

BROADENING HORIZONS

A professional resource for
occupational justice and participation

**Broadening Horizons:
A Professional Resource for Occupational
Justice and Participation**

JENNI MACE & CLARE HOCKING, EDITORS

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FOREWORD

Broadening Horizons: A Professional Resource for Occupational Justice and Participation

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February 2010

Jenni Mace and Clare Hocking, Editors, have taken a bold step to position occupational therapy as a radical force with global interests. Consider the radical thrust of this first line in their Introduction: “Occupational therapy is no longer just about disability”. Reading this statement prompted me to imagine a drastically changing, professional landscape, and to ask myself: Was occupational therapy always just about disability? What does it mean to the profession and society if occupational therapy is no longer just about disability?

Broadening Horizons is a wonderful, small book that displays how well Bachelor’s degree students in the Department of Occupational Science and Therapy at the Auckland University of Technology (AUT) are learning that occupational therapy is no longer just about disability. Instead, they are learning about practice based on ideas about occupational justice and participation. The five chapters capture the excitement and knowledge of student groups who, not yet in practice, were able to imagine possibilities, write proposals, and craft chapters. The student authors incorporated lectures on needs analysis, partnership agreements, service user involvement, outcome measurement, marketing and funding into their experiences with local Auckland organizations using the emerging concept of occupational justice, and the World Health Organization (2001) concept of participation.

If you wonder what occupational therapy might do if this profession is no longer just about disability, I urge you to read on. In their quest to develop occupation-based practice, one student group went to an organization with firm medical roots – an acute care hospital. Students learned that addressing occupational justice and participation in this context is possible with a collective commitment to change service conditions, and access to library resources. Other student groups learned to integrate concepts of occupational justice and participation in practice to: enable driving by new immigrants as a matter of occupational justice; launch the *Hands On* project with people with mild mental health issues who are marginalized without access to occupational therapy and other services; develop *Ladies Space* as part of the Methodist Mission Northern with homeless people; and, start *Horizons ... Building Whole People for Tomorrow*, a parenting programme for year 7 and 8 students in an Auckland school.

I hope you will be as energized as I was by reading Broadening Horizons! While the questions I noted above are still outstanding, I learned from AUT students, as I hope others will, how a new generation in occupational therapy is looking at occupational justice and participation, and discovering through innovative experiences that occupational therapy is not just about disability.

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Broadening Horizons: An Introduction

JENNI MACE AND CLARE HOCKING

Occupational therapy is no longer just about disability. Townsend and Polatajko (2007) describe occupational therapy as:

The art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life. (pp. 372)

Whilst occupational therapists have always been advocates for their clients within the larger community, the concept of occupational therapists enabling just and inclusive communities or population groups through meaningful occupation is a relatively new idea. New theories, concepts and research are enabling occupational therapy schools to include these ideas in their curricula. In response to this broader vision of the profession's scope, the Department of Occupational Science and Therapy at Auckland University of Technology (AUT) has developed a paper called 'Promoting Occupational Justice and Participation' (POJP) as part of its undergraduate occupational therapy programme.

Occupational justice prompts us as a profession to break down barriers and build resources to enable participation in occupations that satisfy personal needs and encourage full citizenship (Wilcock & Townsend, 2000). Townsend and Polatajko (2007, Section IV) outlined four main ways that occupational therapists can do this:

1. Collaborating with organisations that have the resources to build evidence of occupational injustice, investigate its effects, develop potential solutions and establish occupational rights
2. Exerting power through documentation. For example publishing results of research or service development projects, ensuring an occupation focus when writing client notes or reports, blogs, newsletters or using the media around a particular cause
3. Seeking out funding for new services and research
4. Encouraging our own profession to reflect on practice to ensure it not only improves impairments but, first and foremost, enables occupation.

These four methods to promoting occupational justice are integrated into the POJP paper. Working in small project

groups, the students are required to develop a programme proposal for a local organisation that will encourage occupational justice and participation for the population groups it works with. Each group meets with key representatives of the organisation at the beginning of the process, and presents their proposal to the organisation at the end of the 6 week period. Students then use the information gathered by their group to individually document their version of the proposal to be submitted as an assignment.

To assist students in developing their proposals, they receive lectures on topics such as needs analysis, partnership agreements, service user involvement, outcome measurement, marketing and funding. These lectures are supported by Fazio's (2008) book, 'Developing occupation-centred programs for the community', which also provides the structure for presenting the students' work. To ensure they maintain an evidence-based occupation focus, students also hear from guest lecturers who have either carried out occupation-based research or have developed occupational justice focused programmes. In addition, the student groups receive support and guidance through weekly supervision meetings. After the assignments are marked, each organisation involved in the project receives the best of the proposals written for them. Whether they take these proposals forward is up to the individual organisations.

In 2009, the students worked in 11 small groups. Our thanks go to their organisational partners for providing this invaluable learning opportunity. The organisations involved in the projects presented here were an NGO providing services to homeless people, a mental health service in a District Health Board (DHB), an organisation that assists immigrants with English as an additional language, a decile 1 school for year 1-8 students, and an occupational therapy service in a hospital in another DHB. This book presents five of the best examples of student work, as named below:

1. Developing a Programme for Women Experiencing Homelessness in Auckland City
2. Developing a Primary Care role for Mental Health and Wellbeing
3. English Speakers of Other Languages Experiencing Occupational Injustice - The Issues of Learning to Drive in New Zealand

4. Developing a Parenting Programme for Year 7 and 8 Students
5. Moving Towards Occupation-Based Practice.

One purpose in publishing the best of the proposals developed by final year students in the AUT programme is to showcase the skills and knowledge new graduates have developed, in the hope that they will be called on to use those capabilities to build an inclusive and occupationally just society. In sharing the particular projects included in this book, students have generously agreed to share the literature and ideas they gathered on innovative ways occupational therapists can work with their local communities and institutions. As paper leader, Jenni has added a commentary at the beginning of each proposal to give it context, highlight its strengths and discuss how it might be implemented. While the students have not had an opportunity to hone their ideas by putting them into practice, we believe they represent a collective resource that will inspire the development of services that will broaden our vision of the contribution occupational therapists might make to New Zealand society.

Moving Towards Occupation-Based Practice

SUE NICHOLLS

Other Project Members: Amanda Jacobs, Catherine Heaney, Fiona Perry, Hayley Murray, Jennifer Bennett, Kate Steven, Shannon McRae

PAPER CO-ORDINATOR'S COMMENTARY

Students were asked to work with the Occupational Therapy Professional Leader for Auckland DHB who had identified a mismatch between enabling occupational engagement contextualised within a predominantly medical model practice setting. This mismatch was observed to impact on acute care setting occupational therapists' identity and their pursuit of occupational practice, despite systems being in place such as 'washing away SOAP notes' (Blijlevens & Murphy, 2003) and regular supervision, formal peer review, journal club, and routine inservice at ADHB. Sue's proposal expands on this mismatch articulately in her introduction clearly showing through the use of literature that this is a concern currently being raised by occupational therapists internationally.

The task that was set for this group was to explore ways in which the occupational therapists servicing acute wards can practice in an occupation-focused way whilst still meeting the requirements of a medical setting. To accompany their proposal, the group developed a resource manual outlining ideas on how to achieve this and still maintain the required rapid turnover of clients.

