the Taieri Shed for six months and following this conducted six qualitative theme-checking interviews with selected Shed members.

Data analysis

Although there are multiple approaches to the detailed analysis of data collected in ethnographic research the basic mechanics are relatively straightforward. Figure 3 provides a summary of the data analysis procedure. Data collection and analysis often happen simultaneously when the researcher is trying to make sense of what they are observing as it happens (the here and now).

Figure 3. Data Analysis Summary for Ethnographic Research Source: Fielding (2011, p.27)

In this research, all empirical materials were subjected to an analytical phase using the 'Framework' matrix-based tool for qualitative data analysis developed by the Qualitative Research Unit at the National Centre for Social Research in the United Kingdom. This tool requires the organisation of data into a series of matrices from which a thematic analysis is conducted (marking up and constructing outline). It aims to organize and manage empirical data. Matrices assisted in the generation of meaning and interpretations (Smith & Firth 2011).

Ethics approval

Ethical approval for this research was granted by the Otago Polytechnic Ethics Committee in October 2011.

FINDINGS

Research findings are included under three identified areas of benefit for members of the shed, meaningful and purposeful occupation; social inclusion; and community contribution. These areas of benefit are realised through regular engagement, alongside others, in the physical setting of the Taieri Blokes Shed.

Meaningful and purposeful occupation

For many members engagement in constructive work at The Shed directly links to their previous identities as tradesmen, farmers, or home repair peoples' occupational identities that are compromised because, of retirement. Kielhofner (2008) defines occupational identity as "... a composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation. One's volition, habituation, and experience as a lived body are all integrated into occupational identity" (p. 106).

Constructive work provides challenge and enables them to realise their skills and knowledge, gaining occupational satisfaction. Occupational satisfaction is about getting what one wants out of occupational pursuits, achieving flow where challenge meets skill, while finding balance with other occupational life requirements (Morgan, 2010). Project work offers opportunity for teaching and learning roles as well as management and governance roles. There is a strong work ethic within the Shed membership, where application to task and the quality of end products is enforced. Projects are allocated, after discussion amongst the membership, to a work team where a leader is appointed based on required skills.

All members of the Taieri Blokes Shed are able to have a say about decisions that are made in relation to community projects, Shed design and maintenance, social activities, and funding applications. Equality is a core value as is self-governance. The Shed has elected representatives in the roles of president, vice president, secretary, and treasurers as well as media liaison. These roles provide a structure for Shed processes and those elected to these positions are often done so in recognition of their past employment skills and community involvements. Members in these roles recognised that these roles are additional to constructive work and have a clear purpose that benefited The Shed. On reflection, the members in these roles found they provided meaningful occupation, although not without frustrations.

Workshop spaces are highly organised to afford specific activities (woodwork, painting, metalwork). Storage areas are clearly defined and health and safety policies are in place for machinery use, layout, and the lighting and ventilation of work areas. This organisation is reflective of members past work experience and is formalised in the policies and procedures of the Shed.

Involvement in The Shed has helped address occupational deprivation for many members. Occupational deprivation is a state in which members were unable to disseminate the practical skills they had being restricted from doing with others (Whiteford, 2000). For the majority of members restrictions came with retirement; including not having access to a workshop environment and tools; no longer having a reason to make and create moving to a new area where knowledge of services, supports and social connections are diminished. Retiring from paid employment or moving from known communities affected the occupational identity and balance of members. This is not to say individuals were doing nothing before Shed membership. However, active involvement at the Taieri Blokes Shed provides a structure to access social support, and to do meaningful work in which they can identify. For some, Shed membership has added to already active lives. For others it filled a large gap in their weekly routine.

With the transition from paid employment to retirement, a number of members talked about finding ways of productively using their time as opposed to just passing time.

> We've got a lot of people with a lot of experience and they're living in their little corners. I live in my shed, you live in your flat, and you do your crossword puzzle in the morning and you walk down to the shop and you walk back and you're really just decaying away health wise and mentally, and all this resource knowledge you have is not being disseminated

(Bob)

> 'When you work over 40 hours per week, for over 40 years of your life, it can come as a bit of a shock to the system when that finishes and you find yourself with a lot of time on your hands'

(John)

There is a robust belief amongst members that constructive work is the key to realising other benefits of social inclusion and community contribution.

Figure 4. Members of the Taieri Blokes Shed Source: Author

Social inclusion

For several members, the initial attraction of The Shed was access to tools and 'work' opportunities they did not have at home, due to downsizing homes (land, garaging, and workshops) and retiring from paid employment. Yet the health and connectedness of The Shed community requires that the focus move beyond individual gain to reciprocity in the conduct of not only constructive work but also social engagement. Presence in The Shed as a place is essential, sharing time together 'at work' and socially.

With the transition from paid or self-employment, to retirement, and moving to Mosgiel, members talked about being isolated from previous social networks. The Shed, although not the complete solution to these issues, has helped members find a routine and valued social network in their retirement.

The Shed provided a chance to make new friends as we've recently moved to Mosgiel. Mosgiel properties, particularly in the new regions, all have high fences and the only time you see your neighbour is when you go in the street ... we came from the place where you had low fences and were in constant communication with our neighbours so we found it quite a struggle when we moved here

(Don)

Smoko is an anchor point for the daily activities of The Shed. Within New Zealand the term smoko has its origins in the cigarette breaks taken in military service. Over time it has been altered to include coffee breaks and outdoor rests. The term is used primarily in New Zealand amongst the building and manufacturing communities ("Smoko," 2017). Smoko occurs during every morning session between 10-10.30am. The smoko room is a room that is separate from the workshop areas. There is a clear physical definition in regards workshop and social/meeting places. There is an expectation that all members take a break for smoko.

Smoko puts the social side of The Shed to the forefront. Smoko is a time when general Shed information is passed on to the members including up-coming out-of Shed events. Wider community relationships and significant personal milestones are acknowledged. Smoko provides a time when members catch up and visitors, or potential members, can be included,

> We put a lot of emphasis on our lounge room and having morning tea there. Just the fellowship we have in that room. People can sit beside different people at morning tea and you talk about things. That lounge or smoko room is the making of The Taieri Shed

(Don)

The way members shared information at The Shed indicates good networks of communication outside of The Shed. If someone is absent for more than a few sessions it is likely they will be phoned by a Shed member,

> Anyone 's only got to be sick or have a partner in the hospital or something and there are always two or three enquiring how they are, or can they help

(Colin)

There is emphasis on mixing as a group at The Shed as well as including wives and partners in regular social events in the wider community. Shed members share in each other's lives. Meaning is also found through contribution to their local community.

Community contribution

Being of use to others is the other key benefit recognised by The Shed members. As a non-profit organisation members are aware of not competing with local businesses, aiming to be of use to other non-profit groups, and individuals, in the local area. Projects are designed and built for purpose. Pride is taken to ensure projects are durable, reliable, affordable, and well finished. The membership understands that there are limits to the projects they can take on, given the parameters of their own resources.

> This is a community where things get done and people know what you do. We're happy to take on community projects within our ability. It should never be an intention to do things to make money ...Community connections come with the project work

(Neil)

There are identified procedures within The Shed to liaise with the wider community about project work. This relationship starts when there is a project enquiry. If the project is commissioned a person or persons are delegated to liaise with the community until completion. The members of the Shed are conscious that The Shed needs to be visible in its local community. The members of The Shed makes themselves available to local media and have regular stories published in local and regional newspapers and magazines, which along with word of mouth from project work, helps to generate new members and ongoing projects. Finished projects are delivered to community groups and individuals. These parties are often invited to The Shed to discuss projects. The support The Shed has is evident in not only the media coverage they receive but also through the numerous, cards letters, and morning tea shouts local groups have provided in appreciation. In addition to contributing to the local community two members are active in assisting other Men's Shed with the logistics of setting up services, and helping structure governance. Having experienced the benefits of involvement in a Men's Shed they are committed to offering others these opportunities.

DISCUSSION

Membership of the Taieri Blokes Shed provides access to a place where members feel valued; where they can learn and share skills with the support of others; and where they can contribute to their wider community. Membership of The Taieri Blokes Shed requires productivity as well as engaging on a social level, where members value each other's company, care for one another, and can tolerate difference.

As with other Men's Sheds constructive work is the anchoring occupation. Shared occupations are the basis of all communities (Poplin, 1994). There is an understanding, within The Shed, that the main purpose of The Shed is productivity. As such the physical place, the workshop areas, have been built to afford constructive activities while also considering safety, accessibility and the storage of materials and equipment. Constructive work provides the platform for social inclusion and community contribution. For individuals to achieve personal benefit, including health and well-being benefits, they must finding a match between their own occupational identity and needs, and the ethos of The Shed. Men's Sheds are not for everyone.

The Taieri Blokes Shed offers something that other retirement activities do not. This is not a sporting pursuit, a golf, croquet or bowls club. It is not a place to commune and engage with others who have served in the military like the Returned Service Mens' Association. It is not based on beneficence through fundraising and business connection like the Rotary and Lions clubs. The Shed is a place where the focus is squarely on constructive work, where members plan, design, build and engineer alongside others who share these interests, or these skills, however acquired. Within the Men's Shed literature there is recognition of the centrality of meaningful constructive work to productive involvement of Shed members, many of who are making life transitions (Golding 2009; Martin & Wicks, 2008).

The Shed provides a community where members reconnect, or remain connected to, an occupational identity that includes constructive work and community work, where engagement provides occupational satisfaction, autonomy, and positive recognition from others. These are known factors in enabling wellbeing in retirement and wellness in ageing (Koopman-Boyden & Wadegrave, 2007). The Shed provides the opportunity to connect, not only with their previous occupational experiences but also to people with similar interests, skills and knowledge. These connections are instrumental in preserving and growing occupational participation following transition/retirement (Klinger, 2005).

The Shed offers regular, routine occupation that is set in place. And a necessity in orchestrating successful transition to retirement (Wiseman & Whiteford, 2009).

Men's Sheds succeed when they are self-governing and the products of their industry serves local communities, growing from 'the grass roots', rather than being prescribed or requiring the ongoing facilitation of a third party (Golding, 2015). Men's Sheds are not intended as places to hide; they are not refuges from the outside world. Men's Sheds need to be open to new projects, new members and their local community.

There is a strong synergy between what Men's Sheds can offer and occupational therapy's core belief about engagement in meaningful occupation as a determinant of health and well-being. Given this complementarity, the profession has a role in advocating for the Men's Shed movement. However, this does not mean occupational therapists should be involved in the day-to-day activities of Shed Communities. Giving the findings of this and other research there is value placed on self-governance and control. Occupational therapy can offer support in the form of research (such as this study), which in turn could benefit advocacy, funding and governmental recognition of the movement. Occupational therapists may choose to provide practical support and become involved with Sheds at a local level. Support of the Men's Shed movement is in line with the World Federation of Occupational Therapies positioning on human and occupational rights. Their position states that all people have the right to access and participate in occupations that enable them to be involved in the community and find satisfaction in occupations that have educative, productive, social and restorative benefit (Position Statement on Human Rights, 2006).

Practical occupational therapy support may include projects such as the ones completed by students of the Otago Polytechnic Occupational Therapy School (tool drives, advertising pamphlets). Where appropriate practitioners should look to build relationships with local Men's' Sheds informing the referral persons who might benefit from membership. Sheds relationships have the potential to be reciprocal. For example, given the body of knowledge and skills at the Taieri Blokes Shed there is an ability to make aids, devices and products for groups and individuals that occupational therapists work with. The Taieri Shed has already completed a number of projects for disability communities such as CCS and Riding for the Disabled. Men's Sheds have the potential to take on some of the project work traditionally conducted by occupational therapy workshops, especially if a need cannot be addressed by commercial equipment.

CONCLUSION

The findings from this study, although limited to one Men's Shed, complements and expands on the body of research. The Taieri Blokes Shed provides a place where members feel valued; where they can learn and share skills with the support of others; and where they can contribute to wider society. The Shed is non-hierarchical, self-funding, and strongly affiliated with the local community. Benefits depend on individuals finding a match between their own needs and the ethos of The Shed. Membership means associating on a social level where men value each other's company, care for one another, and can tolerate difference. As with other Men's Sheds constructive work is the anchoring occupation.

Acknowledgements

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THE ROLE OF A CAFÉ ON THE PREMISES OF AN AGED CARE FACILITY IN FACILITATING MEANINGFUL OCCUPATION FOR RESIDENTS AND THEIR FRIENDS/FAMILY.

Alexa Andrew

INTRODUCTION

This article is a reflection on the concepts of 'place' and 'health' in relation to the findings of a research project which explored the value of a café on the premises of an aged care facility. The participants, who were all users of the café, consisted of; residents of the facility and their friends and family members. Interpretative descriptive methodology was used in the data analysis of the primary data. The findings of the research highlighted the participants' appreciation of the café as a place, from both a physical and social perspective, as well as the way in which it provided opportunities for meaningful occupation for residents and their family/friends.

Background

The built environment of Aged Care Residential Facilities (ACRF) can have a major impact on the quality of life of its residents (Bicket et al., 2010; Parker et al., 2004; Barnes, 2002). There are many variables to consider in the design of ACRF's; functionality, aesthetics, comfort, privacy, safety, and there is added complexity in that the building is a residence/home for some and a workplace for others. A recent drive to provide more homely residences rather than traditional institutional type environments has resulted in the development of several models of design. Some models have focussed on the design of the residence such as the 'Neighbourbood Model' whereby larger facilities are resized and renovated to smaller homelike proportions, which include separate dining, and living areas (Ragsdale & McDougall, 2008; Mitty, 2005). Others have focussed more on the residents' ability to engage with the environment such as 'The Eden Alternative' where plants, animals and children become an integral part of the residence which residents are encouraged to care for and interact with (Brownie, 2011).

The occupational wellbeing of older adults who reside in ACRF has become a significant issue of concern over the last several decades for the occupational therapy profession (Wilcock & Townsend, 2009). Occupation is defined as "an activity or group of activities that engages a person in everyday life, has personal meaning, provides structure to time and is seen by the individual as part of her/his identity" (Creek, 2006, p.205). Research has shown that older people in aged-care residential facilities spend the majority of their time, 69%, inactive and alone (Morgan-Brown, Ormerod, Newton, & Manley, 2011; Harper-Ice, 2002). The person who has moved into a residential facility has frequently left behind a home, garden, local community as well as the occupations embedded within those environments. Hocking (1996) asserts that the most significant feature of entering residential aged-care is the discontinuity with the previous environment and an older person's occupations which are not easily translated to the new residential environment (Walker & McNamara, 2013). In addition, the older person, due to the fact of having been admitted to a residential care facility, will likely be experiencing complex health conditions and functional decline (Rodriguez-Blazquez et al., 2012) which will compound the impact on their occupational participation.

METHOD

This article is a reflection on the concepts of place and health in relation to the findings of a research project which explored the value of a café on the premises of an aged care facility. The original research project used interpretative descriptive methodology and data was collected through semi-structured interviews. Participants consisted of both residents of the aged care facility and their family and friends who were users of the cafe. Recruitment was achieved by the manager of the facility initially compiling a list of regular users of the cafe and invitation letters were sent to residents she identified had the communicative and cognitive capacity to participate in an interview. The manager had a working knowledge of the café users and was able to screen the possible participants according to the health status of this vulnerable population. There was no other exclusion criterion established on regularity of café use as all users (frequent or infrequent) were relevant to the study. Thirty-two residents and twenty family/friends were invited to participate in the study; eleven residents and nine friends/family consented to be interviewed. Both written and verbal consent was gained from each participant. The Southern Regional Health and Disability Ethics Committee (NZ) approved the study, in 2010.

Data analysis in the original research was carried out according to the seven phases outlined by Marshall and Rossman (2011), three major themes were established and are illustrated in Figure 1. The flow of themes represents the way each created the opprtunities for the following, rather than a hierarchy of importance.
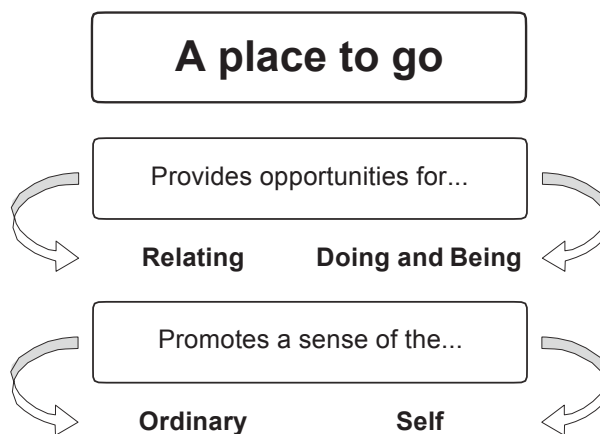
Figure 1. Participant themes. Source: Author

Following reflection, a clear congruence between themes established in the original research and concepts of place and health were evident and a further two themes have been created to illustrate the compatibility of concepts; "Attributes of Place" and "Meaningful Occupation". Quotes are used to illustrate themes and are presented according to the following key:

R = Resident

F = Family/Friend

Pseudonyms are also used to differentiate the participants.

The café referred to in this research was established in a large 123 bed ACRF during a process of major redesign and renovation in 2006. This large ACRF has five different units; two rest-home level care, two-hospital level care and one dementia care. The café is situated in the foyer at the front entrance of the ACRF and is open seven days a week from 09.45hrs to 16.00hrs and services the residents of the facility, their family and friends as well as being open to the public. The café consists of three distinct areas; indoor tables and chairs, comfortable couches in front of a fireplace and an outdoor courtyard. The menu at the café offers barista coffee, tea, a variety of light meals, sandwiches and cakes, and is priced just below market rates. The café is funded and supervised by the management of the facility.

FINDINGS

Interviews with participants revealed the importance of the café as a place when discussing its value. The physical and social attributes were appreciated as well as the café being an ordinary place removed from the rest of the facility which is more clinical in nature.

Attributes of place

The resident participants described aspects of the physical environment they valued. The design and decor of the café and resulting ambience according to the seasons were highlighted. This resident described her appreciation of the indoor aspects of the café in winter:

> …it is nice and cosy in front of the fire place, "cause in the winter time that fire's going and its beautiful sitting around on the comfy suite there and having a cup of coffee.
>
> (Alice = R)

Another resident appreciated the ability to sit outdoors:

> Yes I was in here over the summer or autumn or something and that was open so we sat out there and it was lovely, and you wait for the days where you can sit out there again.
>
> (Anna = R)

This family member commented on the difference between the environment of the café and the environment of the care facility:

…it's different scenery, the sun's still shining on the pansies, there's still people buzzing around her and it just gives a nice feeling of, kind of different from the monotony of everyday in the hospital.

(Fiona = F)

The café environment was considered an ordinary place where people do ordinary things:

I mean the cafe's quite attractive, it feels like kind of a normal, it feels like you're out…

(Ruth = R)

Going to the café was also considered an outing for some residents, particularly those with mobility issues:

It's like going out, when you can't go out, its good food and its good coffee and you know you see everybody.
(Helen = R)

The residents and their family/friends also appreciated the social environment of the café, this resident commented on the friendliness of staff:

It's very friendly, the staff, the counter staff are all very chatty and friendly and it's like a big family.

(Helen = R)

Friends and family also spoke of the café as being the center of a community which they and the residents could feel a part of:

…and it is a community hub, so, um, you know if that cafe wasn't there it would just be awful.

(Fiona = F)

…it's my home away from home really I know, everybody knows him, everybody knows me.

(Sarah = F)

Meaningful occupation

The café enabled occupations for the residents and their friends and family and their meaning was attributed from a variety of perspectives.

Going to the café provided the residents with an everyday occupation which provides structure and routine and opportunities for choice in the residents' everyday lives. This resident described a regular arrangement to meet a friend:

Every Sunday we congregate down there and we have afternoon tea with them every Sunday.

(Irene = R)

The activity of making choices is also part of a normal daily routine. Family and friends specifically expressed the value of residents being able to make choices:

…it provides mum with something that she enjoys too which is making choices and decisions about what she wants hot chocolate or a cheese roll.

(Alice = F)

The presence of the café also enabled residents to continue to fulfill established life roles which are part of a person's identity, for example, hostess, friend, parent and grandparent. Residents and family reported on the value of the café as a place to host special family occasions such as birthdays. By hosting events at the café the resident is able to take part in important family celebrations:

…it'll be her birthday on the thirteenth of March, last year and the year before we had um a little birthday celebration for her in the café.

(Ella = F)

The café was described as resembling a family home which enables residents to show hospitality:

…be able to offer them a cup of tea, it's like, for her it's like family home, it's a way of showing hospitality.

(Susan = F)

Relocation of meetings by various community groups, such as book clubs and senior citizen groups, has enabled some residents to continue to belong and participate:

I belong to a clan and we have committee meetings with up to twenty in that for lunch and quite a lot of us now do different clubs and things and have lunch here.

(Dorothy = R)

The café is situated in the front foyer of the facility and generates a hub of activity and an atmosphere of liveliness within the core of the facility. The view from the café is the foyer of the ACRF, where the comings and goings of the facility are easily seen. The pastime of people watching, typical in a café environment, was described by a resident:

> …*we would watch people come in and the door opens and people go in and people go out.*

(Greta = R)

Being at the café also keeps residents in touch with activities which are occurring within its proximity, this daughter commented on how the busy atmosphere lifts her mother spirits. F;

> …*because of where it's positioned it's near other things that are happening like there's a lot of activity in the chapel, it's a catalyst to engaging with what's going on around and I've found that kind of lifted Mum's wellbeing all round.*

(Alice = F)

DISCUSSION

The way in which place affords an older person opportunities for occupation and social interaction is particularly important as the frail older resident spends the majority of their time within the facility (Parker et al., 2004). Rowles (2008), an environmental gerontologist, recommends focussing on the older person "being in place" (p.129), and refers to the space within the visual field of the older person's environment as "the surveillance zone" (Rowles, 1991, p.265). The café provides residents with a unique surveillance zone; participants commented on the value of sitting in the café and watching the people and the activity occurring within its proximity. In addition, visiting the café provides an opportunity which is normally experienced as an outing away from home. Residents expressed the notion that going to the café like going on an outing. The café provides a place, which due to its placement in the foyer, is on the cusp of the local community and provides residents with the experience of being connected to that community. Scheidt and Windley (2003) recommend that ACRF's should aim to "provide residents with the widest of environmental options that enrich and sustain life" (p. 44). A café on the premises of an ACRF is one environmental option that can enrich the opportunities available to the residents.