The students suggested in-services and journal clubs specific to occupation, the use of reflection so that individual therapists can assess their own occupation focus, the use of occupation centred interview and assessment tools and minor changes to documentation followed by audits. These ideas can be challenging for the therapist engaged in the assessment-discharge cycle however, like ADHB, most occupational therapy services do all these things already. The only change for many will be a change in emphasis. Sue outlines a workable implementation plan to ensure all these ideas are carried out over time (not all at once) within professional governance activities and are supported by in-service education and supervision.

EXECUTIVE SUMMARY

Occupational therapists are recognised members of multi-disciplinary teams (MDTs) in acute hospitals, however, their unique occupational approach to therapy is often disregarded in favour of impairment-focused approaches of the dominant medical model (Blaga & Robertson, 2008; Wilding & Whiteford, 2008). By conforming to the demands of the medical model occupational therapists may be leaving themselves and their profession open to a number of risks, including the loss of professional identity (Shiri, 2006). In addition, there is potential for occupational deprivation in the acute hospital ward as clients may be denied opportunities for meaningful and beneficial occupational therapy by occupational therapists compelled to conform to the medical model (Whiteford, 2000).

The purpose of the proposed project entitled "Occupation – our preoccupation" is to generate a shift in the culture of occupational therapists working in an acute care context, towards occupation-based practice and clinical reasoning, by returning to the core concepts of the profession (Kielhofner, 2004).

A programme of meetings has been designed to encourage the occupational therapy team to support each other and engage in an exchange of ideas in relation to occupational theory and occupation-based practice. Progress towards occupation-based practice will be frequently monitored and there will be ongoing evaluation of the programme to ensure it is meeting the needs of the occupational therapy team.

INTRODUCTION

Occupational therapists recognise the health benefits of meaningful occupation and aim to enable clients to use meaningful occupation to improve their health and well-being (Townsend & Polatajko, 2008; Wilcock, 2005). However it is also recognised that there is a gap between understanding and appreciating the theory of occupation and applying it in practice (Fisher, 1998; Kielhofner, 2004; Molineux, 2004).

One area where there is a perceived difficulty of using occupation as a therapeutic medium is the acute care setting (Blaga & Robertson, 2008; Craig, Robertson, & Milligan,

2004). Problems arise for the occupational therapist as the demands of the service require fast paced decision making with a view for a safe but speedy discharge from hospital (Blaga & Robertson; Craig et al.). These requirements often lead to practice with an impairment focus because of the dominant medical model (Blaga & Robertson; Griffin & McConell, 2001).

The practice and clinical reasoning of occupational therapists in these environments tend to be less client centred and occupation-focused, such as considering how a client will continue to perform their usual roles and routines, and more impairment focused for example prescribing adaptive equipment on the basis of a medical condition without considering the individual needs of a client (Hoffmann & McKenna, 2004).

Occupational therapists who practice without an occupational theory base risk being “taken over by the theories of other ... powerful, articulate groups such as medicine” (Creek & Ormston, 1996, p. 8). By conforming to the medical model they risk losing their claim to be experts in occupation and risk losing their professional standing as occupational therapists (Molineux, 2004).

The World Federation of Occupational Therapists recognises that occupational therapists should stand up for occupational justice and make a stand against occupational deprivation (WFOT, 2006). This statement can be applied to occupational therapists taking a standpoint to practice with an occupational focus in a hospital environment, as well as advocating for the opportunity for our clients to receive beneficial therapy from an occupational expert (Wilding & Whiteford, 2008).

Occupational therapists should be able to articulate their expertise to ensure their professional standing amongst other, clearly recognisable health professionals such as nurses and physiotherapists and to enable clients understand how occupational therapy can benefit them (Wilding, 2008).

OVERALL AIM

To empower occupational therapists working in an acute care context to confidently articulate and sustain occupation-based practice.

OBJECTIVES

1. The acute occupational therapy team will encourage and support each other to identify and enhance occupation-based practice through regular group discussions.
2. Occupational therapists will be encouraged to use a reflective model in regular supervision to reflect on their occupational-based practice.
3. Occupational therapists will sustain occupation-focused reasoning through their clinical documentation.

NEED FOR THE PROGRAMME

The need for a programme has been highlighted by the Professional Leader (PL), Occupational Therapy Physical Health Services, Allied Health, Auckland District Health Board (ADHB) (C. Simmons Carlsson, personal communication, September 29, 2009). The ADHB is the largest district health board in New Zealand in terms of total budget and serves over 400,000 residents (Auckland District Health Board, 2009b). Acute adult services are delivered at Auckland City Hospital (Auckland District Health Board, 2009a). The programme of moving towards occupation-based practice is aimed at the 23 occupational therapists employed in this service.

The PL recognises that failure to move towards occupation-focused practice may leave the profession open to many risks (Simmons Carlsson, 2009). These risks, at an individual level, include failure to meet the competencies required for registration, for example Performance Criteria 1.6: Demonstrate understanding of perspectives of occupation as a core modality (Occupational Therapy Board of New Zealand, 2008). On an organisational level, there is the risk of loss of professional identity (Eschenfelder, 2005; Fortune, 2000; Shiri, 2006; Wilding & Whiteford, 2007).

The challenge in the acute service context is to move towards occupation-focused practice whilst managing a full workload (Blaga & Robertson, 2008; Craig et al., 2004). In spite of this, there is evidence to suggest that over time a shift in thinking for occupational therapists brings personal and professional benefits such as confidence to articulate what occupational therapy is to clients as well as articulating to other health professionals what it is that occupational therapists do resulting in an increase in self-respect and a perceived increase in the level of respect for occupational therapists from other members of the MDT (Wilding, 2008).

MAPPING SIMILAR PROJECTS

There is evidence of similar projects that have been conducted in a New Zealand (NZ) hospital (NZROT, personal communication, September 25, 2009) and an Australian hospital (Wilding, 2008). Occupation-based practice was championed in a NZ hospital when it was realised that the occupational therapy team was working primarily with a medical-model focus that clashed with the beliefs and values of occupational therapy (NZROT, personal communication, September 25, 2009). Several strategies were put into place including the introduction of an occupational therapy model to guide practice. That included adopting the Canadian Model of Occupational Performance (Townsend, 2002) as the basis of future in-service education, to ensure that they were guided by occupational theory. The team also critiqued regularly used assessments to establish their occupational basis and presented their findings at in-services. When it was agreed that these assessments did not fit into an occupational model of care, they moved towards occupation-focused assessments (NZROT, personal communication, September 25, 2009).

Verbal reports from occupational therapists who practised in this setting suggest some of the changes were not sustained following the departure of the therapist who championed for change. This experience is not unusual and has been observed in an overseas study of occupational therapists adopting a new practice (Chard, 2006).

The Australian based project was a research project into the nature of the service offered by occupational therapists in an acute service (Wilding, 2008). The therapists in this service had some difficulty articulating the role of occupational therapy and there was a lack of occupational theory behind their practice. The researcher encouraged the team to examine the beliefs and values of occupational therapy, to discuss this amongst themselves to gain the confidence they originally lacked to be able to explain their role to clients and to other health professionals. Wilding noted that a lack of understanding of the role of an occupational therapist among other health professionals is common and often leads to inappropriate referrals, but also acknowledged that one of the study's limitations is being unable to confirm if the occupational therapists sustained the changes to their practice.

PARTNERSHIP ARRANGEMENTS

Occupational therapists working in the acute setting work alongside other health professionals as part of the MDT. The effects of a shift in thinking and practice of occupational therapists, may impact on the other members of the MDT. For example it is not unusual for doctors to ask an occupational therapist to assess a client using a clinical-based assessment such as MMSE (Psychological Assessment Resources (PAR) Inc, 2009), whereas an occupational therapist may prefer to use occupational assessments in order to remain faithful to their occupational foundations (Hocking, 2001).

To overcome possible problems that might arise, occupational therapists should consider how the MDT may be affected. For example it should be articulated clearly, perhaps at an MDT in-service, what the occupational therapy team is embarking on so that the MDT members have an opportunity to add to the discussion (Robertson & Finlay, 2007). The occupational therapists may need to develop the skills required to challenge the, often incorrect, perceptions that occupational therapists are only interested in equipment provision and cognitive screening (Bлага & Robertson, 2008; Craig et al., 2004).

SERVICE USERS' VIEWS ON THE PROJECT

Key findings from the literature review suggest that a change in thinking and practice can only happen if the occupational therapists themselves recognise and understand the need for change (Wilding, 2008). Therefore it is essential to empower occupational therapists to play an active role in developing and evaluating this programme through supportive teamwork (Robertson & Finlay, 2007). However, given the demands of the workload and time constraints of occupational therapists working in an acute setting it may be appropriate to begin at the inform level of participation (as described by The International Association for Public Participation (IAP2)) by providing fact sheets such as suggested readings or recommended actions to be taken for in-services or journal clubs (IAP2, 2007). It may then be appropriate to move onto the consult level of participation and organise focus groups to obtain feedback on these suggestions. At the involve level of participation workshops could be held to ensure any team concerns or objectives are included in the development of the programme. This ultimately moves towards a collaborative level of participation to ensure the team plays a full role in making decisions about the programme. Evaluation of the

programme will be ongoing and carried out at all levels of the service.

IMPLEMENTATION PLAN

Following the presentation of the programme the PL will meet with the adult services Occupational Therapy Practice

Supervisors (PS) to discuss how the programme could be put into place. It is recommended this meeting take place within the following week. The PL will oversee the implementation of the programme and delegate tasks to the PS where appropriate. Monitoring and evaluation timescales are included in the implementation plan as follows:

Table 2.1: Implementation Plan

Time frames	Implementation steps	Actioned by whom
0-1 week	Attend presentation by AUT students	PL, PS
2-3 weeks	Meeting to establish champions for change	PL, PS
2-3 weeks	Arrange meeting for PLs and PS of MDT	PL
4-6 weeks	Meet with PLs and PS of MDT to put forward proposal for change, ask for their input / advice	PL, PS
6-7 weeks	Meeting to discuss above and develop outline of in-service topics	PL, PS
8-9 weeks	First occupation-focused in-service Occupational theory, e.g. Kielhofner, CMOP-E Discussion on relevance to practice	Champion – could be PL or PS
10-12 weeks	First individual supervision sessions following in-service Reflect on in-service and relevance to individual thinking and practice	PS Occupational therapist
11 weeks	Steering group meeting	PL, PS
14 weeks	Second occupation-focused in-service Models of Reflection presented, discussed and their relevance to practice highlighted	Champion
15 weeks	Steering group meeting	PL, PS
4 months	Regular individual supervision sessions following reflection in-service could now be based on a reflective model	PS, occupational therapist
4-5 months	Third occupation-based in-service Clinical documentation – avoiding SOAP format	Champion
4-5 months	Instigate use of occupation-focused clinical documentation	PS, occupational therapist
5 months	Supervision sessions – supervisor could gain an understanding of occupational therapist's views on the programme so far	PS, occupational therapist
5 months	Steering group meeting	PL, PS
5-6 months	Fourth occupation-based in-service Evidence-based practice, critiquing research, introduce journal club, establish journal club champions	Champion
6 months	Instigate self audit	Occupational therapist
6 months	Steering group meeting	PL, PS
6-7 months	First occupation-based journal club Develop regulations, time etc e.g. 1 article critiqued by 1 occupational therapist per meeting with time for questions and discussion. Emphasis on occupation-focused literature and relevance to practice.	Champion
6 months +	Regular supervision sessions should continue with an occupational focus and reflective models being used	PS, occupational therapist
7 months	Steering group meetings continue on a monthly basis	PL, PS
7 months +	Further in-services could continue with an occupational focus	Champion

...continued next page

Table 2.1: Implementation Plan (continued)

Time frames	Implementation steps	Actioned by whom
8 months + 12 months	2nd occupation-focused journal club article presented etc Peer review audit	Champion PS, occupational therapists
12 months +	Continue audit in conjunction with ADHB guidelines	

Table 2.2: Project Evaluation

Objectives	Success criteria and outcome measures	Time line
1: The acute occupational therapy team will encourage and support each other to identify and enhance occupation-based practice through regular group discussions.	A log of good ideas / examples of occupation-based practice to be kept by the occupational therapy team with a different therapist taking responsibility for this each meeting.	Ongoing – monthly
	A record to be made of each occupational therapist recalling at least one example of discussing occupation-based practice with a colleague during each meeting.	
	A target of at least 12 occupation-focused groups to take place in 12 months.	Monthly
2: Occupational therapists will be encouraged to use a reflective model in regular supervision to reflect on their occupational-based practice.	A brief, anonymous, reflection-based questionnaire to be completed by each occupational therapist during supervision.	Monthly
	A record of responses to questionnaire to be submitted at steering group meetings by PSs.	Monthly
	A target of at least four reflections based on models to be produced by each occupational therapist in 12 months.	3-monthly
3: Occupational therapists will sustain occupation-focused reasoning through their clinical documentation.	Audits of clinical notes to be undertaken on a monthly to three-monthly basis for self-audit to verify occupational reasoning.	Ongoing - monthly to 3-monthly
	Data from self audits to be presented at steering group meetings.	Monthly
	A target of at least 4 self audits per therapist to be completed in 12 months.	3-monthly
	Annual peer review audit of clinical notes to be conducted by occupational therapy team.	Annually

MONITORING ARRANGEMENTS

It is recommended a steering group consisting of the PL and PS meet bi-monthly to monitor progress of the programme. Measurement of achievement will be qualitative and quantitative.

Monitoring for objective 1: *The acute occupational therapy team will encourage and support each other to identify and enhance occupation-based practice through regular group discussions.*

PS to record number of team meetings related to programme and number of therapists attending. Observed examples of peer support to be recorded. Data to be reported to PL at steering group meeting and retained for duration of the programme and used in final evaluation.

Monitoring for objective 2: *Occupational therapists will be encouraged to use a reflective model in regular supervision to reflect on their occupational-based practice.*

PS to record number of supervision sessions attended by each occupational therapist and number of times a reflective model was used to reflect on occupational-based practice. These sessions could be used to deal with any difficulties the occupational therapists might be experiencing with reflective models. PS to record these difficulties, using a pseudonym to safeguard confidentiality, to assist with planning in-services to address possible future concerns. Data to be reported to PL steering group meeting and retained for the duration of the programme and used in final evaluation.