Prior to entering residential care older people are accustomed to exerting control over their environment and their everyday lives and this is pivotal in maintaining a sense of mastery and control. Loss of that control is significant for the older person in residential care (Anderberg & Berglund, 2010) and has a profound impact on life satisfaction (Jilek 2006; Kane et al., 1997). A person whose life was previously self-determined is now subject to rigid routines which are mainly designed to manage staff workloads (Kane et al., 1997). Recent research has demonstrated that environmental mastery has a significant impact on the mental health of older people in residential care (Knight, Davison, McCabe & Mollor, 2011). Opportunities for mastery included; timing of care received, deciding on the destination of an outing and the nature of social activities on site (Knight et al., 2011). The experience of going to the café provided residents with some opportunities for choice and control; choosing what they want to eat, when to go and eat it, who to go with and where to sit within the cafe.

Participation in occupations which reflect an older person's identity for example their life roles such as mother, housekeeper or gardener are hampered by an institutional environment where policies which focus on health and

safety often preclude residents from participating in occupations which are familiar and purposeful. Häggblom-Kronlöf, Hultberg, Eriksson and Sonn, (2007) examined the daily occupations of 99 year olds and highlighted the capacity of daily occupations to support the sense of self and build identity. The findings of this research demonstrated that participation in the café enabled continuation of residents' life roles such as mother, friend, club member and hostess. The role of hostess was especially significant for the resident participants; it meant being able to 'offer and give' (by hosting morning tea at the café and paying for it) in an environment where the resident is more regularly in receipt of care and attention. Shield, Tyler, Lepore, Looze and Miller (2014) confer that environmental enhancements in ACFR's can "skilfully connect residents to their identities and prior roles" (p. 396). Several community based clubs have been known to relocate their meetings to the café in this ACRF to enable a resident to continue their interests and membership. Continued contact with the residents' previous social networks and interests assists the resident to maintain their social identities in their new environment.

Older people living in residential care can experience occupational deprivation which is defined as "a state of prolonged preclusion with engagement in occupation of necessity and/or meaning due to factors that stand outside of the control of the individual" (Whiteford, 2000, p. 201). Wilcock and Townsend (2009) concur and propose that occupational injustice is prevalent in aged care facilitates where residents sit alone or in other confined settings with nothing to do except watch others in the same situation or a television showing preselected programmes. Quality of life for older people in residential care has been addressed by the New Zealand Healthy Ageing Strategy (2016) and states that "for some people with high and complex needs, moving into aged residential care improves the quality of their lives in their remaining years" (Ministry of Health, 2016, p. 38). The opportunity for participation in meaningful occupation is a matter of justice and access to meaningful occupations which maintain connections with residents' life roles is paramount.

The link between participation in meaningful occupation and the health and wellbeing of older people is well established. A quantitative research project which employed a series of randomised controlled trials assessed the effectiveness of a preventative occupational therapy programme for older people living in the community. The programme focussed on older people understanding the significance of occupation in their lives and how to overcome barriers to participation (Clark et al., 2015). This research assessed the following outcome variables; physical health, social functioning, mental health and life satisfaction (Clark et al., 2015) and results demonstrated that participation in the aforementioned programme resulted in increasing the health-related quality of life for older people and that the results were sustainable (Clark et al., 2015). Similar quantitative research in aged care facilities titled "The Quality of Life Study" explored the connections between depression, activity and life satisfaction in residential aged care (Mozely et al., 2000). Results indicated that the "residents level of satisfaction with the amount of pleasure derived from things done in the home" (p. 17) had an impact on survival. Hearle, Rees and Prince (2012) concur "engagement in self-selected purposeful activities is positively related to physical and psychological well-being" (p. 125) for residents in RACF. The health and well-being of older people in ACRF's is able to be maintained through opportunities to engage in meaningful occupations which provide choice and engagement in life roles.

CONCLUSION

The nature of any environmental innovation in an ACRF needs to be carefully considered in terms of the opportunities it will afford for the residents and their families. The findings of this research, while not generalisable, indicate that a café on the premises of an ACRF can provide a unique place which offers residents opportunities to participate in occupations that are meaningful to them. Maintaining life roles and a sense of mastery over the environment can influence the health and well-being older people in residential care. Any ACRF of the future which claims to provide quality of life for residents must demonstrate a variety of ways in which the occupational needs of this potentially vulnerable population of older people can be met.

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Review

NARRATIVE EXPLORATION OF THE LETTERBOX: A PORTAL TO LEARNING ABOUT HOME

Josie Crawley

INTRODUCTION

Home is a place that is key to humanity while home, can be explored by research, this research is enriched and given meaning by the sharing of narrative experience. Narratives are explored as a tool for student reflection about home. This article offers a brief discussion of home as a place, then distills the letterbox as the conduit between home and the outside world by sharing three different types of narrative: a client poem, student nurse reflective narrative and a children's picture book.

We shape our dwellings, and afterwards our dwellings shape us

(Winston Churchill, n.d.)

More than a repository for mail; the letterbox can be interpreted as a symbol of home, a significant place that is central to wellbeing and peoples' sense of self. The exploration of the humble letterbox hints at what home means for the storyteller; narratives make meaningful the realities of the everyday routines, the diversity of humanity and the changes inherent in the passing of time. The narratives discussed below describe lives and experiences, noticed, and collected by the storyteller – a feature of narrative inquiry (Berger & Quinney, 2005).

Background

Home is a concept that is explored by academics across several health and social professions. Mallett (2004) describes the family home as, "…a formative dwelling place, a place of origin and return, a place on which to embark on a journey" (p. 62). Williams (2004) expands that home may or may not be a positive place, it may be a refuge from the world, or a prison that keeps you isolated. Where home is adapted to compensate for disability, its meaning can also change for the person (Morgan, Bonniface & Reagon, 2016). There are many advantages to "ageing in place", the concept by which older adults are able to age in their own home and community rather than an aged care facility (Grimmer, Kay, Foot & Pastakia, 2015). In addition to cost effectiveness, and longer life independence, resilience and autonomy, a sense of self is fostered through a personal home base and home community that provides attachment, familiarity, connection, practical and financial assistance, activity and feelings of security (Grimmer et al., 2015).

Researchers understand home to be a multidimensional concept (Mallett, 2004; Williams, 2004). Williams (2004) developed three dimensions to the meaning of home based on clients' stories: the familiar, a central function and home as a protector. However, individual client's voices and sense of self are not often heard in discussions of the meaning of home.

The place of narratives in nursing

Historically the nursing profession has valued stories and narratives since the 1850's as a research pedagogy, an educational tool and a clinical skill to share and explore client experience and context (Hall & Powell, 2011). Definitions of story and narrative differ across disciplines, however this article uses narrative to refer to formalized storytelling "…that   reflects time-ordered events with a discernible plot and cast of characters and that imparts personal and cultural information from the teller to the audience in a coherent whole" (Hall & Powell, 2011, np). For nurses, clients and students, sharing client and health worker narratives can be a way of unfolding meaning. The stories highlight details important to the writer, patient or client, and encourage the reader to explore multiple perspectives (Tevendale & Armstrong, 2015; Owen, 2004). Reflecting through writing and hearing stories can illuminate both students' and clients' values and knowledge: developing an understanding of peoples' lived experiences by building, interpreting and deconstructing narrative knowing (Greenfield, 2015; McAllister, John, Gray, Williams, Barnes et al., 2009; Diekelmann, 2001; Evans & Severton, 2001; McDrury & Alterio, 2000; Churchill, nd;).

Client's stories challenge practitioners to identify what is most important to patients, to sharpen or widen their focus; and for patients, to distill the essence of their experience (Tevendale & Armstrong, 2105; McAllister et al., 2009; Owen, 2004). Another sort of narrative valuable in learning is literature from published sources providing a rich seam to be mined by educators wanting to deepen student understanding and empathy (Carroll, 2011; Raingruber, 2009; Brown, Kirkpatrick, Mangum & Avery, 2008; Krautz, 2007; Leffers & Martin, 2004; Koenig & Zorn, 2002). Crawley, Ditzell and Walton (2012) report that illustrated literature, such as a well-chosen children's story book is associated with students exploring the space in between the words and the pictures – multiple perspectives, potential interpretations and meanings.

Within Western society, the letterbox marks the boundary between the world and the individualised haven or hell of the home. Narrative responses to the letterbox reflect what meaning the narrator makes from this symbol of place. By choosing narrative as a way of making meaning, personal interpretations are highlighted, which may obscure other aspects of meaning from alternative theoretical bases (Park, 2010); such as the academic theory of home. The following three narratives of home as a place illustrate the layers of meaning that can be evoked through client poetry, student reflective narrative and a children's picture-book – all with the common thread of the letterbox.

Client narratives – a personal experience

In my personal nursing practice, I have found "the letterbox drop" to be a very meaningful moment. This is when you have just had a home visit with the client, and you are seen out the door, down the path, to the letterbox, then opens up; and asks the questions or tells their experience in words they couldn't say within their partner's hearing (disturbing their sense of home as safety); but needed to tell you, the nurse, before you went out the gate – finishing the home visit. Some time ago I found myself in the client's shoes, and (while leaning on my letterbox); remarked to my clinician that the world seemed to be spinning faster and faster; and I felt I had been thrown off in a heap, while it spun on without me. I wrote this poem over the next few weeks, reflecting on what I felt about the changing nature of myself in home.

Our Story: Mail Box Musing

One metal box
Sentry to my bastille
Staunch, resolute
Yet with a definite wobble
Marked by time
Not quite sure who it is,
(one numeral is nestled in the tufted grass)
But standing.
Once host to Easter treats,
childrens' muddy boots,
borrowed books
blue, wafer thin tidbits from afar;
memories fondly probe
the tender bruise of loss.
Conduit now,
my next appointment, medication reviewed, stamped, approved.
And yes, the unexpected handwritten note:
"Please check your garden for my lost cat"
Dead?
My receptacle of living news,
I swear it's further away each month
But we're still standing,
Albeit on a lean

As a patient, writing the poem encouraged me to look a little deeper, to realise that as a result of my health challenges I was cutting myself off from the world (rather than it rejecting me), and that new losses amplified the pain of early losses glossed over. I could feel my own determination – and this gave me somewhere to start; to rehabilitate myself back into my own community.

Student reflective narratives – why do it?

Churchill (nd) describes how writing about their clients in a narrative framework, allowed nursing students to process and make sense of their clinical experience. Quoting Florence Nightingale, "Observation tells us the fact, reflection the meaning of the fact" (Nightingale, cited by Churchill, nd); health professionals are encouraged to write narrative reflections of their clinical experience. This form of reflective, formal storytelling invites … "additional layers of interpretation and meaning making" (Greenfield, 2015, p. 2) and evolves practice from a care-based focus to uncover and explore the complex web of client context, values and societal issues (Greenfield, 2015). Jack (2015) found that poetry writing supported nursing students to increase their understanding of a subject, learn about themselves, and grow in confidence and empathy for others.

In the below excerpt from a reflective essay a nursing student used her first impressions of a client's home to challenge her own assumptions, and reflect that meaning can only be made by the person living within the home, integral to their personal sense of self.

> Driving by Mister Grant's home, it reveals a cold, unlived in feeling. There is never a car in the driveway, an overgrown garden, a bent, graphitized mailbox and never any clothes on the line. This is the view of the outsider, but for Mister Grant, it is a place of joy and a social barrier from the outside world. Classical music swells the walls, cluttered with keepsakes and photographs from generations passed. Mister Grant resides in the home he grew up in as a boy. He returned home in the late eighties to care for his mother after her stroke, and ironically is now living there independently and gets care following his own stroke.
>
> (Cited with permission, pseudonyms used)

Can an illustrated children's story help learning?

In addition to health students and professionals writing narrative reflections, literature is richly sown with stories that illustrate human experience, yet provide a 'safe" place for reflective learning. Sources used by nurse educators include novels, biographies, poetry, and films (Raingruber, 2009; Brown et al., 2008; Leffers & Martin, 2004; Koenig & Zorn, 2002). Exploration of literature enriches factually presented texts with a human dimension and context (Carroll, 2011; Krautz, 2007; Darbyshire, 1995).

Children's picture books are designed to be read, and re-read. Crafted to hold attention and draw the listener into the multiple layers of the story, through the interplay of words and illustrations (Crawley, 2009; Lynch-Brown & Tomlinson, 2008). Complex human concepts are folded into about 100 words, with multiple interpretations hinted at within the illustrations. Crawley et al., (2012), Krautz (2007) and Davidson (2004) all employ picture books in nursing contexts, encouraging students to use a reflective interpretive approach, challenging pre-conceptions and building empathy. Structured teacher strategy is effective when encouraging reflective learning from children's picture books, Crawley et al., (2012) describe a model they have utilized to explore grief and death- a delicate subject to teach.

The children's picture book, *Old Henry* (Blos & Gammell, 1987) explores diversity, communication, community and home using a range of literary techniques, for example humor, subversion, different character perspectives and character development. All of these themes are relevant for nurses working with clients in the community, and students have their own pre-conceived ideas about whether Henry is free spirit, or a health hazard.

Henry moves into an empty house in a close-knit community. But he doesn't fit in with societal norms. The book illustrates a home that looks dilapidated and overgrown, including a personalised, but neglected letterbox, stuffed with unread mail

Figure 1. Old Henry, the Postie and the Letterbox
Source: Blos and Gammell (1987, np)

The repeated phrase "That place is a disgrace", emphasizes the community response – but as the reader we know that this home is beloved; Henry's sanctuary where his birds fly free and nature has priority over control.

The neighbours make attempts to connect; but Henry just won't conform. Henry retreats from the community's ongoing but intrusive helpfulness, not recognizing that his home's edges are fused and morphed into his surrounding community. He abandons his house, taking his letterbox with him, holding it close to his chest, sitting in a paddock in Dakota with all his belongings – waiting for the letter that brings him home – with negotiated terms of re-engagement.

Figure 2. Old Henry- open to communication
Source: Blos and Gammell (1987, np)

I find the value of using this picture book as a learning tool is in actively reading it aloud, interspersed with a range of rhetorical questions designed to encourage student reflection, to unfold the differing perspectives, and to relate the illustrations and concepts to practice situations. For example in the illustration above, the overflowing letterbox instigates discussion about how to communicate with clients in a way that is meaningful to them; the letterbox is both a barrier to communication, and the marker of the boundary of Henry's sanctuary. In the second illustration (Diagram 2) – the last of the book, Henry is homeless, but the letterbox is clutched tight, like a reminder of the home he felt driven from; and a conduit for reconciliation. Henry shapes where he lives, but it is a reciprocal arrangement.

CONCLUSION

Narratives are a powerful tool for reflective learning about what home means to an individual client. Each of the three differing uses of narrative above enabled the writer, and the reader to make a bridge between space and time, the letterbox and home, and enter the world of others. They also open a window into the values we interpret others' reality from, by encouraging exploration of multiple perspectives. Educators who teach students about the meaning of the home, aging in place, and rehabilitation are aiming to build student practice that is empathetic to the complexities involved. The client's voice needs to be heard. With practice, nurse educators can enhance reflective learning opportunities for students when their teaching strategies include developing and appreciating narratives.

Josie Crawley has been involved in nurse education in both the community and education institutions for over 25 years. She is passionate about opportunities for health promotion in primary health; and her research platform explores the place of narratives within nursing education.

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HOSPITAL AT HOME: OPTIMISING DISEASE MANAGEMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Anna Askerud

INTRODUCTION

Chronic obstructive pulmonary disease is estimated to affect 300 million people worldwide and is the fourth leading cause of chronic morbidity and mortality, both nationally and internationally. Patients with moderate to severe chronic obstructive pulmonary disease, frequently have multi-morbidity, require complex care, and may have repeated and lengthy hospital stays. Increasing numbers of patients with complex long-term conditions are labelled the healthcare challenge of the 21st Century. Alternative models of care have been explored over the last two decades to address the growing numbers of chronically ill patients with complex health states, and the ability of the health system to manage this. Hospital at home is healthcare which would normally be provided in hospital environments, but instead is delivered to people in their own homes. In 2014 the New Zealand National Health Committee undertook a strategic overview of respiratory disease in New Zealand to prioritise a pathway of care for chronic obstructive pulmonary disease patients, and to identify the most appropriate and effective interventions for the New Zealand population with chronic obstructive pulmonary disease. Amongst other interventions this report explored the concept of 'Hospital at Home' and found only Canterbury District Health Board was currently utilising this model of care. This paper reviews a selection of the national and international literature regarding hospital at home as a potential option for the successful management of people with moderate to severe chronic obstructive pulmonary disease in New Zealand.

Background

Chronic Obstructive Pulmonary Disease (COPD) is a major health problem around the world (National Health Committee, 2014). COPD is defined as airflow obstruction that is not fully reversible, is usually progressive and involves an inflammatory lung response. Chronic bronchitis, (bronchiole narrowing and increased mucous and inflammation), and emphysema, (destruction and enlargement of alveoli), caused by smoking are the most common conditions resulting in COPD in New Zealand (National Health Committee, 2014). Internationally and in New Zealand COPD is the fourth leading cause of chronic morbidity and mortality. Because it is often associated with other chronic conditions, people with COPD may require complex care and have frequent hospitalisations (Corsello & Tinkelman, 2008).

Hospital at home has been proposed as an alternative model of care for clients diagnosed with COPD. It is a programme which is being used internationally, particularly for clients with COPD, which has high hospital admissions, but may be better managed in the community (Toofany, 2008). This commentary explores some of the issues and research around the hospital at home model of care to provide a platform for discussion and to provide evidence for further exploration of this framework of care for patients/clients with moderate to severe COPD in New Zealand.

Chronic obstrctive Pulmonary Disease

New Zealand (NZ) has high hospital admission rates for COPD compared to other countries in the Organisation for Economic Co-operation and Development (OECD) (Milne & Beasley, 2015). In 2012, the Southern District Health Board (SDHB) had 963 COPD admissions of 352 people causing a budget impact of NZ$4.6 million (Milne & Beasley, 2015). Hospital admission rates for Māori, Pacific Islanders, men and women from low socioeconomic areas, the elderly and those from rural areas have disproportionate hospital admission rates and NZ Māori have twice the COPD hospitalisation rates of non-Māori (Milne & Beasley, 2015). The World Health Organisation has suggested strategies to improve the burden of COPD internationally. These suggestions include better surveillance to map the magnitude of the disease and analyse determinants, and primary prevention to reduce risk factors such as smoking, poor nutrition, lower respiratory infections and air pollution. Secondary and tertiary prevention strategies such as identifying cost effective interventions, improving accessibility and upgrading standards of care considered as integral to improved health outcomes for COPD (World Health Organisation, 2002).

In 2014, the National Health Committee used both the Australasian COPD-X guidelines and the UK National Institute for Health and Care Excellence (NICE) COPD guidelines to inform a strategic review of respiratory disease in NZ. The goal of the National Health Committee was to prioritise an evidence-based pathway of care for people with COPD (National Health Committee, 2014). The mandate was also to identify the most appropriate and effective interventions for the NZ COPD population. Similar to other western countries the report found that over half of people with COPD had co-morbidities meaning their care requirements were complex. The report states that people with moderate to severe and end stage COPD comprise 6% of the COPD population, but utilise half of all the costs for this condition (National Health Committee, 2014). The largest costs sustained are attributed to hospital care, including emergency department visits (National Health Committee, 2014).

As well as reviewing the current pathway for COPD the National Health Committee reviewed new opportunities for COPD care and investigated telehealth, emerging technology and primary and secondary integrated models of care utilising respiratory personnel in the home – a hospital at home model of care (National Health Committee, 2014). An integrated care model with access to respiratory physicians was found to be currently utilised only at the Canterbury District Health Board (CDHB). The hospital at home model of care was found to be most useful for the moderate to severe COPD population. Programmes such as the CDHB respiratory service have developed in Christchurch are usually based on an integrated model of care working between primary and secondary care (Wigens, 2016). This programme identifies patients most at risk of hospital admission and utilises registered nurses and care assistants to provide a programme of support. The patients have access to a respiratory physician and acute action plans are developed, along with referral to pulmonary rehabilitation and discussions around advanced care plans (Wigens, 2016).

Following international trends Primary Health Care (PHC) could be an integral part of hospital at home care if it was to be utilised in New Zealand (Corsello & Tinkleman, 2008). Until the 1990s the NZ health system had a fragmented primary health care system with the General Practitioner (GP) as the lead, and often-sole provider of primary care (National Health Committee, 2007). At the end of the last century, increasing long-term conditions and the ageing population meant that current model of healthcare was predicted to be unsustainable in future years (National Health Committee, 2007). In 2007 the National Health Committee suggested that an American model of care, the Chronic Care Model (Wagner, 1998), be integrated into NZ, PHC programmes. The model proposed a redesign of PHC and suggested that primary healthcare organisations identify people with complex and multi-morbid chronic conditions. The aim of the model has been to improve the management of patient care

through regular assessments of both physical and psychosocial status (Wagner, 1998). This model is now utilised in PHC worldwide and provides sustainable integrated care as multi-disciplinary teams work proactively with patients to improve management of their condition in a long-term relationship. This model seeks to empower patients to self-manage their conditions and thus prevent hospital admissions (Coleman, Austin, Brach & Wagner, 2013).

From the beginning of this century, the USA health organisations Kaiser Permanente and Veterans Health began to develop large integrated care delivery systems based on the Chronic Care Model (National Health Committee, 2007). These health systems advanced the concept of the medical home to help co-ordinate and navigate healthcare for those with complex long-term conditions. In the UK, the Virtual ward utilises community matrons who employ hospital at home principles to work collaboratively with the patient and provide options for integrated care (Ross, Curry & Goodwin, 2011; Toofany, 2008). Shared personal health information is integral to the success of the medical home and a central database of health information, which, works seamlessly between the patient and their primary and secondary health organisations, is vital. Action plans, which caregivers and patients have access to, are important tools. These action plans ensure patients know what to do when exacerbations of their condition occur and their care wishes are communicated to health professionals. Care plans are created in collaboration with the primary healthcare multi-disciplinary team and, due to the integrated health information database, are visible to all people involved in the person's healthcare with the patient having ownership of their own care plan (Jalota & Jain, 2016).