Monitoring for objective 3: *Occupational therapists will sustain occupation-focused reasoning through their clinical documentation.*

PS to monthly randomly select one client file for each occupational therapist to self-audit focusing on occupational clinical reasoning. A check list completed at the time to be presented to PL at steering group meeting and retained for the duration of the programme and used in final evaluation. Occupational therapists to engage in an annual peer review audit that is currently a requirement for working at ADHB (C. Simmons Carlsson, personal communication, October 29, 2009).

FUNDING AND RESOURCES

Funding and resources are available through the hospital to allow the PL to put the programme into place and the occupational therapy team has “many opportunities for in-house PD [professional development] in the hospital” (C. Simmons Carlsson, personal communication, October 21, 2009). Meetings should be no less than once a month, over a period of at least 18 months. This reflects the meeting schedule for the Australian research programme which produced encouraging results, in terms of a shift in thinking and practice, in that timeframe (Wilding, 2008).

The in-services will be facilitated by the PS who “oversee their local in-services at team level” (C. Simmons Carlsson, personal communication, October 13, 2009). It will be the responsibility of the PL to appoint facilitators with the appropriate breadth of knowledge / experience of occupational theory and practice to increase the likelihood of achieving the programme’s aims.

Successful implementation of the programme requires certain resources. The team needs access to online libraries to source useful data such as professional journals and articles, text books and other literature that promotes occupation-based thinking and practice. (A resource manual will be provided with suggestions for reading). Physical resources required include meeting rooms for in-services; computer with PowerPoint and internet access; projector; screen and a photocopier.

English Speakers of Other Languages Experiencing Occupational Injustice: The Issues of Learning to Drive in New Zealand

KATRINA LANGENHOVEN

Other Project Members: Leddie Lou Corpus, Weam Macadaan, Joan Magalong, Claire De Jagar, Buthaina Al Aufer, Charlotte Rogers

PAPER CO-ORDINATOR'S COMMENTARY

One organisation that has really seen the potential of occupational therapy is English Language Partners North Shore (ELPNS). English Language Partners New Zealand (ELPNZ) is New Zealand's largest settlement agency and operates in 23 locations throughout the country. A lot of the service users of this organisation are new to NZ, isolated and have few opportunities for occupational participation for a number of reasons. Students met with the manager of ELPNS who had identified many unmet needs and presented a number of ideas for new programmes. The students chose to develop resources for home tutors to help immigrants learning to drive in New Zealand.

Occupational therapists are becoming increasingly aware of the impact that not being able to drive has on people's occupations and citizenship within the community. Last year another group of occupational therapy students from AUT developed resources for driving cessation groups for the elderly. However the challenges of learning to drive in a new country can result in just as much isolation. Katrina's proposal pulls on occupational theories about place and displacement to make this point very clear. This proposal also shows a thorough mapping of relevant services such as driving schools, which highlights a lack of provision for the needs of immigrants.

The group's research also is evident in the easy to read fact sheets they designed to be used by home tutors and their students. They cover subjects that many of us may overlook when working with immigrants, for instance how to pump petrol, what to do if you are involved in an accident, how to get a vehicle information report when buying a car, and getting a warrant of fitness and insurance. This proposal is simple and very effective in its solution and ELPNS are eager to start implementing these ideas.

EXECUTIVE SUMMARY

Immigrants to New Zealand face significant changes to their lives and often experience a loss of meaningful roles and occupations they had in the country they migrated from. The barriers that come with not being able to speak English in a predominantly English speaking country are considerable, and often impair the individual's feelings of identity and can result in social exclusion (Gupta & Sullivan, 2008).

English Language Partners North Shore (ELPNS) provides English language and social support to adult migrants and refugees who are English speakers of other languages (ESOL) to aid them with the resettlement process in New Zealand (English Language Partners New Zealand, 2009). They identified in this group a significant lack of education in driving in New Zealand (NZ) - a vital aspect for new migrants to be able to access a new environment and start adapting to it.

Occupational therapists in this area will work with migrants to help address these issues in order to safely access their community, re-engage in meaningful occupations and roles, thereby increasing feelings of identity and enabling their full rights as citizens. This can incorporate facilitating occupational roles (such as that of being a community participant) through mastering the occupational tasks that are necessary to attain the role (which in this case is driving).

This proposal will address the need through providing education - in easy English - about driving in NZ and all the tasks that go hand in hand with driving. To this end all written work is done in a basic structure. Sentences are short, and simple words are used. The education will be in the form of fact sheets and a session plan (about using an interactive driving rules website) to ELPNS tutors, and particularly for their learners. It will be evaluated through the use of a feedback form from the clients and tutors, and in quarterly meetings with the tutors.

INTRODUCTION

Stadnyk, Townsend and Wilcock (2010) present the idea of occupational justice as looking at “diverse occupational needs, strengths and potential of individuals and groups, while at the same time considering issues of rights, fairness, empowerment and enablement of occupational opportunities.” It is the right of those immigrating to New Zealand to be presented with fair opportunities to participate in desired and meaningful occupations (p. 331).

However, the language barriers that many immigrants have can increase feelings of isolation and lead to loss of meaningful roles in life. It can also significantly decrease opportunities to adapt to a new environment and therefore engage in it (Christiansen, Baum, & Bass-Haugen, 2004). Therefore, ESOL are not experiencing occupational justice. They may instead be experiencing occupational alienation, as their loss of roles can result in experiencing life as meaningless or purposeless (Stadnyk, Townsend, & Wilcock, 2009).

Driving is an essential occupation that enables an individual to access the community. The American Occupational Therapy Association (2008) states that transport to different locations enables participation in necessary and desired occupations, and that accessing and participating in the community contributes to identity is an important way to feel part of the community. According to Fazio (2008) community is a locale which enables social interaction and where those in it contain common ties.

One of the unaddressed occupational justice issues for this population is the difficulty that comes with driving in NZ and all the tasks related to driving. This includes car maintenance tasks such as getting car licensing and Warrant of Fitness (WOF) as well as what to do and how to communicate in case of a car accident. Their lack of knowledge in these areas results in fear and decreased confidence to drive and access the community, and a decreased ability to live meaningful and occupationally balanced lives (Stadnyk, Townsend, & Wilcock, 2009).

OVERALL AIM

To provide second language English migrants with opportunities to participate in the community and to get out and about, through education about driving.

OBJECTIVES

1. To inform learners of NZ Road rules in easy English.
2. To inform learners around procedures to be taken in case of a car accident or emergency.
3. To inform learners how to safely buy a car in New Zealand.
4. To inform learners about driver car maintenance required in New Zealand.

THE NEED FOR THE PROGRAMME OR SERVICE

Immigrant experience

According to Martins and Reid (2007), upon immigrating and undergoing a change in environment, individuals experience absence from family and feelings of loneliness, something which can be detrimental to their meaningful occupations and roles. They must often drastically modify familiar habits, as well as deal with the loss of traditional roles, the pressure to engage in new and unfamiliar role behaviours, and role imbalance (Khoo & Renwick, 1989).

The Ministry of Social Development (2008) explores the idea of social cohesion, saying that it requires engagement, participation, belonging, inclusion, recognition (as opposed to rejection) and legitimacy. And the whole process of settling in an unfamiliar environment (such as finding a job and learning what services are available and how to access them), can result in migrants having limited involvement in the community and engagement in meaningful occupations. As a result, this can lead to immigrants feeling unvalued and socially excluded which can negatively impact social cohesion, which, in turn, is detrimental to New Zealand as a whole.