For healthcare providers, organisations and people with COPD the goal is to improve the pathway of care and their quality of life (Corsello & Tinkleman, 2008). Utilising evidence-based guidelines suggests that enhancing people's access to healthcare and providing integrated care from a multi-disciplinary team provides patient centred and effective care. Applying Wagner's (1998) Chronic Care Model in PHC may help to align treatment methods and goals and improve care co-ordination for people with complex long-term conditions (Coleman, Austin, Brach & Wagner, 2013). COPD in particular is a chronic disease where integrated and collaborative care is vital as self-management, ongoing home monitoring and early intervention can significantly improve health outcomes (Corsello & Tinkelman, 2008). A hospital at home model of care, utilising an integrated multi-disciplinary healthcare team seeks to work collaboratively with the patient to mutually agree treatment and provide a pathway of care in an environment suited to the persons' needs.

Defining hospital at home for COPD

Hospital at home was originally developed in France in 1961 as an alternative to hospital care for terminally ill patients, and began to be utilised in the United Kingdom in 1978 (Toofany, 2008). From its inception, there has been criticism around the cost effectiveness and patient satisfaction with the scheme (Toofany, 2008). Ideally, hospital at home should provide equally good healthcare to the care received by an inpatient, and this care should be at least cost equivalent and acceptable to patients and their caregivers (Toofany, 2008). Although financially superior in the short term, the longer treatment time of hospital at home often negates any cost savings. Toofany (2008) suggests that health outcomes for patients receiving hospital at home care were similar to those receiving hospital based care.

A study of hospital at home completed by Ricauda et al., (2008) evaluated hospital readmission rates and mortality after six months for elderly people with COPD. There were 52 people assigned to a medical ward and 52 people allocated to a hospital at home service. Ricauda's et al., (2008) findings noted that acute hospital admissions

were particularly hazardous for the elderly with more risk of iatrogenic illness, functional decline and an increased risk of falls and confusion. The hospital at home programme emphasised education regarding smoking cessation, nutrition and the management of daily activities. Energy conservation, education regarding pharmaceuticals and early recognition of exacerbations of their condition were also included in the care plan for hospital at home care. The result of this focus on self-management was that hospital at home care was associated with a reduction in hospital readmissions and subsequently a reduction in the cost of care. Hospital at home patients were cared for approximately twice as long as patients in the hospital, but none of these patients were consequently admitted to hospital or to long-term residential care. The study concluded that this programme was cost effective and significantly reduced the burden on acute hospital beds in the long term (Ricauda, et al., 2008)

In NZ, an integrated long-term condition service by CDHB brings together hospital and community services to provide care for COPD patients in a primary healthcare setting and strives to keep people at home managing their own health conditions with support. Along with support at home, patients with COPD enrolled in the Canterbury Community Rehabilitation Enablement and Support (CREST) scheme are identified individually with a 'blue card'. The individualised management plan identifies their ideal oxygen saturation levels as well as usual medications and other important information regarding their care wishes. These people also have telephone access to a respiratory doctor. The goal of CREST is to improve the patient journey, reduce length of hospital stay, prevent readmissions and delay admission to rest homes for over 65year olds. This six-week programme initially provides daily visits and is staffed by healthcare assistants with Registered Nurse (RN) oversight, respiratory physicians and allied health care professionals. It cares for up to 90 patients at one time (Wigens, 2016).

Primary healthcare for optimising management of COPD in NZ

The National Health Committee (2014) proposed an ideal pathway for people with COPD. Early detection is important to ensure timely treatment can begin and smoking cessation is instigated promptly. Pulmonary rehabilitation referral is an important link in providing education and information on advanced care planning and medications, in addition to teaching breathing techniques and coping strategies. The National Health Committee (2014) confirmed that people should ideally be cared for in primary healthcare organisations rather than in secondary care. In the last two decades, there have been many models of care proposed for the management of long term conditions in which primary health care has been highlighted as the preferred principle health organisation. Hospital at home for people with COPD is another model of care in which primary health care is fundamental (National Health Committee, 2007).

A recent Otago study highlighted some of the issues in long-term conditions care in the NZ, PHC context (Stokes, Tumilty, Doolan-Noble & Gauld, 2017). Multi-morbidity, is defined as having two or more chronic conditions, and may be difficult to manage in primary care where the disease management model is for single disease care (Stokes, Tumilty, Doolan-Noble & Gauld, 2017). This qualitative study revealed that GPs and Practice Nurses (PN) struggled to give people with multi-morbidity satisfactory care due to time constraints and clinical decision-making processes (Stokes, Tumilty, Doolan-Noble & Gauld, 2017). The disadvantage of optimising management of COPD in the primary healthcare setting is that the NZ model of PHC is fee based. Due to financial constraints, people will often utilise one 15-minute GP appointment for all their problems leaving many important issues and patient education unable to be completed (Carryer, Snell, Perry, Hunt & Blakey (2008). Care Plus, which is the funding stream for long-term conditions in NZ, only partially addresses this issue. People who qualify for Care Plus are funded for four appointments per year at a reduced rate and they are often unwilling to see the GP or PN in between these times. Historically there is fragmentation between primary and secondary care due to the lack of a shared information

system (Stokes, Tumilty, Doolan-Noble & Gauld, 2017).

Wagner (1998) suggests that long-term condition management should be delivered by multi-disciplinary teams with clear roles, good communication and a willingness to work together to provide patient centred care. Utilising a case management model of care for people with moderate to severe COPD, within a hospital at home framework that is based in PHC with secondary care support, may be a successful model of care for those with moderate to severe COPD (Askerud & Conder, 2016; Coleman, Austin, Brach & Wagner, 2013).

COPD patients' perspective on hospital at home care

Research by Williams, Hardinge, Ryan and Farmer (2014) found that readmissions to hospital for COPD occur in one in three people. This research, working on the understanding that early detection of COPD exacerbations is crucial, attempted to understand the reasons why people did not seek help for their exacerbation early. The researchers recruited 44 people with COPD in the UK and found that people often delay seeking medical help, as they preferred to manage their exacerbations alone first. Despite the fact that this delay sometimes meant an ED visit, the research found that people were mostly confident to manage exacerbations at home and would seek help if this did not work. The research concluded that that there was a need to acknowledge the patient's own expertise in COPD and that the patient may be the best predictor of their own health and exacerbation status (Williams, Hardinge, Ryan & Farmer, 2014).

In a similar study Lowey, Norton, Quinn and Quill (2014) also found that people with end stage COPD had an overwhelming desire to avoid hospital, which caused them to delay seeking care in fear of receiving a serious diagnosis. These researchers interviewed 20 participants who had multiple hospital admissions for COPD and found that the participants viewed a hospital admission as a setback. While COPD patients often felt that they had no control over the progression of their disease, they could control when they sought help for their symptoms and would frequently wait until their health status was unbearable before seeking help. This research found that home based palliative care meant they could manage their symptoms, retain functional ability and self-manage their conditions with support if required (Lowey, Norton, Quinn, & Quill, 2014).

Moving the burden of care to family members was a frequently voiced concern regarding hospital at home care (Leff et al., 2008). Australian research by Leff et al., (2008) looked at the stress experienced by family members and compared them to family members whose loved ones were receiving traditional care in hospital. This study looked at 214 patients who required acute hospital admission for respiratory conditions who either were admitted to a hospital at home programme, or had an acute hospital admission. The stress of family members of both groups were compared together and it was found that family members of those who were looked after at home experienced lower stress. Fear of death, overall stress as a caregiver, loss of companionship and the logistics of hospital visiting were measured. The results suggested that the carers and families of those looked after in hospital experienced greater stress than those cared for at home (Leff et al., 2008).

CONCLUSION

Increasing numbers of COPD presentations to hospital emergency departments mean that worldwide strategies have been developed to try to reduce the burden on our healthcare system. Wagner's (1998) Chronic Care Model suggests primary healthcare organisations develop their long-term conditions programmes to work collaboratively with people in their own homes and communities. PHC organisations have capacity for early diagnosis of COPD, smoking cessation programmes and the ability to refer to pulmonary rehabilitation to provide support and education for these people. Historically, successful hospital at home models of care involve multi-disciplinary teams caring for people with COPD in their own homes using a case management model of care. Providing medications for exacerbations and developing acute and long-term care plans can give people with COPD knowledge and control over their health and allow them to improve the management of their condition. Integrated information databases between primary and secondary healthcare institutions ensure that care institutions can provide seamless care. With support and education, people with COPD and their carers may be able to care for themselves more effectively at home avoiding hospital admissions and the resulting risks and stress of hospital care. International studies, and our own successful CDHB respiratory service suggest that hospital at home is an important model of care and additional research could be undertaken in New Zealand to further develop this as an alternative model of care for people with moderate to end stage COPD.

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THE VIRTUAL SCHOOL GATE: STORYPARK AN ONLINE MEETING PLACE FOR FAMILIES, TEACHERS, AND THERAPIST.

James Sunderland & Dave Speden

INTRODUCTION

Conventional definitions of place and community have been challenged over the past 20 years as humans have replaced, or augmented, occupation in physical place with online activity. This research used a qualitative methodology to examine how therapists, teachers, parents, and family members perceive the use of an e-portfolio platform (Storypark) to support the Kimi Ora School community. Kimi Ora is a special needs school located in Wellington, New Zealand. It is a school that caters for a diverse range of students with high, and very high complex special needs. Kimi Ora students come from a large geographical catchment area. Contact between school and home is reliant on use of student communication journals, emails, phone calls, and the use of Storypark. Storypark is a secure social media platform that enables education providers and families to share photos, videos and text about students learning activities. Although labeled an e-portfolio, Storypark enables virtual community through the engagement of multiple parties with a shared interest. A literature review of e-portfolio use in special needs schools did not produce significant results, indicating a gap in research. The benefits of e-portfolio use in mainstream schooling has been researched in a number of empirical studies, indicating e-portfolio use compliments current teaching practices while also engaging students and the wider family network in classroom activities. Nine semi-structured qualitative interviews constituted the primary form of data collection, with contextual information about the setting and Storypark gathered from secondary sources. Findings indicate the e-portfolios platform is the 'right fit' for the context.

Background

Humans' comprehension of place and community is a process of continuous evolution. Change in communal life is consequently echoed in change in society (Prodnik, 2012). Change impacts on people, place and occupation. Until recent human history definition of community has been geographically circumscribed (Castree, Kitchin, & Rogers, 2013). Community was sustained by regular connection in physical place, where the proximity of place both enabled, and directed our occupational interactions with one another. Humans have, and continue to, connect most often with those whom we share physical place, those who are in close proximity. These conventional definitions of place and community have been challenged over the past 20 years as we have replaced, or augmented, our occupation in physical place with occupation in online place, community, and domain.

One of the most momentous developments that has accompanied the widespread acceptance of the internet is the emergence of virtual communities with attributes that are not bound to share geography. An ability to engage with others online has impacted on how humans work, learn, play, create, communicate, and manage daily occupations. Our online exchanges have intwined with our real world interactions in place. Virtual community can be defined as a community of people sharing common interests, ideas, and feelings over the internet (Virtual Community, 2017). There is a broad scope to what fits under this definition including, but not limited to, chatrooms, social

networking site, and virtual worlds. Although not constrained to a specific physical setting, virtual communities still possess distinction between their members and non-members, having specific purposes which delineate them as communities in their own right (Pears, 1998).

Kimi Ora School's use of an e-portfolio platform (Storypark) to sustain and benefit their community, complimenting real world interactions between teachers, therapists, and school families for the benefit of students' heath, wellbeing, and education. Within the literature there is no universally agreed definition of what an e-portfolio is. E-porfolios have been widely adopted in the field of education from preschool to tertiary education however the differing nature and scope of e-portfolio use has resulted in varying understandings and definitions. In its simplest form an e-portfolio is a collection of electronic evidence assembled and managed by a user, or users. Storypark is a platform that allows the engagement of multiple users who all hold a shared interest in a student who attends Kimi Ora. Although Storypark is labelled as, and broadly fits under the definition of an e-portfolio, the engagement of multiple parties with shared interest also fits the criteria of a virtual community.

The conclusions in this paper are based on collaborative qualitative research conducted in 2016 between The Otago Polytechnics School of Occupational Therapy and Kimi Ora School. Relevant literature is reviewed and background information is provided on Kimi Ora School and Storypark. The reasearch structure is outlined and finding are presented and discussed with implications noted for Kimi Ora School, occupational therapy, and other health professions.

Kimi Ora School

Kimi Ora School is a special needs school located in Wellington, New Zealand. It caters for a diverse range of students, aged from five to twenty-one years, with high, and very high complex special needs. Special educational needs are defined as any need that cannot be met within a regular, school, home or family setting without extra support. Students may have learning or communication delay, social, emotional or behavioral difficulty, physical and mobility restrictions, or a combination of these factors. Extra support in a learning environment is required to address student needs (Valentine, 2017).

Kimi Ora means, "seeking wellbeing in health". The school offers an holistic approach to education, working with the family to achieve the best outcomes for students. Occupational therapy, speech language therapy, physiotherapy, and music therapy are offered on site (http://www.kimiora.school.nz). Kimi Ora students come from the wider Wellington region. The vast majority of students are transported to and from school by a specialized taxi services. As a result, parents and family members do not have routine contact with the physical setting of Kimi Ora School and the staff that come with pick-ups and drop offs. 'School Gate' communications around pick up and drop off are recognized as being an important form of information exchange between teachers and families, even though they are often unstructured and happen at a demanding time for teachers (Zellman & Perlman, 2006; Stonehouse & Gonzalez-Mena, 2004). Considerable literature exists in relation to teacher-parent communication, and the importance of parental engagement in the success of a student's education (Olmstead, 2013). In New Zealand, the National Education Guidelines and National Administrative Guidelines mandate parental involvement in schools. These provisions are governed by section 60A of the Education Act 1989.

At Kimi Ora School regular contact between school and home is reliant on the use of written communication journals, emails, phone calls, formal parent teacher events, school events and for the past two years the use of Storypark (https://www.storypark.com). Kimi Ora has a history of trying to improve school and home communications via the use of technology. They subscribe to the theory that as access to technology continues to expand, the capabilities for connecting parents to schools will continue to grow (Olmstead, 2013). In the early stages of the schools investigation of technology Blogger, an online blogging tool, was identified as having potential. Its use was trialed at the school but issues related to usability, access, and reliability resulted in limited long term adoption in the functions of the school community. Storypark replaced Blogger, as a learning platform three years ago and it is now integrated into the schools operations.

Storypark

Storypark is a secure social media platform that enables education providers and families to share photos, videos, audio and text related to students learning activities. It was developed in New Zealand to be used in preschool education, where shared information contributes to a student's e-portfolio. An e-portfolio (electronic portfolio) refers to online spaces personalised to individuals through the presentation and collaboration of digital artifacts of achievement and learning to a selected audience (Ministry of Education, 2011; Becta, 2007; Goldsmith, 2007).

Storypark is accessible across multiple platforms (computer, tablet, smartphone), requiring an account to be set up. There is a subscription cost to maintain the service. Families and education providers make decisions about who has access to individual student's accounts, which are password protected. Families can invite significant others allowing them to view and contribute to content. Essentially they can create online communities focused around an individual student. Therapist and teachers can add content to individual sites as well as posting messages and information across multiple student sites.

Though Kimi Ora does not match Storyparks original target market, being a special needs school and not a mainstream preschool, the platform was trialed and found to have merit. StoryPark appealed due to its simplicity and ease of use. Prior to conducting our research incidental feedback from therapists, teachers, and families indicated Storypark was well regarded and widely used at Kimi Ora.

LITERATURE REVIEW

Prior to conducting this research the authors reviewed literature related to e-portfolio use in 'main stream' education, as well as e-portfolio use in 'special needs' education. In addition to this a wider review of e-portfolio use in therapy settings was undertaken (physiotherapy, occupational therapy, and speech and language therapy). This is in line with the therapy services offered at Kimi Ora. Key studies of virtual community were also appraised.

The benefits of e-portfolio use in mainstream schooling has been examined in a number of empirical studies, indicating e-portfolio use compliments contemporary teaching practices (Theodosiadou & Konstantinidis, 2015; Nicolaidou, 2013; Meyer & Latham, 2008; Buzzetto-More & Alade, 2006), while also engaging students and the wider family network in classroom activities (Papp, 2014; Ministry of Education, 2011; Strudler & Wetzel, 2008; Wade, Abrami & Sclater, 2005).

A search for literature of e-portfolio use in special needs schools did not produce significant results, indicating a gap in research. In regards e-portfolio use and students with disabilities there are some emerging studies that looked at use of e-portfolios in assisting students with disabilities in transitioning from high school to post-secondary learning environments (McBurney, Eaton, & Torunski, 2017). Occupational therapy and physiotherapy research on e-portfolios does exist but is focused on implementation in the training of therapists and not the use of e-portfolios in practice as a therapeutic tool or as a client record (Cordier, et al., 2015).

In relation to online learning communities, Booth's (2011) multiple case study of professional learning communities found that online communities had a greater chance of success if the following dimension where present collective identity and clear purpose; leadership and effective moderation; opportunities for sharing knowledge, expertise, and experiences; governance structures and guidelines for participation, community sociability and usability; and the ability to measure success. When there is a balance of power across the various parties engaging, terms such as reciprocal engagement, shared decision-making, and participation are used to describe relationships (Hedges, 2010), and there are better outcomes for all involved (Stonehouse & Gonzalez-Mena, 2004).

Aims of the research

Research aimed to capture the perceptions of families, teachers and therapists in regards Storyparks use in the Kimi Ora community. More specifically the research was interested in how Storypark facilitated communication between therapist, teacher and families; what types of communication is fostered; how Storyparks use influenced teacher, therapist, parent relationships, and in turn the benefits to students on-going learning and therapy. In a broader sense we wanted to understand if Storypark has complimented and strengthened the Kimi Ora community, providing a 'virtual school gate' where regular and routine connections can be made between home and school. This would be true to Kimi Ora offering a holistic approach to education, working with the family to achieve the best outcomes for students.

METHODOLOGY

A qualitative research methodology was adopted for this study. Qualitative research is focused on understanding meaning and the lived experiences of those researched. Qualitative researchers are interested in the knowing of truth or what is considered to be true in the studied community (Creswell, 2008; Rubin & Rubin 2005; Snape & Spencer, 2003).

Data collection

Nine qualitative interviews were conducted at Kimi Ora, three with parents of students, three with teachers, and the remaining three with therapists (occupational therapy, physiotherapy and speech language therapy). An interview guide, topical approach, was used. This entailed a set of questions based on themes informed by the literature review and knowledge of the setting. Research participants were supplied with the interview guide one week in advance of their interviews.

Data analysis

Interview transcripts were subjected to an analytical phase using the 'Framework' matrix tool. Developed by the Qualitative Research Unit at the National Centre for Social Research in the United Kingdom Framework requires the organisation of data into a series of matrices from which a thematic analysis is conducted (Smith & Firth, 2011).

Ethics approval

Ethical approval for this research was granted by the Otago Polytechnic Ethics Committee in 2015.

RESULTS

Findings indicate Storypark is the 'right fit' for the context. For those interviewed the expression of 'right fit' was based on comparison with previously used platforms, notably Blogger. All interviewed parties perceived Storypark as a highly valued, if not essential tool that supports the Kimi Ora community, specifically the learning and health and wellbeing needs of students. All participants felt the use of Storypark had improved connections between home and school and in turn the wider Kimi Ora community. Storypark is a regular, routine, and relied upon communication tool, complementing, written journals, emails and irregular face-to-face meetings. These findings relate to Booth's (2011) identification of usability and clear purpose as dimensions of successful virtual communities.

Further to the identification of usability, ease of use and the simplicity of the platform were commonly cited reasons for the wide spread adoption of Storypark. Therapists and teachers perceived Storypark as a tool, which required limited initial training, with support readily available if needed by phone and email. Staff also supported each other in the use of the platform. Parents and family members appreciated the ability to access Storypark across multiple platforms (phones, iPads, laptops). They noted that limited time was required to pick up the basics of using Storypark. All parents and families interviewed were able to invite participants and communicate with them and teachers and therapists.

Therapist, and teachers, felt Storypark had significant value in regards to sharing and recording students learning. This was due to recorded information being more dynamic (multiple media) and easier to distribute to parents and families. Each student's e-portfolio provides a record of learning and treatment, which was seen as being superior to traditional note taking. Progress can be seen, teaching and therapy reinforced, and information is easy to retrieve and analyse. This archive of retrievable information allowed for measurement of Storyparks use by participants as well as measurement of student progress in learning, communication and other occupations (Booth, 2011).

Storypark was seen to provide opportunities for repetition and reinforcement of therapy exercises. Sharing knowledge, expertise and experiences (Booth, 2011). For example the speech language therapists post videos for the sign of the day, while the physiotherapist and occupational therapist would post regular videos of activities and treatment sessions. The availability of Storypark across multiple platforms meant content for student's individual accounts can be premeditated alongside lesson and therapy planning sessions, as well as being spontaneous. The physiotherapist shared an example of capturing a student's walking gait over an uneven surface when on a beach trip. Having the Storypark App on her phone meant she could capture the event via video and post content within five minutes, receiving a reply from parents within 20 minutes.

Type of communication fostered

All therapists felt their use of Storypark helped affirm their practice, enabling a feedback loop with families, where feedback was regular and prompt. Feedback is not only encouragement for the students but is also recognition of the hard work being done by teachers and therapists. In addition to family feedback, therapists placed value on a seeing what other therapist and teachers were doing with individual students. Although therapist and teachers work closely in the physical setting, content posted to Storypark provided an overview that emphasised different professionals approaches while reinforcing the connection between the different professional approaches. Storypark is seen to assist the definition of teaching and therapy roles while also showing how each party collaborates (Booth, 2011).