This relates to the idea of displacement as presented by Hamilton (2010). He explains that places can strongly influence what we choose to do and can add a lot of meaning to occupations. “Changes in place can interfere with the performance of even the most routine occupations” (p. 268). Upon migrating to another country, immigrants experience a significant shift in place and have to find new meaning. Before being able to find meaning in a new environment or place, they must have the ability to access it safely.

The importance of driving to access ‘place’

Gupta and Sullivan (2008) explain that “when immigrants are able to successfully engage in ‘doing’ meaningful occupations with competence and to their satisfaction, their health and

well being are positively affected” (p. 26). This will assist in them finding meaning in the new environment or place. One very vital aspect of being able to ‘do’ is community mobility through driving. The American Occupational Therapy Association (2008) writes that mobility through driving enables us to participate in occupations from which we draw meaning.

In their comprehensive review of the interrelationship of access to transport and social exclusion, Priya and Uteng (2009) explored the idea that lack of transport limits immigrants’ ability to engage and participate in the community. This in turn leads to a further lack of social cohesion, as it creates isolated neighbourhoods and decreased confidence to undertake driving to access the unfamiliar environment. So, despite having a need to access and participate in the community, some aspect of fear serves as a barrier to doing this.

This results in occupational deprivation. Whiteford (2010) writes that occupational deprivation is “a state of prolonged preclusion from engagement in occupations of necessity and/or meaning due to factors which stand outside of the control of the individual” and can be due to social, economic, political and environmental reasons (p. 305). In this case the environmental barrier of not being able to drive in NZ safely is resulting in English second language citizens being deprived of participation in the occupational opportunities presented by the wider community.

Models

Model of Human Occupation (MOHO)

Kielhofner (2004) explains that human occupation is affected by an individual’s volition (motivation) for occupation, their habituation (routines and patterns of their occupation) but also by their performance capacity (skills and abilities to perform). He also emphasises the vital link between these and the environment. When considering the barriers to occupations of ESOL it is vital to realise the role played by the environment. As mentioned before, driving is a way of accessing a new environment. If driving is serving as a barrier to access the community, interventions must occur in the areas of volition, habituation and especially in performance capacity - an aspect this proposal aims to facilitate through education.

Person-Environment-Occupation model

This model views occupational performance as a result of the relationship between the person, environment and

occupation (Law, Cooper, Strong, Stewart, Rigby & Letts, 1996). A change in one component of the model causes change in all other components, which ultimately affects occupational performance. Therefore intervention in any of these three areas can increase occupational performance. In this case, intervention is occurring through education of the person to enable more confidence in accessing the environment, thereby enabling more occupational participation and engagement and increased quality of life.

MAPPING SIMILAR SERVICES

Driving schools

There are no services that provide education about driving and driving related tasks for ESOL. However, there are several driving schools in the North Shore (11 private and 14 government funded). All of those contacted identified that difficulties in speaking English is a barrier to understanding driving tasks in New Zealand. One respondent felt that the road code was a difficult manual to understand and that there is a considerable lack of awareness about the process involved to run a vehicle, resulting in some people being taken advantage of. Despite realising this gap they all felt that they do not have the resources required to accommodate teaching for ESOL, mainly due to the huge amount of time taken to do this. Referring people to other driving schools or instructors who are multilingual is for them a much easier way to compensate for this.

This project, with an occupational therapy perspective, will enhance this service for the reason that occupational therapists have a very client centred perspective on each individual’s needs and will be addressing this particular gap through the service.

English schools

There are several adult ESOL programmes on offer by the Ministry of Education, private schools and high schools. However, despite most of these schools advertising that they offer ESOL New Zealand driver training programmes, contact with them revealed that no such training is provided within their curriculum due to time and resource constraints. This project is different from the existing one as it is once again targeting the population that is falling through the cracks.

New Zealand Transport Agency (formerly Land Transport New Zealand)

Their purpose is to contribute to “an integrated, safe, responsive and sustainable land transport system” that aims to deliver “integration, safety and sustainability” (New Zealand Transport Agency, 2009, p. 2). As part of their endeavour to provide this, they offer information in the form of a pamphlet about what is different about driving in New Zealand. However, this is not specifically targeted at ESOL, so can be hard to understand, and does not go into information about other driving related tasks in NZ other than road rules. Therefore this project is not duplicating the service, but complimenting it through providing an easy to understand resource.

Citizens Advice Bureau

This organisation provides “information, advice, advocacy and support to individuals” and ensures that these individuals “do not suffer through ignorance of their rights and responsibilities, or of the services available; or through an inability to express their needs effectively” (Citizens Advice Bureaux, 2009, p. 4). Contact with their North Shore office revealed that they don’t have any official information resources available on driving and car maintenance tasks in New Zealand. However, if an English speaker of another language was to get in contact with them regarding this, they have Chinese and Korean speaking employees who can provide them with advice in their mother language.

This however does not address the issue of improving their confidence to communicate in English. Therefore this project serves as a solution to the issue rather than a compensation for the issue.

PARTNERSHIP ARRANGEMENTS

This project is only for use by ELPNS. However, if they find the final product to be useful, they may decide to introduce it to other ELPNZ offices across Auckland, or even New Zealand. If this transpires, the main partnership arrangements would only have to occur between regional managers at different offices.

Other than that, there are no formal partnerships that need to be arranged for this project. However, the final product will contain contact information about organisations in the North Shore that offer different services, and they are regarded to be indirect partners related to the project. These include the different insurance, WOF and vehicle inspection companies.

SERVICE USERS’ VIEWS ON THE PROJECT

The service users of this project are ELPNS tutors and learners, who were the ones that identified the need for this project. Contact with the manager ensured that this need was correctly understood and that the final product would be useful to the service users. The project is mainly in the form of written education to facilitate their learning. Therefore according to the government standards (International Association for Public Participation (IAP2), 2007) they are at the first level of service user involvement of ‘informing’.

The service user involvement is essential in the evaluation process. Their views are essential as to the usefulness of the product, and it can undergo adaptations and changes in order to meet their opinions. This brings their level of involvement to ‘Consult’ (IAP2, 2007).