Three respondents (two therapist and one teacher) were conscious that the platform had the potential to be focused on the celebration of student achievements rather than a fuller clinical/educational picture of the student's progress. This view was based on the limited regulation of how Storypark is used in the setting compared to traditional note taking, as well as the possibilities provided by a multimedia platform verses a text account. There was awareness that Storypark was used in an unregulated way, informally guided by the professional practices of teachers and therapist. Storypark was seen as an adjunct to clinical notes.

Family members felt Storypark provided a valuable link to Kimi Ora, affording details about day-to-day school life and their child's progress. Families regularly responded to post often supplying text-based feedback. They valued the control they have over individualised accounts, allowing them to make choices about sharing information with others. They noted that those they have invited to contribute to their child's Storypark account are now more engaged with their children. They are able to post comments to Storypark, or follow up on what they have seen online with real world conversations and interactions. Families value the capability to involve those geographically distant to Wellington with the Kimi Ora community. This links with Booths (2011) identification that successful virtual communities have dimensions that enable knowledge/information sharing and governance of who has access to this information.

While Storypark has undoubtedly benefited the Kimi OraSchool community its use is not yet viewed as being reciprocal, being weighted towards school-based posts over posts from home. Therapists and teachers noted that posts from home, although prompt and regular, are often limited to text. They were unsure why families and parents were not making fuller use of the platform, with some speculating that limitations could relate to time restrictions and the need for more training, support and encouragement. All therapist and teachers said they would value more multimedia post from the home environments of students. Both family, therapist, and teachers agreed that any additions to shared knowledge of what a student can and cannot achieve at home and at school is an important factor in consistency of approach between school and home ultimately benefiting the students' education, health and well-being. Parents and family noted they regularly responded to post from teachers and therapists, acknowledging text only postings were due to lack of knowledge, as well as time limitations. All families stated they would value additional training and guidance. This inequity in use and the desire for more recoprical information sharing links with Booths (2011) identification of the balance of power, where reciprocal engagement leads to better outcomes for all (Stonehouse & Gonzalez-Mena, 2004).

Therapists felt their professional practice helped to set boundaries around what was recorded and how it was shared. They felt practising true to their profession enabled trust in the materials they posted. Although all teachers, therapists and parents monitor what they posted to StoryPark there is provision for moderating and enforcing

boundaries around content posted. This provision exist within the schools hierarchy as well as the avenues through which parents can express their concerns. Interviews with participants highlighted limited concerns about content posted and the security of information. The School hierarchy was trusted, if needed, to provide effective moderation and leadership (Booth, 2011).

DISCUSSION

In line with Prodnik's (2012) quote at the beginning of this article Kimi Ora School is a community in transition, where the interactions of home and school are effected by technology. Storypark supports and enhances the real world Kimi Ora community, which exists in the physical school as place. Storypark provides knowledge and sustains relationships between school and home, augmenting real world interactions at formal and informal school events and meetings. Storypark use has strengthened connections between families, teachers, and therapist, benefiting the education, health and wellbeing of students. It has enabled regular and reliable interactions between parties addressing geographic and transportation barriers specific to Kimi Ora as a special needs school.

The value of Storypark to the school community is evident in the research findings. Therapist, teachers and families value what it has provided. Storypark is a tool that has been accepted because of ease of use, affordability, and the dynamic nature of multimedia recording possibilities. Each students account is not only a repository of rich information about their learning, therapy, and daily life at school, it is also a 'place' where invited members can visits and contribute. Storybook accounts are virtual communities where the purpose and identity of the community is centred on the student. The results of this research evidence positive association to Booth's identified dimensions of successful virtual communities collective identity and clear purpose; leadership and effective moderation; opportunities for sharing knowledge, expertise, and experiences; governance structures and guidelines for participation, community sociability and usability; and the ability to measure success.

Although Storypark has proven effective in the setting there are identified issues in relation to the reciprocal nature of information sharing between home and school. As noted in the findings there are disparities in the use of Storypark within the community. Therapist and teachers are more active in posting information in multiple media formats. Although replies are regular from the home environment they are often text based. This research indicated a misunderstanding between therapist, teachers and families about the sharing of information. Therapist and teachers would value more photos and videos from home but have not made this explicit to families. Although time restriction was stated as a factor for contributions from home this was only one factor. Families would be willing to contribute photos and videos to Storypark if teachers and therapist encouraged them. To do so they would appreciate further training. At the time of writing the school was addressing this issue in partnership with Storypark. Storypark also released a support and training App in early 2017 which is being utilised as this community continues to develop their use of Storypark, and potentially other online platforms. There are some unique possibilities around a more reciprocal approach to information sharing which in theory will be of benefit to all parties particularly students. When there is a balance of power across the various parties there is potential for better outcomes for all involved (Hedges, 2010; Stonehouse & Gonzalez-Mena, 2004). Kimi Ora will continue to develop as a community and as such the use and fit of platforms like Storypark needs to be monitored so benefits are maximized and problem are addressed. Tools, like Storypark, will continue to evolve to meet needs or be surpassed by other programs. Assessment of the 'right tool for the job' is an ongoing process for communities.

In this setting therapists (speech language, occupational therapy, physiotherapy) all acknowledged the benefits and possibilities of using e-portfolios as their main recording platform, however they are required to practice note taking in a traditional sense. This poses a challenge to these professionals in regards to how opportunities are realised and integrated and the formal acceptability of Storypark as a professional record. If Storypark or any other e-portfolio platform were to be adopted as an official note taking repository questions would be raised about the security of information and who has access to specific areas. Therapists have professional guidelines and competencies they must adhere to. Any change in recording platforms from traditional note taking would challenge conventions especially if others (clients and families) had control over the sharing of information. Professional adoption platforms like Storypark would require professional bodies to create new policies and guidelines for recording and sharing information. However given the potential of tools like e-portfolios further investigation is warranted.

It should be noted that this research is narrow in scale and hence any claims of application or implication for similar setting are limited. Given that lack of other research in this area there is potential for larger scale research on the use of virtual community to support home and school connections in special needs schooling.

CONCLUSION

Through the active use of Storypark Kimi Ora has enhanced communication and interaction between the home and the school environments, in turn strengthening their community. Kimi Ora School is a community that is not just fixed to a physical place. Storypark is an 'online place' which has enabled this community to overcome geographic and transportation barriers to communication. This platform has provided more than a replication of traditional school gate connections, it has provided a place of convenience where a large resource of information can be accessed and easily shared across multiple parties. The interactions on Story park impact real-world interactions in place, both at school and at home. In mainstream media it is often the case that we hear about social media tools when they don't work, or when they disrupt our daily lives, forcing us to change and adapt. Storypark is a platform that has positively enhanced a community providing a 'virtual school gate' that not only compliments but enhances connections in physical place.

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WHEN HOME IS NOT A PLACE OF SAFETY

Laurie Mahoney

INTRODUCTION

This paper addresses the concept of the *place* that home is, how it is normally considered a *place* of safety, and when this *place* is no longer a *place* of sanctuary as a result of violence. Intimate Partner Violence (IPV) is discussed with particular reference to the *place* of IPV in rural areas. Implications for nursing practice are considered with reference to home being an unsafe *place*. The effects of IPV has a devastating impact on victims as they experience trauma. Women living in rurally isolated areas are at an increased risk of being victims of IPV. Additional complexities are considered for victims of IPV living in rural areas, including a lack of resources and an assumed lack of privacy. Finally, nursing considerations are discussed including routine enquiry for IPV and how nurses manage disclosures of violence.

Background

Home for most people should be, or is usually thought of, as a place of safety and refuge. When you think about home, people think about where they grew up, their parents/whanau and other relatives that they have strong links to. The concept of home as a place gives a feeling of belonging and helps build a sense of who you are as a person (Peter, 2002). However if the home is not a safe place, then the sense of who you are as a person can be affected. Home should be the place that is safe. It should not be a place of fear and loathing.

This paper addresses the concept of the *place* that home is, how it is normally considered a *place* of safety, and when this *place* is no longer a *place* of sanctuary as a result of violence. Literature on family violence (often referred to as intimate partner violence or IPV), is reviewed with particular reference to the *place* of IPV in rural areas. Implications for nursing practice are considered with reference to home being an unsafe place.

Place

The concept of place is complex, dynamic, culturally based and fluid, and has several meanings including geographical location, setting, relationship to people, individual or groups, and local (Giesbrecht,; Lovell, Gray & Boucher, 2017; Crooks & Stajduhar, 2014; Carolan, Andrews & Hodnett, 2006; McGarry, 2004; Peter, 2002). The meaning, or how people create their understanding of place, is through their experience; and their experience is the key to understanding the importance of place (Lovell, et al., 2017; Giesbrecht et al., 2014; Bender, Clune & Gurunge, 2009; Gavin et al., 2006; Andrews & Moon, 2005; Williams, 2004). Peter (2002, p. 65) quotes the 1994 seminal work of Liaschenko as:

> Places are symbolic constructions reminding us of our connections to others, to the natural world and animals, and to projects – they give meaning to our lives. Thought of in this way, we can see place is important in shaping our identities and in fostering (or depleting) our sense of self.

In this paper, I consider the context of place as being in the home or place of residence.

Home as a context of place

Home is a subjective experience and therefore significant to those who live there (Williams, 2004). Williams (2004) discusses the different meanings of home as being; home as familiar, centre, protector and locator. These concepts refer to:

Home as familiar – where the person is comfortable, and where routines are established

Home as centre – where the everyday experience of interaction and social activity occurs;

Home as locator – takes a wider perspective of the context of the home and includes the socio-economic status, community and service involvement, and geographical location, and,

Home as protector – where privacy, identity, safety and security are guaranteed.

'Home as a protector' is the focus for discussion. When home is not a protective place, then rather than seeing home as a protector (Williams, 2004) it can be viewed as home as a place of persecution or as a place of fear and un-safety. When home is an unsafe place due to partner or family violence, victims of that violence report living in fear of saying or doing the wrong thing (Williams, 2004). They report that it is "like walking on eggshells", that their feelings or even thoughts are not validated, or are told they are stupid or worse where insults are used to demean and put them down (Campbell, 2004; Women's Refuge, 2017). People outside the relationship wonder why people stay living in violent relationships; but for victims of IPV, leaving is the hardest thing to do. The term 'the devil you know is sometimes better than the devil you don't know' is common. Features of many victims are that they are estranged from their families and friends, or they have so little self-esteem and they are frightened that people will not believe them. Or it may be because the perpetrator controls every aspect of their lives including access to resources and money. Subsequently, living in and with fear is a prescript for mental health issues, including depression, anxiety and drug and alcohol abuse, and the ability to make decisions about leaving the relationship is often impossible (Campo & Tayton, 2015; Women's Refuge, 2017).

Family violence

Recent changes to the New Zealand (NZ) legislation (currently known as the Domestic Violence Act, 1995, the first reading of the Family and Whanau Violence Legislation Bill was introduced to the NZ Parliament in March 2017, and will amend the Domestic Violence and other Acts) has defined family violence as "violence inflicted against a person, and by any other person with who that person is, or has been, in a family relationship" (Section 3, Family and Whanau Violence Legislation Bill, 2017, p. 3). Violence means physical, sexual and psychological abuse which includes a pattern of behaviour including coercive or controlling behaviours that cause or may cause cumulative harm (Fanslow, Kelly & Ministry of Health, 2016). This Bill and current Ministerial (Ministries of Health, Justice and Social Development) documents (for instance Fanslow, et.al., 2016) show a clear indication that the New Zealand Government is taking active steps in reducing and preventing the effects of family violence and intimate partner violence in NZ.

Intimate Partner Violence

Intimate Partner Violence (IPV) is recognised as a public health issue (Fanslow et al., 2016; World Health Organisation, 2012 Hughes, 2010; Campbell, 2002). It is defined as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm" (WHO, 2012, p.1) and includes threats of harm, intimidation, stalking and controlling behaviours. It includes any form if violence perpetrated by a family member, intimate partner or significant partner. It is also known as family violence, battered women, spousal abuse and violence against women. IPV occurs in any configuration of family, across all socio-economic and ethnic groups (Campbell, 2002).

The result of IPV affects all bodily systems, and includes both physical injuries (including unwanted pregnancy and death) and emotional/psychological injuries including forms of mental illness and substance abuse, the effects of Post-Traumatic Stress Disorder (Campbell, 2002). It also includes the effects of financial abuse for example controlling money that prevents the person (victim) from working or having access to appropriate housing, work or essential items including food and sanitary items (Women's Refuge, 2017; Fanslow, et al., 2016). People (more often they are women) who experience IPV are more likely to visit health care settings including emergency department, women's health services and primary health care for example general practices, more frequently than non-abused people (Campbell, 2002).

New Zealand Statistics on IPV

It is evident that 1 in 3 (35.4%) women in NZ who have had a partner, reported experiencing physical and/or sexual abuse in their lifetime, with approximately 1 in 20 women having experienced IPV in the last year; compared to 18% of men in their lifetime and 6% in the previous year (Fanslow, et al., 2016; NZ Family Violence Clearinghouse, 2016). However when emotional abuse is considered this rates increases considerably to 55% of women reporting IPV in their lifetimes. Those at an increased risk of IPV are women, Maori, people with disabilities and those who identify as gay, lesbian, bi-sexual and transgender (Fanslow et al, 2016). Herbert, Hill and Dickson (2009) claim that there are particular groups of women in NZ and society that are more likely to be targets of violence and abuse, and these women are more likely to have limited resources, less support and are often living in contexts where violence is normalised. Combinations of factors that may increase women's vulnerability include, ethnicity where young Maori women are more likely to be abused than non-Maori, and where there is intergenerational abuse (Fanslow et al., 2016). Women are not strangers to perpetrating violence on men, however, violence by women against men is reported as being less prevalent and with less severe consequences (Fanslow et al., 2016).

Rural women and IPV

Although the research on the place of IPV in rural areas is not well researched in New Zealand, international literature does show that women living in rural places are at a greater risk of being victims of IPV and are more likely to be killed by their partner than women living in urban areas (Campo & Tayton, 2015; Peek-Asa, Wallis, Harland, Beyer, Dickey & Saftlas, 2011; Riddell, Ford-Gilboe & Gilboe, 2009).

Riddell, et al., (2009) provides a comprehensive understanding of women's experiences of living in unsafe rural places in Canada. This research clearly identifies that rural dwelling women are more to be at risk of being victims of IPV, and that rural cultures may prevent many women from leaving abusing relationships (Riddell, et al., 2009). Rural culture can be described as patriarchal and masculine, where gender roles are clearly identified and are unequal (Campo & Tayton, 2015). The physical isolation of rural communities can be seen as attractive to abusive

men and that they intentionally relocate to these places to isolate their partners which may contribute to the higher incidence and severity of the abuse (Riddell, et.al, 2009). For those women growing up in rural areas, they may have seen first-hand that violence is a means of social control. The societal norms may restrict women from speaking out, which reinforces the message *'what happens at home, stays at home'*. This attitude serves to silence women and reduces the likelihood and opportunity for them to disclose or to talk about the violence (Campo & Tayton, 2015).

Furthermore, the lack of services (health and social including police) in rural places, means there are fewer opportunities for women to talk about their experiences of violence in their home (Peek-Asa, et.al., 2011). Disparities of services have been identified by the Australian Institute for Family Studies as issues that contribute to inequalities for women living in rural places in the following way;

> *Fear of stigma, shame, community gossip, and a lack of perpetrator accountability deter   women from seeking help.*

> *- A lack of privacy due to the high likelihood that police, health professionals and domestic and family violence workers know both the victim and perpetrator can inhibit women's willingness to use local services.*

> *-*

> *- Women who do seek help find difficulty in accessing services due to geographical isolation, lack of transportation options and not having access to their own income.*

> (Campo & Tayton, 2015, p.1)

These issues are equally relevant in rural places in New Zealand. Not only are victims of IPV live in rural places geographically isolated, but they are also socially isolated. There is a disparity of the provision of and access to primary health care and social services in rural places in New Zealand, including early detection and screening procedures, for instance breast and cervical screening and other women's health services (Fernley, Lawrenson & Nixon, 2016). These services are places that routinely enquire about IPV and provide women with the opportunity to talk about or disclose IPV in their home.

Discussion and implications for nursing practice

With gender inequalities for women living in rural areas, there are recognised barriers and less opportunities for women to leave abusive relationships (Hughes, 2010). These barriers include having less resources available, including the lack of guaranteed anonymity and this means that the option for some women to leave their home is decreased. Therefore nurses and other health professionals working in rural areas need to be mindful that for many women they work with, it is a distinct possibility that their home is not a safe place to be. Additionally, nurses are more likely to be the recipient of disclosures of IPV during everyday health care if they enquire about safety issues in a non-judgemental way.

Disclosure may be solicited (direct) as in screening or enquiry for IPV, or unsolicited (indirect) where disclosure might occur without asking or prompting of the client (Fanslow et al, 2016; Hughes, 2010). Although routine enquiry for IPV is recommended (Fanslow, et al. 2016), this does not always occur in primary health care (Sundborg, Saleh-Stattin, Wandell & Tomkvist, 2012). Barriers for primary health care nurses enquiring about IPV and therefore to provide adequate or appropriate care for women in this situation, have been identified as a lack of organisational support (in the form of guidelines and policies), the nurses discomfort in asking about IPV, the lack of resources or knowledge of what to do when a positive disclosure is made, their own personal experience and their attitude towards IPV (Koziol-McLain, Giddings, Rameka & Fyfe, 2008; Sundborg, et.al., 2012). However, women who have experienced IPV have reported that they welcome being asked, giving them an opportunity to talk about their trauma in a safe environment (Koziol-McLain et.al., 2008)

In New Zealand routine enquiry asking client's if they have experienced or are experiencing IPV has been in place for nurses for well over a decade now, with Plunket nurses first introducing this in 2003 (Vallant, Koziol-McLain & Hynes, 2007). This practice was followed by nurses in other areas, including public health, emergency department, women and children's health and mental health. The place (locality) that IPV is enquired about by nurses includes clinics or health care settings and in people's homes, and Williams (2004) identifies that home is a place that is suitable for primary care nurses to be enquiring about IPV.

Nurses provide care for clients/patients and whanau in the home routinely. The majority of the literature on the setting or environment of primary health nursing practice has usually been referred to as nurses working in the community rather than the home environment. Community nursing has been explored in depth over the last two-three decades, of note is the construct of the home environment where nurses provide care. Some research has found that the relationship between nurse and client is seen as being different when the place or environment where the care is being provided is the home (Giesbrecht, et al., 2014). This relationship is reported as being of greater equality, or less of a power-differential between the nurse and client as a result of the nurse feeling as though they are a guest in the client's home, or because of the social nature of the locale of the care being provided (Giesbrecht, et al., 2014; McGarry, 2004; Peter, 2002). Nurses feel as though a greater sense of trust is developed when care is provided in the home setting. This sense of trust places nurses working in the home environment in a unique position to be enquiring about what they see in the home including the relationships of the client's they are caring for (Giesbrecht, et al., 2014, Jack et al, 2012). Indeed the therapeutic relationship between the client and nurse can be viewed as significant enough to be considered a place in itself (Gavin et al, 2006).

However, these crucial relationships in rural places may cause a disparity in how rurally based nurses enquire and respond to IPV disclosures, because they are more likely to know or be related to the victim and/or perpetrator of violence. However Murphy and Fanslow (2012) suggest that professionals working with women who are victims of IPV in rural areas have well developed networks based on trust and social networks. The nurse-client relationship based on trust, acceptance and rapport provides an inimitable opportunity to support women in disclosing and talking about IPV, regardless of the 'place' (of disclosure) this relationship occurs in. When the client-nurse relationship occurs in the home, this may prove to be more difficult where the relationship is not built on trust (Jack, et al, 2012). Jack and colleagues (2012, 2016) identified that structured IPV screening used by nurses does not promote disclosure, however when the nurse 'enquires' about the client's exposure or experience of violence in the home, within the context of parenting, safety and relationships, women are more likely to discuss their experiences.

CONCLUSION

For the majority of people, their home is considered a place where relationships are formed and maintained. However when home is not a place of safety, it becomes imperative that nurses working with clients in the home are able to provide appropriate care and support for the client. Increasingly home is also a place where health care is provided and nurses working in the home environment are in a privileged position to establish trusting relationships at a different level from other environments. More specifically nurses working in rural areas may be the only people working with clients in the home and or the health care environment and may be in a position of having IPV disclosed to them. Yet research has also shown that the relationships and community dynamics inhibits IPV disclosure.

Rates of IPV in urban, rural and remote places has been identified as being higher than in urban areas. Geographical factors and social norms and attitudes that are common to life in rural environments shape the experience of IPV and victims access to services and support. Nurses should have a good understanding if the cycle of abuse, the forms that violence takes particularly within intimate and family relationships, and the impact that IPV has on the victim cannot be underestimated.

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BICULTURALISM: A FOOT IN BOTH CAMPS.

Dr Linda Robertson and Dr Beatrice Hale

INTRODUCTION

Immigrants must come to terms with the cultural norms of the dominant group as well as work out ways of preserving their own cultural heritage. Moving between cultures is difficult and when people from different cultural backgrounds begin to engage with each other a process of acculturation begins, impacting on both parties. In this research report we identify integration strategies that included strong identifications with two cultures (Chinese and New Zealand) and the actions taken to maintain interactions with both cultures

Background

From the detailed Dunedin City Council Report 'Settling In' (Health Research Council, 2012), we learn that the 1871 census recorded 2,641 Chinese immigrants as being the largest number of migrants from any non-British colony. The Chinese experienced considerable discrimination in New Zealand, encapsulated in, for example, the 1881 Chinese Immigration Act which introduced the notorious poll tax at ten pounds a head (subsequently increased to 100 pounds in 1896); and legislation barring Chinese from seeking naturalisation in 1908. Despite these measures, a small, largely male Chinese community remained in New Zealand after the gold ran out, running market gardens and laundries, until the Japanese invasion of Kwangtung prompted the first labour government to allow the families of Chinese in New Zealand to join them as war refugees. The advent of world war two delayed repatriation, and in 1947, they were finally granted permanent residency, facilitating the beginnings of the New Zealand Chinese community in its present form.

There was very little other Asian immigration to New Zealand until changes in New Zealand's immigration policy in 1986, which generated an influx of people of Chinese ethnicity from China, Hong Kong, Malaysia and Taiwan swamping the older New Zealand Chinese population numerically.

One of the major issues highlighted in 'Settling In' (Health Research Council, 2012) was the number of older migrants who came to support their children while they were studying here, and who now find themselves alone because their children have moved elsewhere for better employment, among other reasons. The older people who do not speak good English have relied on their extended family for communication and socialisation so struggle when the younger family members leave Dunedin. Many faced issues of separation, both emotional and practical, and have been supported by the senior Chinese association in Dunedin.

Problems associated with a new country are two-fold. Migrants experience internal familial stresses caused by family disruption, with different members of the family migrating or remaining behind in the home country. Among these may be a lack of emotional resources to cope with difficult changes including the emotional distress when children are able to integrate and learn more quickly than their elders; this can lead to a distancing from the home culture by the children (Wong, 2001; Moon & Pearl, 1991). Further issues amongst the migrants consist of problems of establishing familiarity and a sense of belonging that could lead to a sense of identity (Li, 2011, Ip, 2006). These first generation Chinese immigrants have been socialized into their home culture before moving to New Zealand. Becoming familiar with new cultural practices of the host country and learning to use English effectively and appropriately is necessary to be accepted as a member of the mainstream society and to gain a sense of place. (Liu, 2015). Thus an awareness of language issues as well as a lack of knowledge of major systems and services contributes to negotiating a sense of belonging.

One of the most significant services for migrants is that of health. Much of the research on migration has found ignorance of health care systems to be a major barrier to accessing healthcare (DeSouza, 2006; Ngai & Chu, 2006; Mortensen & Young, 2004; Ho, Au, Bedford, & Cooper, 2003; Hobbs, Moor, Wansbrough, & Calder, 2002; North, 1995). These studies report that the main barriers include being unclear about what services can be accessed, a lack of awareness of available services and costs as well as a lack of English language competency.

While the above might seem to be self-evident, cultural issues explored in an American study found that a number of issues related to knowledge about and use of local health services were not immediately apparent (Chen, Kendall, & Shyu, 2010). For instance, issues such as privacy, unwillingness to share the health problem and a passive mentality contribute to the difficulties in successful usage of the health services. Chen et al., (2010) write of the "Ah Q mentality… [if] you do not find a problem, then there is no problem with the implication that if the problem is not shared, and there is no discovery of the problem, then there is no problem" (p. 344). Added to this is the difficulty when there is limited information given to the health care providers, then the provider will be unable to provide the best sources of help. This can ultimately lead to a lack of trust in the health care provider.

As Chen et al., (2010) found, privacy was valued to the extent that being passive was thought to be more polite than talking about private affairs with strangers such as the doctor. Harmony within personal relationships was important and because the American Health Practitioners were not trusted the Chinese seniors found it hard to follow their advice. Both of these points would lead to limited health information. Additionally it was believed that "western medicine only treated symptoms and did not cure the cause of the illness" and that it "lacked the holistic view that focused on the whole body" (Chen et al; 2013, p. 345). This was supported by a commentary on the article where statistics were cited for a greater number visiting Chinese health providers compared to Western health providers (Norris, 2010).

Essentially the participants in Chen et al., (2010) study favoured health practitioners who had emigrated from their country of origin and spoke their language. Even when they did use local medical assistance, with the help of interpreters, their experience of such translators resulted in them being suspicious that their concerns were not accurately portrayed. The participants indicated they felt they were viewed as 'outsiders' which caused them to feel powerless despite having lived in America for a long time. There was a sense of feeling overwhelmed by a sense of helplessness in most of the health situations they encountered. Interestingly a study of Chinese seniors in Canada found that their utilization of services is not different to other seniors (Chappell & Lai, 1998). It was also noted that

this group had a strong preference for western medicine and western-trained practitioners, unlike those in Chen et al.'s (2010) study, and that only about half of the Chinese seniors seek traditional Chinese care for both minor and serious illnesses. Such a difference in findings may be an attribute of the methodology or the country where the data were gathered.

In New Zealand terms, feelings of safety and security are linked with improved health, as well as the feelings of less stress. Poorer health is reportedly due to factors including concern about family overseas, developing a medical condition in New Zealand and the disruption of support networks. (Ho et al., 2003; Pernice & Brooks, 1996). However, judging from the information from America (Chen et al., 2010), there may well be cultural issues not made explicit in the health literature.

METHOD

Ethical approval was obtained from the Otago Polytechnic ethics committee in 2014. An action research approach was used so that the group could not only understand their own issues but also would be able to recognise their own resources and develop knowledge on how to overcome inequities that they felt were important (Dickson & Green, 2001). Within this framework, both knowledge attainment and empowerment are considered to be outcomes and learning is viewed as a two way process where researchers and community members not only develop knowledge but also learn new ways of interpreting it (Van der Velde, Williamson, & Ogilvie, 2009)

We approached the local Chinese senior association when looking for participants in the project. This began with an introductory meeting in a room in the Chinese gardens. Following this, the research meetings were held in the community house, a central facility used for community meetings and near to bus routes. The research group consisted of about twenty senior Chinese, Mandarin speakers, invited through the senior Chinese association in Dunedin with numbers varying between sessions. There was a preponderance of women, with an age range of between 60s and 80s. All were immigrants and had lived in New Zealand from 10 to 30 years.

Additionally four members formed a steering group which included representatives from health services, migrant social services as well as an interpreter/ liaison person. Their function was both administrative and to act as facilitators to assist the group to identify problems and provide solutions. Additional supportive people such as an experienced Mandarin speaking Chinese researcher and interested Chinese students/professionals joined in with this research on occasions.

The group met for one and a half hours every second week over a 16 week period. This was recorded and transcribed with reflective notes also taken by an observer to capture the major issues and concerns. Due to language differences, the steering group met weekly to summarise the main action points from the meeting and to refocus. An agenda was developed for this meeting and minutes were recorded. The format for the group meetings of the Chinese seniors was an open format with discussions on the topics which most interested the group. The health related topic identified at the beginning of the project developed into a question about how to access health information and use the health system. Many stories were told that identified issues such as using emergency systems, communicating with the General Practitioner (GP), obtaining services for home help, using interpreters and

responses to being Chinese. Following on from the questions raised in the group we invited speakers on particular topics of interest, such as a needs assessor of older people, and the patient affairs advisor in the local district health board. Another feature of the research were two community meetings where the public were invited to attend and information about the group and the findings were shared.

The process of action research begins with sharing views and ideas, thus building trust amongst the group members and with the researchers. A sense of participating in the group method and focus is necessary. The process of research continued through working together to ensuring participation. We were careful to work with our interpreters, checking their understanding, of the project and of our questions, and ensuring our questions were manageable in terms of size and language. This ensured for us as researchers a good sense of the meaning of the responses through the spoken contributions, observing the interactions in the group, and trying to interpret their body language. When such interactions are culturally influenced, and linguistically different, the sharing of information requires careful management (Van der Velde et al., 2009).

To ensure a cooperative process, we adopted an informal approach, meeting and greeting the participants, helping with seating, offered food and drink generally took time before the topic of the session was opened for discussion. To assist in the clarity of messages, ideas and intentions were shared on paper so that those with some language skills could interpret for those with no skills, and that group members could take the questions home and mull over them, with the potential of help from others, e.g. family members or friends. Whiteboards were also used. While this formalised the proceedings and might have detracted from the focus group interactions, we felt it necessary so that we could record key ideas. Use of the whiteboard emphasized the English language visually, to ensure that even if the sound of the words was unfamiliar or difficult, they could be seen and perhaps read, and shared amongst the group for further interpretation and understanding. The numbers of participants maintaining a good attendance at the group suggests that the topics and the atmosphere were sufficient to maintain group involvement.

FINDINGS

The explicit concerns of the group members were lack of knowledge of the local health service; misunderstanding about the role of general practitioners; concerns over translations and interpretations of their health issues. A practical output of this group were two resources, one that would assist Mandarin and Cantonese speakers to locate important contact details for health providers and a 'wallet card' with basic information that could be used in an emergency. The outputs were carefully crafted by the group members with great care taken that the interpretation into the three languages (Mandarin, Cantonese and English) were accurate. These were circulated to the group members, distributed throughout GP practices and at a consultation forum held in community house. They were popular resources and the group were proud of these products.

Developing from the consultation forum where the results of the project was shared, a group of younger bilingual Chinese women organised themselves as contacts with the senior group. The purpose of this 'care group' was to create a network amongst the younger and older, to get to know the senior group. Another objective was to gain a better understanding of the needs of this senior group related to accessing the health system and then to put in place strategies to assist. This has resulted in a monthly network meeting and a buddying system between older and younger where support is provided by accompanying an older person to attend appointment related to health care. It has included elements of both translating and advising.

In discussions within the research group, there were occasions when issues raised were referred to indirectly. This approach to communication is counter to the usual style in New Zealand where there is an expectation that people will communicate directly. This style of communication took the researchers time to realise it was occurring. One such concept that was finally noted was that of 'qi' or life force which is integral to health in Chinese medicine (Ma, 1999). 'Qi' relates to breath or air, and to material energy and the group related it to singing, to assist the individual's health. This reference to cultural differences in understanding health showed how comfortable the group were with each other that they could discuss their culture so fully. It also reminded the steering group just how 'foreign' aspects of a western system were to the group. There were many complex conversations which hinted at these ideas and may have been lost or minimised in translation if they had not been pointed out specifically by the interpreter/ researcher.

A further topic that was quite explicit and warranted considerable discussion in the group was the desire for reciprocity e.g. to volunteer their time to a good cause and to gift their arts, crafts and music skills on a voluntary basis. This was an aspect of a larger theme on how to establish a sense of belonging and familiarity within the host culture. There were two components, being with others from their own culture to reinforce a sense of 'being-at-home' as well as having the opportunity to contribute to the local community and become a productive member of the society they had chosen to live in. However the experience of some of the group members in becoming volunteers demonstrated that they had not understood well enough what being a volunteer in the general population entailed and where the boundaries lay. Their well-meant intentions were interpreted as being 'pushy' and 'intrusive' as they had misread the ethical concerns that were tied to volunteerism in New Zealand.

DISCUSSION

Through the discussions, it became clear that members of the group felt there was a place in New Zealand society which Chinese people could specially occupy. One particular discussion ranged round the sharing of Chinese culture, with the ability to show Chinese arts and crafts and music, and with the possibility of volunteering to help others in some way. This sense of a space to be occupied, of a role to be created and made visible, extended the sense of an identity.

Such discussions led to a conceptualising of place and identity of the Chinese seniors as being 'on the threshold' in a liminal position, for them being neither Chinese at home, nor New Zealanders, but being Chinese in the host New Zealand society. This sense of being and remaining on the threshold (Van Gennep, 1960) emerged in the discussions about what the group members would like to do to create a greater sense of local identity and a sense of familiarity and belonging. Two key strategies were discussed, these were communication and what could be done to 'give back' to the host community. At present, we suggest, many of the senior Chinese are in a liminal space, neither fully Chinese because of living in New Zealand as a host country, nor fully New Zealand, because of their own strong cultural identity. There was a continuum here with language skills and the ability to use a more direct style of communication determining where people were in this liminal space.

While the intention was that an action research approach would be an empowering process we discovered that poor grasp of English resulted in many of the group members being dependent on the interpreter or the few who were fluent in English. This socially oriented approach would seem to be appropriate in a culture that prioritises social relationships as opposed to individualism. However, it is important that the "emphasis is on proper social relationships and their maintenance rather than any abstract concern for a general collective body" (Yum, 1988, p. 375)

To begin with the practical issues of the 'flier' with information about how to access health resources and the wallet card was a tangible way of assisting the group to feel connected to the systems of the host country. They provided a way of helping them to manage the process of accessing health care. The care group instigated by the younger group added to this understanding of health care systems by buddying up with the senior Chinese members and by providing timely responses to their questions. The underlying theme would seem to be that knowledge of such an important system as health assists the sense of being more fully involved in the New Zealand culture. We hypothesise that a good knowledge of the host country's system emphasizes a sense of familiarity with that country and thus a sense of belonging.

The second and conceptual issue we describe as acculturation emerged from group discussions on living in Dunedin. The wish to display Chinese culture by means of arts and crafts, and perhaps music and also to act as volunteers and give to the host culture suggests a particular form of acculturation. The concept of acculturation means generally that the minority ethnic group will conform to the strong and predominant host group. However there are other elements in acculturation, a fourfold model (Berry, 1997) offers the following:

- Assimilation: individuals adopt the cultural norms of a dominant host or culture,

- Separation: individuals reject this dominant host in order to preserve their own culture,

- Integration: individuals can adopt the dominant cultural norms while maintaining their own. This can be considered synonymous with biculturalism

- Marginalization: individuals reject both culture of origin and host culture.

Our understanding from group discussions is that the term biculturalism is the most appropriate to describe the wishes of this group, adopting dominant cultural norms while not only maintaining, but also demonstrating their own ethnic identity. The literature indicates that much of the sense of belonging is created within the public sphere, with 'close' and 'loose' ties being formed through familiarity with the locality (Granovetter, 1973). Taking a role in the public arena was suggested by group members who offered both volunteering and demonstrating their own culture to the host culture by means of arts and crafts displays. We would argue that such a wish emphasizes a sense of biculturalism by creating not only a sense of belonging to the host culture but also by asking the hosts to become familiar with the Chinese culture. Anticipating that there would be an acceptance of some of the elements in the Chinese culture implies that there is a need for a reciprocal arrangement for biculturalism as an ideal to be a reality.

Volunteering, in particular, is a major part of this biculturalism for the group. Acting as a volunteer gives someone a particular role, and in the sense of biculturalism, demonstrates willingness to adopt significant requests and needs in the host country. In a New Zealand study (Dulin, Gavala, Stephens, Kostick, & Mcdonald, 2014, p. 617) it was noted that "volunteering is related to increased happiness, irrespective of ethnicity" and that an opportunity to provide helpful services to members of the community assisted older people to develop a sense of wellbeing. Therefore adopting the volunteer role is both good for health and wellbeing while also declaring 'I am a New Zealander too'.

CONCLUSION

We suggest that both the better understanding and use of the health care system as well as volunteering will assist in moving the individual(s) from a liminal position and having a restricted sense of belonging, to a stronger participation in the host culture. It will provide the individuals with the 'loose connections' of a microsocial system of what Blokland and Nast (2014) discuss in terms of small processes of neighbourhoods and locality living. However, the journey between cultural positions is difficult and requires a close consideration of the process of acculturation for example, taking an initial step of working out what the differences are between what is usually done in the home culture and the norm of the new culture. In summary, it is pertinent to note Lui's (2015) findings regarding Chinese identity negotiation. She suggests that although national identity tended to be derived from citizenship and residence, "a strong sense of place or belonging seemed to be formed based on descent, physical appearances, and values – something that was difficult to change, if not impossible" (p. 34).

Linda Robertson is an Associate Professor in the School of occupational therapy where she teaches on the post graduate programme. Her areas of research interest lie in the wellbeing of older people and in clinical reasoning. Current interests have included the experiences of older immigrants and their views of integration into the local culture.

Beatrice Hale PhD after her retirement from social work, she focused on researching and writing in the areas of ageing and of informal caregiving. As a migrant herself (from Scotland), she is interested in not only ageing in place, but the experiences of other migrants ageing in a different country from 'home', and likewise, their experiences of caregiving, whether there is a cultural clash between the home country and the adopted country or whether the mores of the adopted country predominate.

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Original Research

PROFESSIONAL CULTURES: NEW ZEALAND OCCUPATIONAL THERAPISTS EXPERIENCE OF AN INTERNATIONAL INTERNSHIP.

Dr Mary Butler, Fenja Jones, and Dr Susan E. Ryan

INTRODUCTION

We know little about how therapists educated in a New Zealand context understand the provision of therapy within Indian rehabilitation clinics. This study draws on a qualitative research about an internship in India by recent occupational graduates from New Zealand. It aims to provide a preliminary analysis of the complex freedoms experienced by novice therapists in their clinical practice within different ethnic and professional cultures. The experience challenged NZ students to think deeply about the paradigms that underpin their approaches and models of occupational therapy. They came to learn that there was not only cultural difference associated with ethnicity and nationality but also a distinct culture of occupational therapy in each country. They learned to value the differences and the fact that this highlighted gaps in their knowledge. They also described how the experience taught them to appreciate their knowledge and skills. We recommend internships of this kind for their ability to promote the development of skills and knowledge and to gain exposure to new cultures of occupational therapy, cultural contexts and promote transformative learning.

Background

The impact of globalization on healthcare is an increasingly difficult issue to ignore, nor is it in our best interests to do so with such a wealth of knowledge to be gained from diversity. A worldwide trend of globalization has provided an increase in both the opportunities for working internationally with a steady flow of healthcare workers resulting from increased global mobility (Mu, Coppard, Bracciano, Doll, & Matthews, 2010). Alongside this opportunity is the challenge or need for practitioners to develop skills to serve increasingly diverse populations in the home country in a way that is culturally appropriate (Horton, 2009). Both Canadian Association of Occupational Therapists (CAOT) and World Federation of Occupational Therapists (WFOT) recognise the impact of internationalisation and call for an international perspective on education (Barker, Kinsella & Bossers, 2010). Similarly, Mu et al., (2010) cite The Centennial Vision of the American Occupational Therapy Association (AOTA) which has called for occupational therapy to be globally connected.

Alongside the recognition from professional bodies is a need for education providers to prioritise the effect of globalization on population health and the delivery of healthcare to include more teaching on international health (Simonelis, Njelesani, Novak, Kuzma & Cameron, 2011; Schwarz, 2001). Similarly there are a growing number of student health professionals wanting to gain clinical and cultural experience through international fieldwork placements (Edwards, Rowson & Piachaud, 2001).

One suggested model for delivery of teaching in international health is through developing partnerships with schools in developing countries (Edwards et al., 2001). This mobility within education provides an opportunity to promote interaction between people and ideas from differing backgrounds. Student mobility, with students going abroad for part of their training, is the most common approach to internationalization in education (Niemantsverdriet, van der Vleuten, Majoor & Scherpbier, 2006).

Occupational therapy education programs are now aiming to foster an understanding of the responsibilities of being a global citizen and promoting the development of core professional values such as social responsibility, justice, and altruism (Lattanzi & Pechak, 2011; Horton, 2009). These programs are also valuable in enhancing the cultural awareness of students, who gain elements of cultural competence (Simonelis, 2011; Wells, 2000) within the context of professional practice. Humbert et al., (2012) identified a growth in cultural awareness of participants in acknowledging and contrasting the differences between the new environment and their own.

The culture of professional graduates is not only the culture of their homeland but also the culture of the profession that they belong to (Webster, 2011). Hammell (2009) asserts occupational therapy practitioners acquire specific knowledge, beliefs, concepts, perspectives, ideas, norms, assumptions, and values during education. This socialization informs the culture of occupational therapy and influences service provision in specific ways that are often no representative of the culturally diverse populations they serve (Shelly, 2010). The profession as a whole is increasingly open to the critical examination of cultural norms that shape occupational therapy (Iwama, 2006).

However, within this dialogue, there is an underlying assumption of the universal nature or similarity of occupational therapy internationally. For example, all occupational therapists have the right to practice abroad if they have trained at a college accredited by the World Federation of Occupational Therapy (WFOT). WFOT also describes global mobility as essential to promoting the development, evolution, and sustainability of the profession (WFOT, 2008), suggesting that global movement provides an opportunity for valuable learning. However, there has been very little questioning about how the concept of culture may challenge assumptions about the universal nature of practice. If professional culture leads to differences in the way a profession practices internationally (Niemantsverdriet et al., 2006) it is necessary to consider the culture of the profession of occupational therapy and how this changes across the world.

It is essential to understand how history and culture have shaped occupational therapy in different parts of the world. The culture of occupational therapy in New Zealand has its roots in both European and American schools (Hammell, 2009; Iwama, 2006). Consequently, occupational therapy is reflective of the underlying assumptions, worldview and values of a specific perspective usually referred to as 'western.' Iwama (2006) argues that there is little acknowledgment that occupational therapy knowledge and practice is culturally biased.

Participants in this study were part of a team of eight students involved in the development of an internship in India, which was set up for the first time. Together with the first author they chose two Schools of occupational therapy in India as representative of the public and the private educational sectors in that country: five OTs went to one school and three to the other. This study examines the perspectives of two of these students; Julie went to a private university, which takes students from 55 countries, so western students were a common occurrence; Sally went to a public hospital where neither staff nor patients were accustomed to seeing non-Indians as clinicians.

METHOD

The internship was carried out under the auspices of a New Zealand / India Research Institute Research Award, granted to the author in 2013 to establish voluntary clinical placements/internships between India and New Zealand. Approval from the Otago Polytechnic Ethics Committee was gained in August, 2014. A qualitative descriptive method was used (Sandelowski, 2000) and thematic analysis (Braun & Clarke, 2006) guided the analysis. Convenience sampling was used to access the participants and this research looks at the perspectives of two new graduate occupational therapists as they negotiate an internship in India and it specifically examines the ways that this experience challenged their assumptions about the culture of occupational therapy.

FINDINGS

The first author signed a "Study Abroad" agreement with the Schools of Occupational Therapy. Each student was asked to write a letter to the college principal, asking for a 'clinical observer ship' and explaining their prior experience. The 'clinical observer' role was agreed because it did not create expectations that the interns were either students or registered occupational therapists. Prior to leaving New Zealand each intern sent a full C.V., a medical certificate and a copy of their passports to the college; they paid a fee of $350 for four weeks clinical experience, and $100 per week for accommodation. The visa status of the interns was unclear, and at the private hospital, they were asked to get student visas, whereas this was not a requirement at the public hospital. Once at the hospital the interns rotated through a range of specialty areas including hand therapy, neurology, mental health, and paediatrics. The first author visited both places either during or just after the internship.