Table 3.1: Implementation Plan

Time frames	Implementation steps	Actioned by whom
Week 1-2	ELPNS staff member to contact organisations that are identified in the fact sheets to ensure that permission is gained for printing of their details.	Designated staff member
Week 2-3	Review and editing of draft one of the fact sheets and of the session plan.	Manager
Week 3-4	Budget project for 2010.	Manager
Week 4-5	Send draft copy to designers to add the service logo and service design.	Manager
Week 5-6	Distribute fact sheets and session plan to ESOL tutors.	Administration staff
Week 6 onwards	Tutors implement the use of the fact sheets and session plan.	ELPNS tutors

Table 3.2: Project Evaluation

Objectives	Success criteria and outcome measures	Time line
To inform learners about procedures to be taken in the event of a car accident	Tutor 'testing' by providing a scenario and learner having to explain in English what they will do. Success achieved when tutor feels they can sufficiently respond to different scenarios without prompting. Feedback from client (verbal and from feedback form): Client reporting increased knowledge and confidence regarding what to do and how to communicate in the event of a car accident Feedback from Tutor: Feedback in the quarterly meetings and in annual feedback form show that they found it to be a useful teaching resource and that they feel their client found it to be beneficial.	After completion of the teaching (which varies with each individual) After completion of teaching At any or all of the 4 meetings that occur per year as well as the annual feedback form
To inform learners about driver/car maintenance tasks required in New Zealand	Feedback from clients and tutors in annual feedback forms and meetings regarding the usefulness of the fact sheet.	At any or all of the 4 meetings that occur per year as well as the annual feedback form
To inform learners about how they can safely buy a car in NZ	Feedback from clients and tutors in annual feedback forms and meetings regarding the usefulness of the fact sheet.	At any or all of the 4 meetings that occur per year as well as the annual feedback form
To inform learners of NZ road rules in easy English	An increase in scores from doing the interactive online NZ driving rules test. Tutor can see increased understanding in the client. May choose to do short verbal tests about basic rules to measure improvement. Feedback from clients and tutors in forms and meetings regarding the usefulness of the online tool and fact sheet.	Testing at the start of teaching and when the teaching has finished After completion of teaching At any or all of the 4 meetings that occur per year as well as the annual feedback form

MONITORING ARRANGEMENTS

The tutors have an annual feedback form about the ELPNS service and any changes they may suggest. It is recommended that a question about this product be included within that feedback form. This will give a good indication about how useful the tutors find the resource in teaching ESOL about driving tasks in New Zealand.

Moreover, there are also quarterly meetings with the tutors for the purpose of discussing issues and providing feedback, and this is a prime place to gain information as to the value of this resource and to discuss changes that can be made to ensure it is being utilised more.

This information can then be included in the annual report that is written by the manager for the ELPNZ National office, about the year's projects and the findings of the effectiveness of these projects. This is a good way to ensure that the product is being used and its usefulness measured. It will also ensure that issues are identified and addressed.

However, it is essential to gain feedback not only from the tutors, but also the learners, as they are the main service users. Therefore it is also recommended that a short feedback form (about 3-5 questions) be provided for the learners themselves to complete.

FUNDING AND RESOURCES

The following resources will be required for the purposes of the project:

- Computer, internet access (for design)
- Hard drives (to save online resources)
- Printers, electricity, Ink, paper (for printing)
- Staffing (Management and administrative staff, tutors)

The ELPNZ National Office is responsible for gaining funding for this organisation and a large part of their funding is received through a contract with the Tertiary Education Commission (TEC). This project will be woven into the budget provided by the National Office by the manager.

Hands On: A Proposed Service for a Primary Mental Healthcare Occupational Therapist

ANDREA BOTHA

Appendix Developer: Adelia Sadler

Other Project Members: Austen Gillman, Katie Moroney, Ri Sheng Ang, Sabina Savin, Liesl Meyer

PAPER CO-ORDINATOR'S COMMENTARY

In this project, students have worked with a local community mental health occupational therapist (Andrea Dempsey) who is doing some remarkable work with people who have chronic mental health issues. One of the unmet needs she has identified is for those people in the community with mild to moderate mental health problems who do not qualify for community mental health team support. One group of students focused on developing ideas for a primary healthcare Occupational Therapist Role which could support General Practitioners in providing services for this population group.

Andrea Botha's proposal has been selected as it gives clear and concise options for how to establish this new service. What occupational therapists can cost effectively provide at the first point of contact that others cannot is also backed with evidence based literature, although there is more recent literature that she might also have drawn on (Sutton, 2009). The proposal demonstrates how Andrea has critically selected locally relevant literature and statistics from information collected by her group to make the need for this service very clear.

EXECUTIVE SUMMARY

A local community mental health occupational therapist approached Auckland University of Technology (AUT) after she identified that clients with mild to moderate mental health issues were not receiving adequate assistance. A needs analysis noted that because clients are not classified as severe they do not receive more comprehensive secondary services such as occupational therapy (OT). The Hands On proposal therefore focuses on advocating for an OT service to be developed to work alongside general practitioners (GP's) to meet the needs of this client group. The purpose of the proposal is to outline to this occupational therapist and to her managers at the Waitemata District Health Board (WDHB) what this service may entail and how it would improve the health outcomes of this group. This service was designed using principles of the Model of Human Occupation (MOHO). By enabling clients to re engage in meaningful occupations they will not only re-learn important skills but will also develop their sense of self confidence and identity. Occupational therapists are able to holistically view clients within their environments and address any barriers to engagement in everyday occupations. The proposed programme will be evaluated using the Occupational Self Assessment (OSA) which is based on MOHO to evaluate clients own perceptions of their occupational competence.

INTRODUCTION

The Primary Health Care Strategy (PHCS) as outlined by the Ministry of Health (2001) speaks of the need for the primary health care system to tackle inequalities in health. However, it has been noted that often clients who present to GP's with mild to moderate mental health issues do not receive the comprehensive form of assistance they need. They are currently supported by medication and/or access to counselling. The limited early intervention received may lead to this group becoming increasingly isolated and can eventually lead to worse health outcomes or even hospitalisation. Smith and Cumming (2009) speak of the need of integrating primary care and community care to move beyond the traditional role of PHO's in order to best meet the complex needs of client populations. By providing OT services to address this need, Hands On looks at promoting participation and addressing issues of occupational justice for this client group.

OVERALL AIM

To provide occupational therapy services in primary health care clinics through lifestyle changes, using everyday activities that maintain and enhance emotional wellbeing, enabling clients to be the best they can be.

OBJECTIVES

1. To create OT services within a year which are integrated within primary health care clinics for clients experiencing mild to moderate mental health issues.
2. To design and implement a programme based on lifestyle interventions in order to equip the clients with lifelong skills within the year (Appendix 1).
3. Assist clients to maintain and enhance participation in everyday occupations thereby supporting their roles, habits and routines.

NEED FOR THE SERVICE

Evidence for this proposal includes looking at legislation which relates to mental and primary health care services, published research, and looking at similar projects.

According to the Mental Health Commission (1998), the Blueprint for Mental Health Services requires that 3% of the population most affected by mental illness should have mental health services delivered to them. However, the New Zealand Mental Health Survey (Ministry of Health, 2006) notes that almost 40% of people interviewed had met the criteria for a DSM IV mental disorder at some time of their life, 6.6% of which had been diagnosed as experiencing a mild disorder. This group of people would therefore not be included in the 3% prioritised for receiving necessary support. The second health plan: Improving Mental Health widens this focus to include providing services to an estimated 17% of those who experience mild to moderate mental illness (Ministry of Health 2005).

The Mental Health and General Practice Investigation Research Group (2003) report that GP services provide most of the treatment for people diagnosed with mental health issues in New Zealand. According to this group, 36% of people accessing GP services had anxiety, depression or a substance-use disorder, most of which were mild to moderate conditions. Individuals with sub threshold anxiety and depression which do not meet the criteria of a DSM IV mental health disorder are also commonly seen by GP's in primary care (Mathieson, Collings & Dowell, 2009). These individuals often receive no intervention even though they are more at risk of developing clinical depression than the general population. This demonstrates why addressing the service provision at the primary health care level is so important.