In India, a bachelor's degree in occupational therapy involves four and a half years of study. It is only after four years they have six months of placement, where they are allowed to have cases on their own. The clinics were all on-site at the universities, and these units were run by master degree students in their second year, with supervision by a specialist occupational therapist who had overall responsibility. Occupational therapists in India tend to stay in the same specialist area for their whole career. In comparison, New Zealand has a three-year degree, and students are sent all over the country on short intensive placements from their first year. Occupational therapists in New Zealand tend to be generalists, and they expect to change role regularly during their career.

The use of a 'medical model'

The first difference that participants noted was the fact that Indian OTs practiced what they identified as a 'medical model.' They rapidly identified the knowledge and skills of Indian occupational therapists as something that they admired. From the outset, they were aware of the different scope of the training. The interns recognized that there was knowledge that they did not have, and at times this threatened to overwhelm them. However, Julie responded with admiration for the education of the Indian students:

> I really admired the undergraduate students and masters students' both for their knowledge, it was expansive! ... I would have loved to have learned more about what they knew about!

> (J)

The experience became an opportunity for participants to reflect on the strengths of their training:

There were lots of things that they just had such an in-depth knowledge of the medical dysfunction, but on the other hand, we had that occupation/function perspective.

(J)

At the same time the interns noted that, in a reversed situation, Indian students might also struggle:

We gained more I think, but if they were to come here they would gain more, they probably would too. In our eyes, they know so much, but then I think they would be confused with our system, you know, going round to people's homes.

(S)

Challenging professional boundaries

The relationship with clients was something that was different. Julie and Sally were accustomed to a client-centred approach, within the context of a liberal society. They struggled with warnings about boundaries, and what was considered appropriate with clients:

They used to tell us we weren't meant to talk to him. I just didn't get why we had to ignore him and the only time we could talk to him was if we were asking questions about his illness.

(S)

Interns were required to wear white medical coats, which is not an expectation in New Zealand. The interns associated the wearing of white coats as aligning professional values with a medical profession which is something that New Zealand occupational therapists have distanced themselves from for many reasons, including making patients feel more at ease. At times wearing white coats was seen as counterproductive:

White coats, which we all wore because of the hierarchal thing was kind of unnecessary. I don't even know why we needed a white coat. Many children were scared of the white coat, so I don't know why we wore one, but we did…

(J)

Lacking a focus on occupation

The interns rotated around many areas, but the one that they all found most challenging was mental health. They experienced the approach as particularly stigmatizing for the patient, and they were upset when patients were forced to do activities even if they didn't want to. In this case, the therapist coerced a patient to play cards:

I was annoyed because it completely defeated one of the main things we are taught which is about meaningful, productive occupation. She was going, 'I don't want to play this game.' I hold that value in autonomy and it was upsetting to see all their choices taken away from them. You want to give them some kind of choice…

(J)

Interns observed that there was a lack of individualization of treatment:

> *They'd treat to the condition or, they don't actually individualize the treatments or anything, it's not client-centred, it's just more diagnosis-centred…*

(S)

They both described how the primary focus was on physical remediation, and often this meant that therapy never involved meaningful:

> *As long as the person was physically all right and able to go home, they didn't actually really care about other stuff that we would maybe think about…*

(S)

There was a large volume of patients in both settings, and this led to time pressures for therapists. The interns began to see just how difficult an individualised approach to therapy would be in that context:

> *Sometimes because they were so rushed between people that maybe they didn't really think about that. They were thinking about the physical dysfunction before they were thinking about occupation*

(J)

Sally also highlighted how a client-centred approach was something of a luxury within that context:

> *Over there they don't get, I guess, the luxuries of what we get here, of being able to see our patient in their homes, and go, you know, out to their houses and observe them, and work on things that are meaningful as well as ADL's (Activities of Daily Living)*

(S)

However, in other areas like paediatrics, they found that the focus on occupation was more like the practice in New Zealand:

> *In paediatrics I got the most hands-on experience. It was play-focused so we had a lot of opportunities to play*

(J)

They also began to see that culture of everyday activities influences an occupation-based approach:

> *Their culture and their tradition is just so rich when it comes to activities of daily living. Those three occupations of toileting eating and dressing are just so completely different to what you would do in New Zealand.*

(J)

The influence of the system on the practice

The interns were struck by the lack of note taking in all areas of service provision, not just for occupational therapy:

> *Notes were literally just the date this person had treatment and whether they paid. They did mention the diagnosis, and that's it. There were no notes to carry on a therapy session from another, so you had no idea what another therapist had done before you. So you just had to go off what you knew…*

(J)

Additionally, the lack of a booking system meant that participants were unable to prepare for sessions:

> *We would be just sitting there and then all of a sudden, a patient would come in, and we would just have to be ready on the mark. And then all of a sudden everyone would get up off their feet, and we would go into the room, and we would begin therapy…*

(J)

Eventually, the interns learned to adapt to the lack of a booking system, and they could even see the benefits from the perspective of the patient:

> *I sort of thought, 'Oh my god' people not having appointments, I thought that was kind of horrendous, but then I did learn that it actually can be more beneficial if people can come in when they want…*

(S)

The impact of carrying out therapy in a country where there were myriad cultures was a new experience for the interns. The language barrier was endemic to the practice of health care in this context. Students and patients are from all over India, and in the area of the private university, there were at least three different languages. Health professional had a range of strategies, including using some English or finding students or other patients to translate:

> *The language barrier was huge because it was in-between everybody. It was between the medical staff, the patients, the students, everybody. That was one of the biggest things…*

(J)

The importance of healthcare to the population became apparent in a whole new way:

> *People are so willing to come from miles. They would have those sort of barriers, and they have to save up just to go to the clinic…*

(S)

The clinics were part of a "user-pays" system, and this influenced the scope of occupational therapy practice. The patient might not distinguish between different therapies, and so the occupational therapist would capitalize on that confusion to create a generic approach:

> *Patients literally chose whether they want occupational therapy or physical therapy and they paid them. So if you are an OT, then you want to convince your patient to choose and pay for your service. So you might do some kind of physiotherapy, and then you go on and do the occupation based stuff…*

(J)

The focus of treatment was all hospital focused, and neither of the interns identified any element of community-focused practice. Patients had to return to hospital for any further treatment:

> *It is sad to know that they don't have sort of facilities to follow up people. It means that his life will be just circulating between hospitals and out in the community, and back around.*

(S)

However, the lack of community services also created a particular kind of family-oriented therapy that the interns had not experienced before. Families came to all therapy sessions, and it was part of the culture to expect help from family members if there was a disability or injury:

> *I had my first real shock when I learned that the patient we had been seeing was sent home from the ward. He had been in a coma for 30 days and had been receiving OT input passively for 20 days. As soon as he was able to open his eyes and say yes/no he was gone! There wasn't other help that you can get in the community. Then it just had to be family members. You just had to make do…*

(J)

Some other things shocked the interns, for example, the use of a single brush for multiple patients in the context of treatment using sensory integration as a modality.

> *We came from a middle class and were lucky enough to have toothbrushes cheaply dispensed at any place, and I guess that was the whole context…*

(J)

In the end, for the interns, it was important that they felt that they managed to maintain their own sense of values in a very different environment:

> *I'm proud of the outcome. I know that I stuck to my morals and my beliefs, and my values. But I still managed to remain respectful of others and I know I built really good relationships…*

(J)

DISCUSSION

Most voluntary internships available for those working in the health field involve placement with Non-Government Organisations (NGO) for community development projects. Internships with NGOs provide valuable experience, but they do not provide skilled professional supervision for therapists, who are looking to develop specific therapeutic skills. Humbert (2012) describes a tension between being a learner and volunteer in a different cultural context, similar to the liminal space inhabited by the interns as they tried to juggle to the role of being a learner and therapist. They found that being a graduate came with an expectation of skills and knowledge which made them feel intensely inadequate at times. In fact, New Zealand graduates have been perceived in the past to have a weakness in the more practical skills of occupational therapy and intervention (Nayar et al., 2013; Gray et al., 2012; Robertson & Griffiths, 2009). However, it is difficult to distinguish whether the perceived inadequacy would be a typical experience for every new graduate, or whether it was specific to an international experience. This study makes it clear that placement in an educational clinic in India can develop skills in NZ trained occupational therapists.

The internship described in this paper is different from most international fieldwork placements, which usually involve supervision from the home country. Local supervision meant that the interns were exposed to the judgments of the Indian therapists and needed to prove themselves as valuable members of the team. Usually, international placements are completed with supervision from the participant's faculty (Simonelis et al., 2011; Mu et al., 2010). However, local supervision represents integration within a different cultural context, and also within a distinct culture of occupational therapy itself. Julie identified local supervision as important in understanding the diverse nature of occupational therapists role in India. The provision of supervision and support by local host therapists was particularly valuable in creating a sense of dissonance regarding issues related to professional culture. Dissonance is the "incongruence between participants' prior frame of reference and aspects of the contextual factors" that shape the international experience (Kieley, 2005, p. 8). Confronting this dissonance was a significant challenge for the interns that eventually enabled reflections on cultural difference both of occupational therapy and the broader contextual influences of culture on health. The domains of occupational therapy and the cultural context should therefore not be seen as separate entities but as interconnected aspects of the same experience.

The acknowledgment of differences in occupational therapy practice brought about an appreciation of the strengths of the host country. The interns strongly valued the biomedical knowledge of the Indian occupational therapists, particularly in the areas of neurology and hand therapy. This finding is in contrast to Barker (2010) who found a 'western' approach was incompatible with rural practice in India. There were fewer differences in paediatrics and interns felt they gained valuable practical experience in this area, which concurs with previous research identifying the universal nature of play (Humbert et al., 2012; Ekelman et al., 2003).

Other areas were less compatible, notably mental health. Interns were particularly conflicted by an approach to mental health that was reminiscent of practice in New Zealand before de-institutionalisation in the early 1990s (O'Brien & Kydd, 2013). Perspectives on disability are culturally mediated (Simonelis et al., 2011), and interns responded by aligning themselves with deeply felt values around using the social model, incorporating meaningful activity and being client-centred.

WFOT (2008) describes global mobility of occupational therapists as essential for the development, evolution, and sustainability of the profession. Immersion is a crucial factor in the learning associated with international

experiences because of exposure to new skills, new knowledge, and different client bases when navigating a foreign culture (Mu et al., 2010; Kieley, 2005; Ekelman et al., 2003). International experiences offer an opportunity to challenge assumptions (Leung, 2003; St. Clair & McKenry, 1999). For participants this meant adapting to cultural norms, re-evaluating and re-affirming their own beliefs, and accepting their own potential limitations. Faced with situations that differed widely from their values, interns responded by asserting their values (Kieley, 2005), for example, client-centred practice. At other times, when there was only a small incongruence with participants' values, they adapted to the expected cultural norms (Barker et al. 2010), for example, agreeing to wear a white coat. Both participants emphasized the importance of remaining open-minded while still adhering to one's code.

Barker et al., (2010) questioned, from an ethical perspective, the transferability of occupational therapy, suggesting an incompatibility between developed and resource-poor countries. In contrast, Iwama (2006) denies that practices are incompatible, but argues that reflection and acknowledgment of the cultural bias of occupational therapy are necessary, both to progress as a profession and to be more culturally inclusive. We must critically examine the cultural norms that shape occupational therapy to determine its relevance to specific social contexts. In this study, interns came to acknowledge the many pragmatic factors that limited the scope of practice in India, for example, sheer numbers of clients as well as the geographic space militated against the development of community rehabilitation. On the other hand, the challenge of having little time to prepare promoted the development of clinical reasoning whereby the interns were required to react to novel situations quickly and decisively (Simonelis et al., 2011; Mu et al., 2010).

An obvious limitation of the present study is the small number of participants and the fact that interviews were carried out about eight months after the participants returned home. However, the experience became a powerful memory, and the stories of these interns give an invaluable insight into the possibilities of future communication between occupational therapists in India and New Zealand. The fact that the interns rotated across several specialty areas gave them significant insights into the areas where their practice could be genuinely enhanced, while also capturing the full range of potential practice. The weakness of this approach was that the interns did not reach a position where they could feel expert in their practice.

We recommend internships of this kind for future graduates because of their ability to foster cultural learning, gain appreciation of the culture of the profession of occupational therapy, understand the broader societal influences of health, and to increase exposure to new skills and conditions. Recommendations for future internships (or clinical placements) would include focusing on the areas of most robust practice, such as paediatrics, neurology and hand therapy.

This study has added to the literature by describing a unique experience of 'the voluntary internship.' It speaks to the unique experience of being a new graduate and describes the value of a learning experience that goes beyond 'voluntary service' by situating itself within a relevant clinical context. It also describes an experience that may enhance the potential for international fieldwork that accepts the expertise of occupation therapists who happen to practice differently. Occupational therapy has increasingly recognised the challenge of cultural bias (Hammell, 2009; Iwama, 2006) and the experience of these interns is another way that the profession can build bridges across cultures to enhance our global connectivity.

Most importantly this study has demonstrated that cultural experiences are made up of both the cultural differences within the profession of occupational therapy and also within the broader "other cultural" context. Accreditation by the World Federation of Occupation Therapy gives a mandate for occupational therapists from diverse schools to travel the world. However, the cultural context will always shape occupational therapy practice. The internship challenges the temptation to insularity, by giving an example of what it feels like to take on the role of an outsider, and to gradually learn the rules about how to 'fit in'. Occupational therapy manifests in different ways across cultures and embracing this awareness is a way of enabling the profession to explore new possibilities and ways of being.

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MENTAL HEALTH SIMULATION MODEL: A PLACE FOR LEARNING IN A NEW ZEALAND CONTEXT

Suzie Bartlett

INTRODUCTION

Simulations in various forms are becoming an essential pedagogical addition to clinical training within the health sector. Simulation using human actors/performers are both cognitive and affective in nature and therefore, present students with a realistic and meaningful experience that is high in authenticity and engagement, but low in risk. In terms of knowledge acquisition and skill development, the literature shows that there is a place for simulation in undergraduate nursing education. The simulated experience helps to demystify misconceptions of and presupposition associated with mental health. Placing simulation within a sequenced series of educational events better prepares students for their subsequent clinical practicums. There are real benefits of simulation introduced to a nursing curriculum not as a stand-alone activity, but aligned within broader developmental learning processes. A new model The Simulation Cycle of how this alignment can be achieved is presented in this paper.

Background

Simulation is having a profound impact on the direction of training for healthcare professionals (Brown, 2008). These advances offer exciting possibilities for many areas of healthcare education, including mental health nursing. Human actors utilised in simulation are able to replicate complex states associated with facial expression and body language essential in identifying dispositions, attitudes and thought processes critical in mental health assessment (Bartlett, 2014). In these cases, mental health nurses who have proficient knowledge of patients with acute mental illness can be used as performers/actors. These performers/actors are often used in simulation experiences to replicate a high fidelity of realism exposing students to real life clinical scenarios and teaching skills in decision making, problem solving, and communication in a safe, non-threatening learning environment. (Brown, 2015). In this authentic, supportive environment, students are exposed to various mental health conditions in an accurate and consistent manner, without risk to themselves or patients/clients (Knudson, 2013).

Simulations offers an excellent approach to create a clinical environment that are representative of real life scenarios, without risk to the public (Robinson-Smith et al., 2009). However, simulation needs to be carried out in the correct sequence of educational events for students to gain the most benefit. Simulation has been well documented as being beneficial to learning, (Boynton et al., 2007; Razack et al., 2007; Morgan et al., 2006; Yule et al., 2006) but to gain the most leveraging potential from all course components including theory, simulation and clinical practice, simulation needs to be embedded into the curriculum and not added to the curriculum (Bartlett, 2014)

The Bachelor of Nursing (BN) programme comprises a mental health component that is presented in year two and three of the three year degree programme. The mental health content is provided as a clinical course including a simulation which is often students' first introduction to mental health within the curriculum. Mental health can be a challenging specialty within nursing practice (Choi, 2012). Myths and stereotypes formed by society and the media related to psychiatric service users can heighten student anxiety and create fear among students (Choi, 2012). Simulation, when embedded into an educational sequence helps to demystify this complex and

challenging environment (Bartlett, 2014). Immersion in a realistic clinical scenario prior to clinical practice has the ability to reduce student anxiety and increase the effectiveness of students' therapeutic interactions, with authentic experiences to draw on when they are working alongside health professionals and clients in practice (Choi, 2012).

Students can be unprepared when entering the mental health clinical field, which can be a challenging, and confronting environment. Student's anxiety can increase and cause them to fear people suffering from mental illness if they do not have adequate classroom preparation prior to being, immersed in this clinical environment. If students fear the placement then therapeutic communication with clients/patients can be difficult (Luther-Szpak & Kameg, 2013).

Simulation experience

Anecdotal evidence from students suggests that exposing students to mental health environments without adequate preparation could be detrimental to their ability to form therapeutic relationships and engage with service users. Student nurses completing the mental health component of their BN programme are, immersed in simulation. The expectation is that the simulation acts as a mediating tool between students' classroom (theory) and clinical (practice) experience. Trained actors are utilised to portray acutely unwell psychiatric patients, suffering from psychotic symptoms associated with schizophrenia. Schizophrenia is a disorder characterized by a major disturbance in thought, perception, thinking and psychosocial functioning; it is a severe mental illness. The students carry out a risk assessment and mental state assessment with the simulated patient. To assist in this exposure a new model The Simulation Cycle (Figure 1) developed by the author to demonstrate how simulation can be embedded into, rather than just "added to" a nursing curriculum, in order to offer greater benefit to student learning.

Implications for the curriculum - a new model

If students are exposed to simulation without delivery of the necessary guidance (theory/practice) beforehand then this is likely to impede the learning process (Bartlett, 2014). If students are not well prepared prior to simulation they can become unable to continue with the simulated scenarios due to not being able to make the necessary clinical judgments to move forward and provide solutions and best outcomes for the patient. Debrief sessions, as part of the simulation experience are an important part of the simulated learning sequence (AL Sabei & Lasater, 2016). The debriefing process, immediately after the simulation, allows students to reflect on the experience; how they behaved; what they did well and what they would change in the future. Debrief also offers an ideal teaching context where expert knowledge and experience are engaged with and become a part of the conversations at appropriate times.

The Simulation Cycle illustrates a hybrid model that combines action of simulation with the preparation and reflection inherent with debrief sessions. This model details the sequence in which simulation can be embedded into the nursing curriculum to maximize its potential to augment learning and demystify practice.
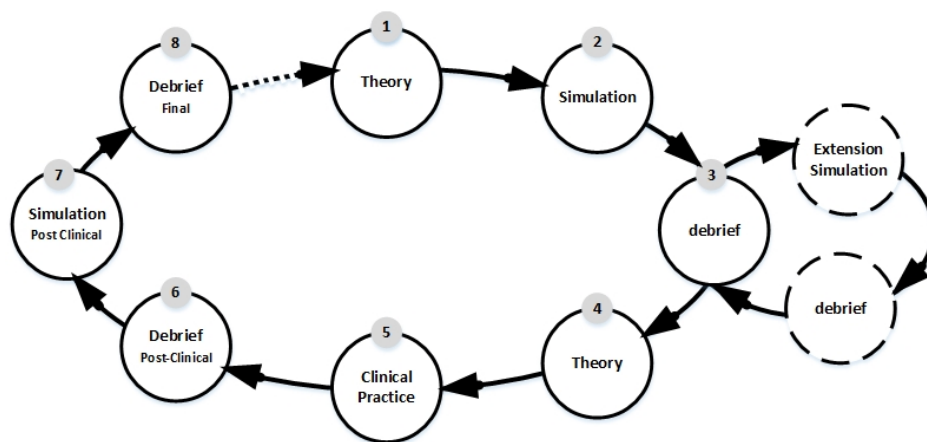
Figure 1. The Simulation Cycle. Source: Bartlett (2014)

Elements of the Simulation Cycle Model

The Simulation Cycle details the sequence in which the simulation can be embedded into the nursing curriculum. The aim is to maximize the leveraging potential simulation can add to existing program components. This model has eight elements it is recommended all of these elements be engaged with for beneficial results (Bartlett, 2014).

The first element of the model is related to and titled, *Theory*. Students are required to attend tutorial sessions where information regarding assessment and communication skills, theoretical models, required frameworks and legislation are introduced and discussed. The students take part in scenario work to introduce them to mental state and risk assessment, suicide assessment, application of the Mental Health Act 1992 (Compulsory Assessment & Treatment), recovery and medication. There is an expectation students complete the online resources prior to presenting for simulation that have been designed to give the students' knowledge needed to progress through the simulated event. In this element of the model the students are in a state of equilibrium, they feel comfortable with content presented and are able to achieve what is asked of them easily, without feeling confronted.

The second element of the model is *Simulation*. Students are required to take part in the simulated event where they are asked to complete a mental state and risk assessment on a client. The client in the scenario has co-existing problems with drug and alcohol misuse. Students are put into roles including; Registered Nurse/student nurse/ family member or peer observer. They then read the provided information needed to complete the scenario. Students are reassured that the scenario is a safe environment for them to learn in where they are able to make mistakes without any 'real world' risk to clients and where they can speak freely with supporting lecturing staff. The

lecturer takes notes on the students' performance and discusses this further with them at the time of the post simulation debrief. Students in the debrief stage can became anxious and feel uncomfortable in a situation that is unfamiliar.

The third element of the model is *First Debrief*. Students move away from the simulation room and are escorted to a separate debriefing room. Debrief is aimed at promoting reflective thinking. Learning is dependent on the integration of experience and reflection (Decker, et al., 2013). Students use the reflective process during the debriefing phase which facilitates them to view the simulated clinical scenario from different angles, identify their learning style and improve their decision making and problem solving ability. Reflection is the conscious consideration of the meaning and implication of an action, which includes the assimilation of knowledge, skills and attitudes with pre-existing knowledge (Decker et al., 2013). Students are able to unpack their learning with an expert lecturer and begin to understand how this applies to their clinical practice. In effect, students are blending the learning from simulation and theory, and transferring knowledge to the clinical environment. Students are able to think about how they feel during simulation, what learning they are experiencing, and how they can improve on their clinical judgments.

Debrief allows students to come back to a state of equilibrium where they feel comfortable and have the knowledge required to proceed to the clinical environment.

After the *First Debrief,* an extension simulation can be included if required. Students may want to transfer knowledge gained from the first debrief into a second *Extension Simulation* directly after the debrief process. This enables students to consolidate their knowledge and remember the correct way in which the scenario should be carried out. Following the *Extension Simulation*, another debrief is required for decompression and "unpacking" of new learning. The reflective process is used once again to understand the simulation experience.

The fourth element is related to and titled, *Theory*. Again the students are put into a state of equilibrium as they are exposed to more theory in the form of tutorials, with expert mental health lecturers, before being exposed to the mental health clinical environment. This is a chance to identify with students any additional knowledge they need that is critical in order for them to make good clinical judgments in their practicum.

The fifth element is *Clinical Practice*. Students are now ready to be immersed in the mental health clinical environment. Students have a clinical preceptor who is a registered nurse with whom they work closely for the duration of their clinical practicum. Preceptor's support the students by encouraging them to reflect on their practice, teaching them practical skills, and adding to the knowledge gained from the educational institution. This element of the model places students back into a state of disequilibrium due to the challenging and sometimes confronting environments that mental health facilities can induce.

The sixth element is *Post Clinical Debrief.* The students return to class post clinical practice for a follow up debrief of their clinical experience. The students reflect on their clinical placement by sharing their experiences. They are able to discuss ethical issues that arose for them, challenging situations, how these were dealt with and whether

they thought this management was effective, what they could have done to improve their clinical experience, what they learnt from their placement and how this new knowledge would influence their future nursing practice. From this process, students are able to pass on the knowledge they have gained from their own experience, engage with fellow students and learn from each other's experiences. Students are now in a state of equilibrium again as they begin to feel comfortable with the new knowledge acquired and how the different contexts of practice and theory interrelate.

The seventh element is *Second Simulation*. A second simulation experience can be added here so students could apply all knowledge that they have learnt from theory, clinical, debrief and their first simulated experience. This is an excellent way for students to consolidate and reinforce their knowledge. This stage places students back into a controlled state of disequilibrium, as simulation is anxiety provoking regardless of students' preparation.

The eighth element is *Final Debrief*. Debrief is again implemented as outlined in the third element of the model, a reflective piece of writing may or may not be required. Students will finally be in a state of equilibrium where they feel comfortable with the knowledge procured, capable and empowered to make the necessary theoretical links to their mental health clinical practice.

DISCUSSION

Ideally, students should have theory related to clinical practice taught in the classroom by expert lecturers in the field of mental health nursing, before simulation. The *Simulation Cycle* demonstrates the most beneficial sequence for student learning using educational events as presented in (Figure 1).

CONCLUSION

Embedding simulation into a curriculum as a collection of sequenced elements is of greater benefit to students than just 'adding in' simulation as a stand-alone activity to fit with curriculum timetabling. The *Simulation Cycle* (Figure 1) was developed to give students the best leveraging potential from all aspects of the curriculum including theory, clinical practice, debriefing, online teaching and simulation. If all of these educational aspects of the curriculum are considered carefully, an optimal learning process can be achieved for students in order for them to maximise their learning potential through the simulated experience. The simulation cycle outlines how this can be achieved through embedding simulation correctly into an undergraduate nursing curriculum.

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A PLACE FOR SIMULATION IN PRIMARY HEALTH NURSING EDUCATION: WHAT DOES IT LOOK LIKE?

Josie Crawley & Dr Jean Ross

INTRODUCTION

It will prove difficult to establish a therapeutic relationship with a dummy, albeit one that is capable of bleeding, passing urine and uttering the occasional word while being injected, catheterized. prodded and poked in the course of the learning process.

(Foster & Hawkins, 2005, p.698)

Providing nursing students with quality learning opportunities in all health care settings is increasingly more challenging to obtain and sustain due to a growth in student numbers and a shortage of clinical placements. Simulation has developed as a response to these challenges to replicate the reality of clinical environments providing students with the opportunity to practice nursing assessment and nursing management in a safe space. This safe space is up for debate as highlighted in the above quote by Foster and Hawkins (2005) which raises the question as to the applicability of student nurses' interacting with a "dummy"? Therefore to make the simulation more realistic the context and place specific location in which the client is situated and the nurse visits is recognized as an essential feature in the simulation scenario. This paper describes the process of embedding primary health simulations in an undergraduate nursing curriculum to develop students' therapeutic communication skills to promote health and wellbeing.

Background

Student nurses need multiple opportunities to practice thinking and acting like a Registered Nurse (RN). Providing students with quality learning opportunities in all health care settings is increasingly more challenging to obtain and sustain due to a growth in student numbers and a shortage of clinical placements (Spence, Valiant, Roud & Aspinall, 2012; Bambini, Washburn & Perkins, 2009; Mannix, Wilkes & Luck, 2009). Furthermore, once a clinical placement is secured for a student, learning opportunities are dependent on factors such as the student/preceptor relationship, a time pressured environment, patient's/client's clinical presentations and the context in which the placement is situated. The context or physical environment coupled with distance from local and regional health services are stressed as a component of the simulation exercise. The aim of presenting this background information is to ensure health care planning is specific to the clients' physical, psychological, spititual and geographical context. Ross (2012) stresses that "knowledge about context is imporatant for nurses who work in urban as well as rural facilities" (p. 87)

As a response to these challenges, utilising simulation to teach nursing skills, assessment and management is rapidly gaining popularity as it offers a breadth of experience difficult to obtain in clinical placements and students can learn in a safe structured supportive environment (Bushy & Hewett, 2012; Lasater, 2011; Bambini et al., 2009). Simulation aims to replicate the reality of clinical placements and provides a settting for students to participate in a scenario, commonly termed 'simulation' and is generally used to complement clinical learning that occurs in health care contexts such as hospitals, clinics and communities (Jeffries, 2012; Ross, 2012). The following definition of simulation is provided by Bland, Topping and Wood (2011);

> *A dynamic process involving the creation of a hypothetical opportunity that incorporates an authentic representation of reality, facilitates active student engagement and integrates the complexities of practical and theoretical learning with opportunity for repetition, feedback, evaluation and reflection.*

(p. 668)

To provide an authentic learning experience in simulation, actors or interactive manikins are used to replicate a real life scenario as closely as possible (Bushy & Hewett, 2012; Norman, Dore & Grierson, 2012; Bartlett, 2014). When using mannikins, the term used to describe the extent to which the simulation mimics reality is measured in the terms of low fidelity, moderate fidelity and high fidelity (Jefferies, 2012). Low fidelity referred to as task trainer or static mannikin does not have any computer interface and is a model in which the student practices a skill on a anatomical model, for example an arm for practicing wound management. Medium fidelity is a computer generated simulation using a mannequin that has been programmed to display clinical conditions such as blood pressure, respiratory rates in which the students can practice clinical decision making. High fidelity simulations are once again computer generated mannikins which allows the student to intervene in the delivery of care, for example as a clinical decision is made and treatment administered, in high fidelity simulation the student receives immediate feedback as the mannikin respondes to the treatment and the condition either improves, remains the same or deteriates the student can then judge as to whether their treatment was appropriate (Bushy & Hewett, 2012). These simulations enable students to see and feel many physiological parameters but are limited in that they are unable to display the full range of human interactions and encounters such as nonverbal skills and psychological withdrawal (Benner, Sutphen, Leonard, & Day, 2009). To provide more authentic human interaction, actors are frequently used, although they are unable to portray changing physiological parameters (Bushy & Hewett, 2012). Despite these constraints, when designing simulation, educators strive to mimic clinical reality as close as possible to provide an authentic student learning experience.

Simulation experience

Like many undergraduate nursing schools in New Zealand, simulation has a long history in our school with the use of role plays, laboratory sessions and exercises to teach communication and clinical nursing skills. The potential to use simulation for more than skill acquisition was recognized in 2007 when the interactive mannikin 'Nursing Anne' was bought to the front of the class of student nurses to demonstrate breath and heart sounds. The capabilities of this manikin to demonstrate basic physiological parameters and enable scenario based teaching provided another opportunity to prepare students for real patient care. To learn more about the possibilities 'Nursing Anne' could offer our nursing school, staff began attending simulation training and conference opportunities led by the producers of the mannikin. In scenario based learning the mannikin is programmed to mimic human physiological responses dependent on student practice, is able to talk by projecting the technicians voice, however is not able to show facial expressions or reactions.

In 2010 the School of Nursing received approval to re-develop an existing study room to suit our simulation requirements. This room included a one way dividing mirror where the lecturer is positioned to observe the simulation. Working within our budget, a security camera was installed to to film our students for debriefing purposes. The new simulation suite was ready for use for our first students in semester two of 2010, as an adjunct to the lower technological simulation happening regularly in primary health tutorials and skill acquisition in laboratories. It is in this simulation the context is stressed as a component of the simulation exercise to ensure health care planning is specific to the clients' physical, psychological, spititual and geographical background.

Year 2 students enrolled in the medical /surgical course trialled simulation scenarios for example, a patient experiencing chest pain. The course coordinator observed the scenario behind the one way mirror, provided the voice of the patient and debriefed the experience with the students. Course evaluations were heartening with 95% of students reporting simulation was challenging, interesting and provided opportunities for active participation and learning. Anonymous course evaluations completed by students at the end of each course provide both qualitative and quantitative data. These were promising with 95% of students reporting simulation was challenging, interesting and provided opportunities for active participation and learning.

Following the success of these first simulations, a combined primary/mental health simulation for year two students was added in 2011. This simulation involved a stressed mother visiting the local medical practice asking for sleeping pills and emphasised interpersonal skills and health promotion. Because this scenario required behaviors and non-verbal cues difficult to simulate on a manikin, students and lecturers were used to act in the client role partially due to financial constraints to pay for actors. However this led to problems with consistency and difficulty in controlling the scenario when the actor did not respond the way the simulation was designed. Using a microphone and ear piece for communication between actor and facilitator helps to address this (Keltner, Grant & McLernon, 2011). Our technician currently acts in the client role for many simulations requiring an actor, although this is being reviewed due to the time commitment this involves, as simulations require 30 minutes of 4:1 student/technician time, and each simulation is repeated eight times. The use of technician resource is more financially viable than lecturer resource; but is reliant on technician acting skills and availability and remains resource heavy. The adaptability of new technologies such virtual reality may offer some alternative strategies to portray the client role.

Simulation activity

Our nursing school delivers 15 small group simulations over four clinical nursing disciplines; medical, surgical, mental and primary health and is embedded in all three years of the Bachelor of Nursing Degree. We have expanded facilities, purchased an advanced simulator and employed a full time laboratory technician/teaching assistant to facilitate learning through simulation. Simulation complexity is stair cased throughout the three years to allow educators to empower students through the use of fading support. Parker and Myrick (2012) describe this process as a "graduated withdrawal of support or assistance as the students moves from the beginning phase (where others regulate their learning) to the final stage of self-regulation" (p.367). Students initially observe the educator, advance to undertaking aspects of the task, and then finally take control of the learning situation (Parker & Myrick, 2012). This process of transition to independent practice is replicated throughout the nursing student learning journey, including in clinical practice.

Each student is expected to prepare for simulation with an hour of directed online learning which comprises objectives, readings and access to resources related to the scenario. To participate in the simulation, students are assigned a role as student nurse, RN or relative. A fourth student observes and provides feedback during the debriefing session. Reassurance is provided to the student assigned the RN role that they aren't expected to have the knowledge of a RN they are there to support and work with the student. A lecturer or the technician plays the role of patient/client. Each role has an outline of key questions, challenges and issues to be raised while in the role. These resources are part of the package available to students as part of their preparation to reduce student anxiety and increase opportunity for students to practice positive learning.

Simulation debrief

Paramount to the success of the simulation is providing a debriefing session immediately after the simulation to provide an opportunity for students to explore their decisions and actions and apply their learning to nursing practice (Bushy & Hewett, 2012). Morse (2009) defines debriefing as a learning experience in which students reflect on their actions and link this to theoretical frameworks and didactic knowledge to integrate a new perspective for managing similar future situations. The skill of the facilitator in debriefing is crucial to learning outcomes and avoids putting the participants on the defensive (Bushy & Hewett, 2012). Dufresne (2006) recommends the facilitator utilize a conversational inquiry approach and perceive the students' actions as an intellectual puzzle to be solved. Otago Polytechnic lecturers facilitate and coach the students providing a process so students lead reflection in debriefing. This is consistent with researchers recommendations for debriefing (Reed & Corbette, 2017) with the Otago Polytechnic experience suggesting students appreciate having a framework or process of reflection, enough time to explore and appreciate links to practice frameworks and like to leave de-briefing with a clear, positive goal to work on to strengthen their practice.

Simulation in primary health

In year one, simulation begins with clinical tutorials that are run concurrently with a student visiting families, older adults and community resources. Role play exercises help the student to learn and explore how it feels to be a nurse, build relationships and be 'professional'. Students' learn to identify personal/professional boundaries and build awareness of cultural differences. In addition, students are introduced to the simulation suite by observing an introduction to simulation video and signing a confidentiality and engagement form. Following the introduction to simulation, students participate in a small group simulation involving assessment of a patient experiencing chest pain. The focus in the debriefing session is on subjective interviewing, assessment and handover of assessment findings.

Year two and three clinical courses each include two simulations as an adjunct to their clinical placement hours. Four primary health simulations are provided; three of these are based on the New Zealand Ministry of Health (MOH) national health targets around immunization, smoking and diabetes. The simulations have a low fidelity/technological focus and place a greater emphasis on the development of students' interpersonal skills, communication and empathy. The objectives emphasize working in partnership between student, RN and client and the use of motivational interviewing to promote positive health change and health promotion.

DISCUSSION

The rapid advancement in simulation technology over the last decade has enabled more opportunities to provide realistic student learning experiences in a safe environment through the provision of experiential learning and reflective practice (Bartlett, 2014; Bushy & Hewett, 2012). Students report feeling more confident and competent following simulated learning experiences (Lewis & Ciak, 2011; Bambini et al., 2009). However, Berragan (2011) warns the seduction of these new capable technologies may move us away from our initial views of the undergraduate curriculum which emphasizes relational,holistic care. Simulations are frequently "technologically driven and crisis based" (Limoges, 2010, p 61) and may inadvertently focus on psychomotor skills at the expense of interpersonal relationships (McGovern, Lapum, Clune & Martin, 2012). Limoges (2010) recommends constructing the simulated patient to rebalance the art of nursing towards a holistic approach of wellness in body, mind and spirit to avoid the risk of developing task centred practioners, a concern also mentioned in other literature (Berragan, 2013; McGovern et al., 2012; Chen, 2011; Foster & Hawkins, 2005). Otago Polytechnic has responded to this movement by developing primary health simulations that require students to partner with their client, to work together for wellness. To engage students in thinking holistically , human actor clients provide emotional cues, the scenarios and roles provide context and back story requiring students to develop the art of nursing and communication, rather than rely on task centered skills.

In our nursing school, to provide a holistic approach the primary health simulations use actors as they are able to respond with non-verbal cues and provide emotional nuances, which manikins cannot display. The scenarios are designed to complement the high fidelity medical/surgical simulations by highlighting the importance of holistic assessment, that includes not only the client but their family/significant others. Working in partnership is emphasized along with the need for primary health care nurses to be opportunistic with nursing care and health promotion. In many simulations students are required to respond to an emotional client who may be crying, angry or experience English as a second language which may raise one's self-awareness which can be difficult and bewildering at times, as questions are raised and explored. Anecdotally most Otago Polytechnic students don't perceive somulations to be "real" but do value the safe learning opportunity, and say this aids building effective practice when in clinical.

By providing a safe environment with supportive facilitation where students can acknowledge and explore their values and beliefs during debriefing allows students to make sense of primary health issues and practice, including emotional behavior, socio-cultural determinants of health and developing empathy. If students are able to deal with their own feelings appropriately, they will be able to more confidently deal with others competently and safely. Effective learning can be enhanced through simulation as a more interpretative approach to learning facilitates the student to be able to make sense and find meaning in their learning opportunities (Jefferies, 2012).

One of the big challenges for nursing students is learning how to transition into professional roles and behavior. Transition is defined as "movement or passage from one position, state, stage, subject, concept, to another" (Golan, 1981, p.11). For nursing students, it is about moving on from merely surviving new primary health clinical situations to coping and caring compassionately within complex nursing realities. By providing simulation opportunities for students to focus on their interpersonal skills and communication they learn how to be a nurse as well as the skills of nursing (Berragan, 2011). Developing competence and confidence in interpersonal skills not only alleviates students' anxiety and vulnerability but the vulnerability of others. As new information and expertise is gained and practiced in simulation, students are enabled to interpret similar situations with more understanding and less stress (Admi, 1997).

CONCLUSION

Simulation is a learner centered teaching strategy which effectively allows students active participation in developing their practice and complements the learning which occurs on clinical placements. Anecdotal student feedback reiterates that students feel more prepared for clinical placements after completing simulations. The combination of pre-simulation work, the simulation experience, and debriefing with reflection on their learning, increases their confidence and knowledge. For some it highlights what they need to further explore, whether that be gaps in their theoretical knowledge or social and emotional competence. Providing students the opportunity to reflect on their learning experience and giving feedback on their practice in a safe place will enhance student learning whether they are in simulation or on clinical placement. By using reflection and engaging students in active clinical discussions, nurses mentoring students in practice and education are in a prime position to support students to transition from a first year novice into a beginning professional growing in confidence, independence and expansion of role.

A carefully planned primary health simulation which requires the student to establish meaningful relationships in context can be a valuable addition to preparing students for the reality of establishing primary health care practice in different contexts. Simulating living breathing human beings with emotions, allows students to practice the art of nursing by responding behaving and acting like a nurse, preparing them for the complex realities of health care in numerous clinical placement settings.

Josie Crawley has been involved in nurse education in both the community and education institutions for over 25 years. She is passionate about opportunities for health promotion in primary health; and her research platform explores the place of narratives within nursing education.

Dr Jean Ross, is a registered nurse and principle lecturer in the School of Nursing at Otago Polytechnic, Dunedin. Jean's interests focus on the concept of 'place' and community development, particularly rural communities. Jean facilitates rural community knowledge, the place of image and the powerful effects the use of image can have when combined with written text.

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Original Research

PLACE-BASED RURAL PRIMARY HEALTH CARE NURSING PRACTICE: A STUDY SET IN RURAL OTAGO, NEW ZEALAND.

Dr Jean Ross

INTRODUCTION

The practice of nursing in rural New Zealand has occurred during the past century in a variety of rural places and shifting health care systems. During this time there have been various approaches and changing attitudes of the governance and practice of the delivery of health care, which has moved the responsibility from the state to the local region and community control. Rural Otago situated in the South Island of New Zealand (the setting related to this study) was initially directed by the national government in the 1990s to govern the provision of primary health care and this continues to the present day. In response resident rural primary health care nurses demonstrated a commitment to ensure health care was adapted to accommodate the particular nuances of the rural geographical location and population needs to a ensure that health disparities were minimised.

Background

Primary health care nurses in New Zealand practice relates to numerous diverse rural settings and have cared for local community members throughout the past century, in a shifting health care system (Ross, 2016). The rural place context is one important contributing factor that shapes the practice of these nurses (Bushy, 2012). Likewise the various approaches and changing attitudes of the governance and models of delivering health care have also shaped their practice. These nurses have played a central part in the provision of health care throughout this changing health care landscape. Rural nursing is recognised internationally as a specialty area of nursing practice, situated within the generalist field of nursing (Knight, Kenny & Endecott, 2016). This specialist area of practice is an underrepresented aspect of nursing and its' professional identity is challenged, misunderstood and does not fit easily within the national imaginings, wider nursing profession and policies governing nursing practice (Ross, 2016).

Rural nurses generally care for small populations in isolated and physically remote locations that are considered a unique aspect of rural practice (Francis, Chapman, Hoare & Birks, 2013). Rural practice occurs in either small rural hospitals or in the community, based within the framework of Primary Health Care (PHC) (Carryer, Halcomb & Davidson, 2015; Bushy, 2012). PHC is normally the first point of contact patients or clients have with the health care system (Ministry of Health, 2001). The activities provided by PHC nurses promote the health of the population, manage episodes of illness, including acute and chronic presentations, disease management and end of life care as well as providing for health emergencies (Carryer et al., 2015; Horner, 2008). Rural primary health care nurses care for all ages of the residents, visitors, and transient and seasonal workers (Fitzwater, 2008). Health care is provided within numerous models to ensure residents can access health care '24 hours' a day. However, for some rural nurses this means being on call for long lengths of time or sharing the on-call component with other health care members of their team (Armstrong, 2008).

The majority of rural nurses experience dual-relationships as both an opportunity and a challenge. Opportunities can be considered as engaging with the community and its residents while developing a long-term relationship with patients and their families (Crooks, 2012). Challenges can be associated with working in the geographical context of frequent socioeconomic deprivation (National Health Committee, 2010), geographical barriers and reduced transportation as well as experiencing poor road conditions (Bushy, 2009). Challenges such as these, together with the recognised barriers associated with personal and professional isolation, limited on-going education; lack of anonymity (Davis, Williamson & Chapman, 2014; Bushy, 2012; Crooks, 2012; Molinari & Bushy, 2012) and conflicting professional boundaries and role conflict, add to the complexity of the factors that compound the difficulties of practising health care in the rural location.

Worldwide there is an uneven distribution of rural health professionals per capita of population in rural locations, when compared with urban areas (Hughes, 2009). Allied health practitioners, including physiotherapists, occupational therapists, radiographers, dentists and pharmacists are less likely than doctors and nurses to practice in rural and remote locations (Hegney, Francis & Mills, 2014; Hughes, 2009). A reduction of health care practitioners leads to the lack of availability and recruitment of experienced health practitioners and a corresponding lack of rural planning and dedicated funding. These challenges, together with the limited financial resources and the "uneven geographical distribution of the… health care workforce" (Hughes, 2009 p. 205) are evident, as the rural geographical location becomes more isolated or remote over time. It is in these rural, geographically isolated locations, in developed countries, that rural nurses form the majority of health care practitioners (Hughes, 2009). These primary health care rural nurses deliver a diverse range of health services, often in demanding circumstances (Bushy, 2012) and New Zealand rural nurses are not immune to this challenge (Ross, 2016).