As noted in a Waitemata Health Needs Assessment (2009), 12% of adults report that they have a chronic mental health condition. These reports are higher among the youth, those who identify themselves as European and among females. This is reiterated in

a study completed by a PHO in the Waitemata district, Harbour Health (Maureen Langwell, personal communication, October 8, 2009) where the majority of the clients seen as part of their Mental Health Lifestyle Option were of European ethnicity, female and between the ages of 25 to 44. According to the Waitemata Health Needs Assessment (2009), people in WDHB have a higher contact rate with mental health services but are less likely to be admitted to hospital. If however they are admitted, the duration of their stay is longer than average national statistics.

People with mental health issues are regarded as one of most socially excluded groups in society (Harrison & Sellers, 2008). This limits their opportunity to have choice and control over the activities they would like to participate in, thereby decreasing their overall life satisfaction (Townsend & Polatajko, 2007). Occupational science proposes that engaging in occupations is not only fundamental to human life, but is also an essential component of health as described by Harrison and Sellers (2008). By engaging in meaningful everyday activities individuals perceptions of being not only competent and capable, but also of being valued is increased (Rebeiro, 2001). The service proposed by Hands On will assist individuals to overcome barriers preventing them from engaging in occupations and experiencing optimal health.

RESEARCH

The Well Elderly Study as described by Clark et al. (1997) is a good example of how to better understand a population group in terms of the link between occupation and health even though it includes a different population group with different health concerns. This trial included OT interventions based on lifestyle redesign. The results as discussed by Clark, Jackson and Carlson (2004) note that OT produced benefits in outcomes such as mental health and social functioning. The outcomes achieved through lifestyle redesign also had long term beneficial effects and the intervention was cost effective (Hay et al., 2002). This study includes designing an intervention which is evidence based, trialling the intervention and then evaluating it in terms of client outcomes and cost effectiveness. This is what the service proposed by Hands On is setting out to achieve with clients who have mild to moderate mental health issues.

MAPPING SIMILAR PROJECTS

Other services which have been designed with similar aims include a brief intervention co-ordination service in Canterbury; Tumai Mo Te Iwi PHO initiative entitled Primary Solutions; Turanganui PHO's Primary Health Initiative and the Te Pou Primary Mental

Health Project. Clients seen are mainly adults over the age of 18 who have mild to moderate mental health concerns and are referred by their GP's. These projects aim to coordinate mental health services by providing referral pathways to other services thereby ensuring the individual client's needs are met. The other services often include brief intervention coordination, cognitive behaviour therapy, counselling, education, mental health promotion, and social supports such as housing advice. This improved access promotes an integrated model of care at the primary level. Most of these projects include offering both individual and group sessions and often involve the client's families. These are similar to the Harbour Health Lifestyle Options which aims to ensure that those with mild to moderate mental health issues have timely access to appropriate services (Primary Mental Health, 2009).

All of these services seem to work effectively and ideas can be gleaned from each. The one critique however, is that they do not have direct OT involvement. This is what would make the service proposed by Hands On unique.

PARTNERSHIP ARRANGEMENTS

The key stakeholders involved in the Hands On project include the community mental health occupational therapist; her service manager; the service managers of the still to be identified PHO's as well as the GP's working within those PHO's and representative of the consumer group. The occupational therapist employed as project manager to begin this service will establish an advisory group consisting of these stakeholders.

The primary mental health project coordinator of Te Pou can be contacted. Te Pou (2009) is the New Zealand National Centre for Mental Health Research, Information and Workforce Development. This trust funded by the Ministry of Health aims to continue building a strong workforce to deliver mental health services by continuous service development. They could therefore be approached as a source of feedback and consultation.

Other partnership arrangements may include those with local allied health professionals to ensure that adequate referrals can be made to Asian/ Maori or Pacifica mental health services for example, if necessary. The occupational therapist employed to begin this service would benefit from having good knowledge of how services such as housing New Zealand works and what other supports or groups there are in the local community. The Occupational Therapy Board of New Zealand will provide clinical supervision and support for the occupational therapist employed.

SERVICE USERS' VIEWS

The PHCS envisions primary health care services working with local communities to remove health inequalities (Ministry of Health, 2001). Service users will thus be firstly informed of the service being offered, then consulted using focus groups to obtain their feedback and finally a move to further involve them will be kept in mind for future aspirations.

The International Association for Public Participation (IAP2, 2007) describes how providing information in a purposeful manner to the right people in a way in which they can understand and respond is beneficial to communities. As having OT services in primary care is a newly developing concept, it should be clearly described to inform service users on what OT can offer them. This could take the form of a simple brochure available at PHO's in waiting rooms. It can also be a useful tool for GP's to explain to clients why they are being referred to OT services. Other more active methods of providing information can include sending this informative brochure into the community with local newspapers.

IAP2 (2007) also describes the next level of participation, consultation, as a form of participation of the community whereby the views of individuals are sought. Consultation includes actively listening to service users. As Maori are underrepresented by our population group, it is suggested that service user representatives include using a person of Maori descent. This aligns with the principals of partnership as set out by the Treaty of Waitangi (Moon, 2007). This is most effective when principles such as transparency and respect are adhered to. Feedback and ideas generated from the consultation process should inform the service development and it is also important to report back to all involved in the consultation process show how their input has contributed to final decisions.

Table 4.1: Implementation Plan

Programme	Time frames	Implementation steps	Actioned by whom
Design and Planning Phase	0-1 months	Identify the need for the programme.	AUT students
	1-2 months	Identify PHO's to work with and send survey to GP's (Appendix 2).	Community mental health occupational therapist
	2-3 months	Review collected data, establish goals and objectives and select a theoretical framework to guide programme development.	Community mental health occupational therapist
Preparation and Implementation Phase	3-4 months	Develop the role of the occupational therapist and develop the programme.	Community mental health occupational therapist
	4-5 months	Determine location, furnishings, equipment and supplies needed. Draw up a budget, identify and secure funding.	Community mental health occupational therapist
	5-6 months	Implementation <ul style="list-style-type: none"> • Finalise budget • Purchase equipment and supplies • Set up in the decided upon location • Market service 	Community mental health occupational therapist
Start up and Continuation	6-12 months	The programme will run for 6 months.	Community mental health occupational therapist
Programme Review and Evaluation Phase	11-12 months	Data will be collected throughout the programme and then will be evaluated by an external reviewer. A final feedback forum will be held as well as a meeting with stakeholders.	External reviewer

Table 4.2: Project Evaluation

Objectives	Success criteria and outcome measures	Time line
1: Create OT services within a year which are integrated within primary health care clinics for clients experiencing mild to moderate mental health issues.	Created service Meetings every fortnight with Advisory group to ascertain if integration is occurring - Ongoing collaboration with PHO staff can be measured through semi structured interviews or questionnaires	Within the year At the 11 month mark
2: Design and implement a programme based on lifestyle interventions in order to equip the clients with lifelong skills within the year.	Goal Attainment Scale (GAS) to be completed with clients upon arrival and the session before discharge (pre and post measures) Occupational Self Assessment (OSA) pre and post measurements Focus group to discuss effectiveness of programme giving verbal feedback OT supervision	Focus group meetings to occur prior to start up, during service implementation and at the evaluation stage GAS and OSA before and after intervention Supervision on a monthly basis

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Table 4.2: Project Evaluation (continued)

Objectives	Success criteria and outcome measures	Time line
3: Assist clients to maintain and enhance participation in everyday occupations thereby supporting their roles, habits and routines.	OSA Pre and post measurements	Completed with client during first and last session

MONITORING ARRANGEMENTS

The advisory group established will be responsible for ensuring that the concept of the service remains occupation focused and that the service delivered is of a quality which meets New Zealand standards of practice.