The New Zealand health care system has evolved over an approximate one hundred and sixty year period, in which the rural context has had a profound influence on the development of the country's health care system (National Health Committee, 2010). This health care system evolved through a number of differing phases, population needs and political aspirations. The initial period was associated with the 'pioneering phase' throughout the 1840-1930s, the 'welfare phase' established between 1938-1980s and the 'neo-liberal phase' from the 1990s into the contemporary period. Nurses have been a part of all of these three phases in different guises and to differing degrees providing them the opportunity to adapt their practice to accommodate change and the health needs of community members. In doing so I acknowledge their practice as representative of their commitment and response to the delivery of health care as illustrative as a place-based practice.

In the 'pioneering phase' there was a need for health care to be provided as the population of New Zealand was increasing with the arrival of gold seekers from Asia and Australia, and the European population increased and settled in rural locations to farm the land. Gauld (2001) suggests that the provision of health care needed to become more organized, however funding and the recruitment of doctors was unreliable and difficult because of the isolation and sparsely populated areas termed, the 'Backblocks' (Wood, 2008). In 1909 the 'Backblock Nursing Scheme' (BNS) was established to provide health care for the increasing European settler population (Wood, 2009). A similar nursing scheme was established in 1911 to care for the rural Māori population (indigenous people of Aotearoa, New Zealand) and was referred to initially as the Native Nursing Scheme (NNS) (Burgess, 1984), and was renamed the Māori Health Nursing Service (MHNS) in 1922. The BNS and MHNS was one aspect of formalised nursing practice that provided a health service comprising nursing, public and emergency health care as well as midwifery services in the remote areas of New Zealand (Wood, 2009, 2008). The Backblock nurses demonstrated their contribution to the delivery of an extensive range of health care activities as a result. They

become the local health resource for the settlers and the indigenous population while maintaining regular contact with the nearest resident doctor, who was at a distance (often some fifty miles away) and located at the district's base hospital (Wood, 2008). Backblock nurses responded to the changing health care environment and over time adapted and expanded their practice in response to the needs of the community and the context in which the population resided. In the process of this adaptation, so too did the professional status of these nurses change, according to Wood (2008) "[…] for nurses taking on the role, it provided a chance for independent practice and greater responsibility, far from the hierarchical systems and practice in hospitals" (p. 69).

What is of significant interest in this paper is that the practice of Backblock nurses remained unchanged up until the 1940s. During this time nurses who practiced in rural contexts merged for the first time with urban nurses. This was a time of the establishment of the second phase of the health care reforms the 'welfare state' (Dalziel & Saunders, 2014). Nurses from this time onwards were referred to as district, public health, and Plunket nurses, generally visiting people in their homes and workplaces as well as children at school both in the urban as well as rural settings and remained constant until the redevelopment of new models of health care in rural regions.

As a result of limited funds associated with the global economic downturn, the government enacted major health reforms resulting in a change to the provision of health care (Prince, Kearns & Craig, 2006). This restructuring during the early 1990s aimed to improve efficiency and access to health services (Barnett & Barnett, 2009, 2005) and was influenced by a neo-liberal philosophy. The health care system at this stage was transformed radically-initially in the 1990s as Rural Community Trusts (RCTs) were established. The RCTs were representative of the local rural community residents and consisted of a number of the health care professionals who practiced in these communities (Barnett & Barnett, 2001). The intentions of the RCTs were to identify the health needs of their community residents' and to plan, manage and fund health services and evaluate the outcomes (National Health Committee, 2010; Barnett & Barnett, 2001). Instead of these services being governed and funded nationally they were transferred to that of community control offering rural primary health care nurses the opportunity to develop a health care system responsive to the local community need and effectively self-governance (Barnett and Barnett, 2009).

Aims of the research

This study aimed to generate awareness as to what shaped the identity of the rural primary health care nurses' from the rural Otago region during a significant time of change between the 1990s and 2000s. I was interested to uncover if rural place (as defined in the occupational title of the rural nurses) was a contributing factor. Equally I wished to understand what constitutes being a rural nurse, how they practice and what their contribution has been to the rural health care sector. These were the research questions posed to the participants. This information in turn provides the potential to strengthen the nurses' understanding of their changing and adapting identity and provide them with an ability to articulate the significance of their practice to the rural health care and national nursing sectors. Up until now, there has been little exploration as to the factors that contributed to the innovative practice these rural nurses pioneered.

METHODOLOGY

This qualitative study is positioned within the social sciences, and adopts an interpretivist approach. Unique to the interpretivist paradigm is the notion of 'context' (Whitehead, 2013). Briefly, context is associated with the national and regional contexts of New Zealand and considers the broader social, cultural and organisational circumstances, as well as the physical locations which impact on the study participants practice. The study was conducted in the rural Otago region in the lower central part of the South Island Rural Otago has a landmass of 32,000 kilometers and a population of 215,100 as of June 2015 (Statistics New Zealand, 2015) which is approximately only 5% of the total of New Zealand's population (Otago Regional Council n.d.) resulting in a large geographical location which is relatively unpopulated. The aim of this inclusion is an attempt to engage the reader to become familiar with the unique aspects of rural nursing from the study location.

Data collection

Seventeen regional rural nurse participants agreed to participate and consented (in writing) to be interviewed. I noted the participant's preferences and timetabled the interviews with the participants whether they wished to have a face to face or telephone interview. The semi-structured interviews occurred in rural Otago over a three-week period in April/May 2007 when I travelled around the rural Otago region and visited and interviewed thirteen participants face to face. These interviews ranged from forty-five minutes to two and a half hours duration. The interviews took place at the discretion of the participant at their place of work, or at their home. The remaining four participants were subsequently interviewed over the telephone, during 2007 and 2008. The rural nurse participants' details indicate that all participants were female and their ages ranged between 20-60 plus years at the time of data collection. There were two participants in the 20-29 year group who had experienced rural practice between three months and 1.5 years, at the time of data collection. Two participants were aged between 30-39 years and had experienced rural practice between two and six years. There were five participants whose ages ranged between 40-49 years and had experienced rural practice between three and twenty five years. Equally the age ranges of the rural nurse participants' between the years of 50-59 had experienced rural practice between four and seventeen years. Additionally, there were three participants who identified as 60 years plus and had experienced rural practice between eighteen and twenty years.

This study represented a broad spectrum of regional rural nurse participants ranging from a minimum of three months practice to twenty-five years and a number of years in between these minimum and maximum ranges. The age ranges of the rural nurse participants were representative of the years of experience. However, there was one exception as one participant representative of the 40-49 year range had been the longest in rural practice, in total, twenty-five years at the time of data collection.

Data analysis

The data from these interviews were digitally recorded and then transcribed by a professional typist and analysed by engaging with a thematic analysis, to seek how the practice of these rural primary health care nurses was shaped.

Ethical approval

The University of Otago Human Ethics Committee approved this study in 2006.

FINDINGS

This analysis has led to insightful findings and signal that during the 1990s and early 2000s rural nurses' adapted their practice to ensure the level of health care was initially maintained and latterly, improved. In response rural nurses demonstrated a commitment to ensure that a suitable model of health care has been provided with the benefit that health disparities were minimised. There are some common themes that bind the practice of rural nurses together, namely the community focus, isolation, inadequate resources, limited transport, lack of anonymity and the restricted availability of health care practitioners. This style of practice relies on the rural nurse using initiative, being innovative and flexible, rather than relying on one practice model which fits all rural communities. The participants in this study highlighted the dominant characteristics of distance and isolation that define the rural location and the lives of the people who live rurally. Traditionally, rural people have responded to this isolation by developing self-reliance, hardiness and becoming a close-knit community (Bushy, 2009; Cloke, 2006). Distance can be classified by actual distance measured by kilometres, time taken to travel and the perceived time and distance to services (Bidwell, 2001; Bushy, 2000).

New Zealand rural nurses recognised a number of aspects which identify them with the rural region, such as being aware of the particular nuances of distance and the time taken to provide health care. More specifically rural nurses noted they were aware of being responsive to the particularities associated with the physical terrain, long distances travelled and the factors that promote isolation in which they adapted their practice in accordance with these factors. This means they are required to become as resourceful as possible as they practice within these contexts. Isolation can compromise the rural nurses' practice, often resulting in ethical dilemmas (Hutton, 2016; Bushy, 2009) as to the choices and decisions the rural nurse makes related to the context of their practice. The rural characteristics of hardiness, autonomy, diligence and perseverance are seen to foster self-reliance (Bushy, 2000; Lee, 1998) and further characterised as a result of distance and isolation as, expressed by these rural nurses:

> The rural nurse that identifies with some of the things that are commonly thought of as being part of rural practice as living and working in a rural community, the sort of professional and geographical isolation, some of those common factors are common to all rural nurses.
>
> (P16)

> You are working alone with no, with no immediate backup if something goes wrong although they [rural nurses] have cell phones there is very limited reception out there.
>
> (P6)

The findings identified three main themes from the data. First, a sense of change to the health care structure leading to opportunities for nurses to develop their own models of practice. This sense of change led to a sense of self, highlighted as the second theme, in which the self-governing aspects of practice are embedded within different models of care and a sense of practice is revealed. These models of care are further revealed in the third theme, a sense of difference, in which rural nurses' relationship with the rural context, community members and resident health professionals, adds to the unique aspects of the provision of health care.

Sense of change

Some of the participants were actively involved in shaping the model of rural health care as a result of the restructuring of the health care system, during the late 1990s and early 2000s. The analysis further illustrates that the rural nurses' practice was evolving into new models as they engaged and worked in partnership, initially aligned with RCTs in the early part of the 1990s (Barnett & Barnett, 2001; Gauld, 2000) following the philosophical shift from state welfare to a neo-liberal approach. A 'sense of change' became evident from the data, which was indicated by the participants' who had been a part of the health restructuring 'change process'. In response a rural nurse explained that:

> *Because the hospital closed and poof, there's nothing there. The few of us left that wanted to carry on working…*
> *we didn't know what we were supposed to do, we didn't know what we shouldn't do so we did what we thought*
> *we should do rather than being based on, this is the way it is.*

(P 7)

I was attracted to learn more about the development of the rural health care services and asked this participant to further expand on how the health services developed during the time of the healthcare restructuring. The rural nurses' response signaled that her practice was driven by having local knowledge of the community and location and the way in which this knowledge was assessed through being a local resident member of that community:

> *I think it's coming from being local in your own community and understanding your community.*

(P7)

Practice was driven by a 'can do it' attitude and the rural nurse aimed to offer and maintain a quality health care service identified from this analysis as being based on a flexible approach, by acknowledging community residents' health needs and providing a health care service that was responsive to the local community as expressed by the following rural nurse participants:

> *We definitely adapt the way we work to the needs of the job and especially the community as well as being*
> *associated with the development of the 'new health system'.*

(P2)

> *I think it's… working together to develop systems that work for the community… I think nursing, I think*
> *communities, the older parts of the communities think it was the doctor but I think in a lot of the community-*
> *based decisions, nursing has as valuable input.*

(P5)

The evidence gathered implies that models of rural nursing practice were associated with the collaborative relationships the nurse had developed with the members of the community and local health care professionals. Models of practice such as these have provided an opportunity for rural nurses to further adapt and advance their

practice in accordance with the rural communities' vision and direction that met their health care needs. Rural nurses explain:

> In a small rural place like the [place name removed] here we have a great relationship with our community.
>
> (P15)

> The focus here [rural community] is on doing the best by the person, the person is central within the community.
>
> (P5)

Sense of practice

As I engaged with the data I identified that rural nursing practice occurs within a number of sites situated within the physical rural location of the rural Otago region. The sites and the composition of rural nurses' practice demonstrates the complexity of rural nurses' practice, in- between these sites. These sites may include, the rural community hospital (unlike tertiary hospitals which are typically associated with urban and city locations) residential care (older adult residential facilities), in general practice clinics, rural schools, client's homes, on the sports field, the roadside and on the farm. What comes from practicing in numerous sites is the visibility of the rural nurse and the expectations that either come from community members or from the way in which rural nurses' wish to govern their own practice and accommodate clients' health requirements. The following experienced rural nurse illustrates how rural nurses respond to patient's requests to either stay at home or get back to their local community hospital (from a tertiary hospital) to continue their health care and rehabilitation care:

> They [rural nurses] are prepared to put themselves out there and to go that extra distance and the common understanding is that you want to make, you want it to work for people who are at home so you do your utmost to do that and often sacrificing your own time… we want it to work for them [client's] so we do our best to make it work for them out there.
>
> (P6)

The rural nurse has taken into consideration that resident's recovery could be improved significantly, if they were cared for nearer to their home. In respect of this request the rural nurse "goes the extra distance" and expands her knowledge and learns new technical skills to accommodate the clients' health needs. In the following excerpt another experienced rural nurse explains that to adequately care for this client she needs to become competent to perform the care required for the maintenance of a Hickman Line and the administration of Total Parenteral Nutrition (TPN) in order to be confident to manage the complexity of this specialist area of practice. The nurse is aware of the physiological complications that could occur, including the potential for cross-infection, if she was not competent to perform this aspect of practice. This rural nurse takes into consideration community members' requests and health needs:

> They [community members] say can I come back to your hospital and they've got a Hickman line in and you've never dealt with it or you've only very rarely dealt with a Hickman and you think holy heck, how am I going to bring this patient back, who's got a Hickman line and having TPN but I know that she really wants to get home

for Christmas to be with her family so therefore [nursing position removed] I have to make sure that I know how to do it and that I train the nurses like in three days, so that they can care for it.

(P5)

In practice settings, such as described above, rural nurses advance their practice to provide a health care service specific to the needs of the community members in a particular 'location'. Rural nurses' practice is constructed through moving between practice sites. The ability to move between sites further promotes the essence of place-based care benefitting community members' access to health care that I refer to as the nurse practicing 'in-between' locations.

Sense of difference

In-between practice locations provides an opportunity for the nurse to care for the same clients in numerous sites in the same rural community, as illustrated by the rural nurse who had cared for an older person in her own home:

We have patients who sometimes require oxygen and we can just if we're out visiting them and we feel they need it, we can just bring them back [in our motor vehicle] with us and put the oxygen on and the doctor will come and visit them.

(P2)

The excerpt above illustrates the autonomous nature of rural nursing practice, through the assessment of a client's health status, the management of the case and local treatments as well as carrying out the necessary action to ensure clients receive appropriate health care in a timely manner. The nurse assesses the person's breathing and determines from a nursing diagnosis that this client requires oxygen. The nearest facility that has the ability to provide oxygen therapy (in this scenario) is the local rural hospital. In this scenario the rural nurse decides the most effective way of ensuring this person gets the treatment required is to take her to the local rural hospital in the nurses' work related vehicle. The unique insight of the nurses' practice aligned with 'location and the physical sites of where and how practice occurs is highlighted. The nurses have the ability to practice in an autonomous fashion which demonstrates self-govern while considering the best use which can be made of available resources, including minimising as much as possible disruption for the patients/clients. Autonomous and diverse practice is a theme which is highlighted as the rural nurse expresses the importance of getting to know the clients and their living situations, as this way of practising better accommodates the comfort of the client when they are in their own home (McMurray & Clendon, 2015).

Starting off with a home visit to a chap who can't come into the Medical Centre because of his [condition removed] so he's on my way to work and because it's a local, rural area and you know people in town, you just pop in on your way and you know everybody by their first name and his caregiver […] was there and he knew it was me that came in the door even though he's [disability removed] and took his bloods and carried onto work.

(P17)

The following example has been highlighted as to how some people feel uncomfortable in the doctor's clinic or have difficulty getting to the clinic and so the nurse visits the resident on her way to work or during work time. In the rural context, regardless of which site or sites the rural nurse is practising within, there is an overall theme of

responsibility and expectations of the nurses' practice by 'others' as well as by themselves, to perform in a certain way as expressed in the following excerpt:

> *I think to be fair that some people don't like coming to the doctor, let alone having to sit out in the waiting room and there might be a lot of other people there and there's people coming and going, I mean we do our best I suppose, to make people feel comfortable and things but there's nothing like seeing people in their home. And it's on their terms...I love it when I have to go out, I'll often shoot out and do bloods and things. The district nurses here… doesn't do bloods… I'll often pop out in the car and go [place name removed] I like getting out and seeing people in their home, in their environment, on their terms.*

<div align="right">(P4)</div>

Nursing in diverse locations provides the opportunity for the rural nurse to practice in client's homes, in community facilities such as the local school, workplaces and at the roadside which includes the provision of on-call health care. The provision of on-call may range from palliative care, wound management to acute presentations-or emergencies including accidents such as-motor vehicle accidents involving local community people, visitors and tourists. In the capacity of providing emergency health care the rural nurse does this in connection with the New Zealand Primary Response in Medical Emergencies (PRIME) system (Horner, 2008; Ministry of Health, 1999). The PRIME system relates specifically to rural practice and is identified as specific knowledge related to emergency and on-call events that occur in rural locations, with the aim of improving timely health care because of the particularities related to the 'rural'.

DISCUSSION

 Historically rural nurses' have been at the centre of the delivery of rural primary health care in the more isolated and remote contexts of New Zealand, identified initially as the Backblock nurses and the MHNS. How these nurses went about their day-to-day practice has highlighted aspects of place-based care and continues on in the contemporary period. The rural nurses' practice has been shaped in response to international, national and regional changes and the geographical and population health needs. The global economic downturn of the 1980s and 1990s resulted in major health care restructuring in New Zealand (National Health Committee, 2010). A shift of ideological thinking was a result of these changes from one of a state welfare approach to a neo-liberalist ideology (Dalziel & Saunders, 2014; Oliver, 1988). This shift in thinking began to influence government policy and the provisions of health care funding from the 1980s (Ife, 2013). This new health system changed the philosophy of how health care was to be delivered in rural communities. The stimulus for this was the acknowledgment from the government that there were inequalities in health care provision for some population groups (National Health Committee, 2010). The cost of health care and/or treatment and the difficulty of accessing health care providers, as well as the appropriateness of these providers, were recognised as barriers preventing health care provision. However, as identified from this study, the collaborative rural community relationships rural nurses were engaged with assisted these nurses to adapt their practice which has improved the provision of health care.

As the neo-liberal changes occurred, self-governance structures evolved and, for the rural nurse participants in this study, an opportunity arose to advocate for social justice. This meant developing partnerships with rural community members through which to enhance health care decisions and actions and improve the social determinants of health, in particular access to '24 hour' health care provision (McMurray & Clendon, 2015). These changes were primarily made manifest through the establishment of RCTs in the 1990s and from the early part of the 2000's the

health care system came under the influence of and was shaped by the 'Primary Health Care Strategy' (Ministry of Health, 2001).

The intention of transferring the governance to a partnership arrangement between the rural community residents and the rural nurse aimed to develop a health care service tailor-made to accommodate local residents' new acceptance and engagement with the health care service. Health care professionals then become responsible to the local community in which they recognised the value of local place-based knowledge, wisdom and expertise and understood that universal knowledge cannot simply be applied to the rural community, as context needs to be considered a necessary contributing factor in the delivery of health care planning and provision. In New Zealand, some rural communities from the regional study location were successful in maintaining local access to a range of health care services which when combined with strong community leadership and committed local health professionals, have aided in the retention of local facilities and led in some cases to improved community satisfaction of their health care services. This study has exposed that rural nurses governs their own practice, influenced by local knowledge-which underpins rural culture, rural values and rural behaviour. These governance structures remain as dominant features in contemporary rural locations and continue to influence the power structures within the health care system (Bushy, 2000).

The rural environment comprises a wide range of attributes associated with the physical location, which is broadly identified as context. Context is a central feature of this study and connects all the relational aspects within the social world, the relations between humans and non-humans and the social interactions which occur in place (Agnew, 2011; Woods, 2011). The rural environment also includes how people relate in place, what attachments they have and what it means to identify with a 'location' or sites of practice as a 'sense of place'.

Adapting and broadening the scope of the registered nurses' practice and performing in rural isolation from other nurses is a point of difference. The rural nurse creates a healing place within various rural sites and structures and as this occurs a nurse-client community proximity is established which has entitled this nurse to advance their practice. Examples of their practice includes working in partnership with clients and community members and establishing PRIME access which has benefitted the health care of the clients in these rural communities. Through these encounters, a deeper understanding has been revealed as to how the rural nurses' adapted both personally and professionally. Rural nurses' practice encompasses a vast array of knowledge, skill and expertise, in the rural community (Molinari, 2012).

The findings from this study are a useful reference point for rural and non-rural nurses, planners and policy makers to better understand the different approach rural nurses'-engage with in order to provide fundamental care. Difference in this context is considered a valuable and positive concept in which to recognise the unique features aligned with the provision of care associated with rural nursing practice.

Bushy (2012) has indicated that as yet there is no suitable model encapsulating the unique aspects of rural nursing practice. Therefore, adding to the global rural nursing knowledge base with insights generated from this study may capture important aspects of care in respect to rural nursing practice. This knowledge can contribute to the growing body of knowledge associated with the theoretical base aligned with rural nursing practice. It is important to recognise that knowledge associated with nursing practice is different to urban knowledge and urban models of practice and that, as policies, guidelines and legislation are being developed, the knowledge pertaining to the

'rural' needs to be considered along with the assignment of appropriate rural personnel to add to the debate. It is essential this study and the knowledge generated be translated into practice legislation, policy and education which guides and funds rural practice and recognising those rural primary health care nurses are at the forefront of this endeavor. To this effect it is important that nursing from a national level needs to encompass regional and local rural nurses' experiences that can influence the policy process at governmental levels and share their experiences associated with the changes related to the neo-liberal movement and, in particular, how rural nurses' have governed their practice in the process associated with this approach.

CONCLUSION

This study has revealed that during the past century nurses who have practiced in the rural community in differing health care systems have pioneered models of sustainable practice that meets the needs of community residents and reduced health disparities. This study highlights how the rural nurse aligns the self in the rural community as a meaningful provider of place-based primary health care

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