The outcome measures will be used to monitor the success of the project. And data collection will occur throughout the process to ensure a straightforward review can occur by the end of the twelve month period.

As the OT role in primary mental health is relatively new, the occupational therapist will need to establish a way in which to fit into the existing system of the PHO if co location is to occur. Most PHO's are lead by GP's and so the occupational therapist would need to work collaboratively with the current staff. This includes ensuring the service created fits well with the mission and adheres to the policies and procedures of the PHO.

OT supervision is required for ongoing registration and it is suggested that the person nominated as supervisor has experience working in the primary health care field in order to guide the occupational therapist in his/her new role. The supervisor nominated thus does not necessarily have to be an occupational therapist.

FUNDING AND RESOURCES

Funding

Expressions of interest are one possible source of funding available from the government as advertised by the Ministry of Health (2009). The closing date for submissions has recently passed, however it may open again and this proposal could then be put forward.

PHO's are funded by the DHB's to provide services to their local communities (Ministry of Health, 2001). The project manager will therefore need to ensure that the service

created meets the need for the particular PHO identified and that a strong relationship is created. This will allow the occupational therapist to seek funding from the PHO.

Another source of funding is applying for research grants and two have been identified. The National Institute for both public and mental health along with AUT are currently seeking future research programmes to begin. Te Pou as described in the partnership arrangements has one objective to improve the links between research and service development. Te Pou could therefore also be approached for funding as this new service may be of interest to them.

Resources

Labour costs

A qualified occupational therapist with previous experience working in a mental health capacity will need to be employed on a full time basis for one year. To minimise disruption to the service, an external reviewer will also be employed in the last month to complete a service review.

Non labour costs

Direct costs include the OSA Assessment tool priced at NZ\$54 as well as stationery, paper, envelopes, stamps, ink. Additional funding for marketing will also be required. Indirect costs will include the costs associated with electricity, water, rates, maintenance of the facility and the telephone account. Also needed by the service will be access to a computer with internet, printer, a room for both individual and group sessions, a phone, the use of a library and databases for research as well as bathroom and kitchen facilities.

APPENDIX 1: IDEAS FOR OCCUPATIONAL THERAPY INTERVENTIONS: DOING IN THE DAY-TO-DAY WORLD DEVELOPED BY A.S. SADLER

The Occupational Self-Assessment (OSA) by Baron, Kielhofner, Iyenger, Goldhammer, and Wolenski (2002),

is an evaluation tool and an outcome measure based on the Model of Human Occupation (Kielhofner, 1995). The OSA is designed to capture clients’ perceptions of their own occupational competence and of the impact of their environment on their occupational adaptation. As such, the OSA is designed to be a client-centred assessment that gives voice to the client’s view.

In *Resituating the Meaning of Occupation in the Context of Living*, Reed (2008) focuses our attention on the experience of Being-Called-to Occupation, i.e. a response to something we care about or what concerns us; Being-with-others while engaging in occupation creates a bond and mood, i.e. that the meaning of occupation changes depending on who we do it with, or without; The meaning of occupation is also revealed in the possibilities that are opened up, or closed down. Reed (2008) speaks about what it is ‘we care about’, or what concerns us. The OSA categories below are a source of such things.

Recovery as the Re-fabrication of Every Day Life: Exploring

the Meaning of Doing for People Recovering from Mental Illness by Daniel Sutton (2008) assists us to understand the meaning of day-to-day activities for people recovering from mental illness. Sutton found that everyday activity was an important medium for change as well as a recovery outcome in itself. The study highlights the dynamics at play in different modes of doing (Non-Doing/ Half-Doing/ Engaged-Doing/ Absorbed-Doing) and the different ways in which carers can influence the experience and meaning of activity.

<i>Non-Doing</i>	Where hope is found in the possibility of caring for and committing to something and these points one’s being back toward the everyday world.
<i>Half-Doing</i>	The renewed sense of becoming, achieved through making commitments to things and people in the immediate world.
<i>Engaged-Doing</i>	Full engagement with the everyday world, and acting as if, when that’s too hard.
<i>Absorbed-Doing</i>	Moments of being right with your world.

Table 4.3: Ideas for Occupational Therapy Interventions: Doing in the Day-To-Day World Based on the Occupational Self Assessment (2002), Sutton (2008) and Reed (2008)

OSA categories	Non-Doing intervention ideas	Half-Doing intervention ideas	Engaged-Doing intervention ideas	Absorbed-Doing intervention ideas
Concentrating	Attempt at occupation if it is meaningful	Graded meaningful occupation with many short breaks	Engage in activities of meaningful occupations	Meaningful occupation where moments are experienced as ‘flow’
Physically doing what I need to do	Breathing techniques Graded exercise for e.g. walking to the mailbox Referral to Physiotherapist	Breathing techniques Graded exercise Short term goals for e.g. walking to the shops	Breathing techniques Engaged in the world of doing for e.g. volunteer work. Long term goals	Absorbed in the world of doing. Happy to reach goals, and can deal with it when don’t
Taking care of my home	Graded housework, for example one chore a day	Graded housework, for example problem solving – what has worked in the past; focus attention on one routine a day	Taking care of home with a routine in place	Integrated housework plan with rest of life

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Ideas for Occupational Therapy Interventions: Doing in the Day-To-Day World (continued)

OSA categories	Non-Doing intervention ideas	Half-Doing intervention ideas	Engaged-Doing intervention ideas	Absorbed-Doing intervention ideas
Taking care of myself	Work with one routine; for e.g. getting out of bed, showering and dressing	Work with two routines; for e.g. Getting up, showered, personal grooming, and clean clothes	Normal routines in place	Integrated personal routines with rest of life
Taking care of others	One example for all categories: Making a cup of tea for self and one other	Make sandwich and cup of tea for self and one other. Setting a goal to make a meal	Making meal for self and one other	Meeting with friends at a coffee shop
Getting where I need to go	Have someone pick you up for an appointment	Have someone pick you up and find your own way home	Attending one regular weekly event	Active/ sharing with others close to you the events of your life
Managing Finances	Getting help (OT, budget advice) to manage affairs, for example, make a budget/ set up AP's	Begin to manage own budget, based on what was learnt from assistance received in Non-Doing	Goal setting for future treat. Saving and meeting goals	Consciously managing own affairs
Managing basic needs – food medicine	Using help from: weekly pillboxes, letting others prepare food for you, eat snack like meals 4-6 x a day	Continue weekly pillboxes; contribute to household tasks, for e.g. meal preparation and dishes. Eat 3 meals a day	Normal meal routines in place	No attention needed
Expressing myself to others	Choose one person a day and commit to answering fully when spoken to	Continue to answer fully when spoken to. Choose one person a day to seek out and engage them in a conversation	Engaged in two-way conversations with family and close others	Engagement with family, close others, and meeting new people
Getting along with others	Imagine what getting along with others means to you? Practice this with those you live with, or are closest to you.	Extend your practice with friends and people you know support you	Extend your practice getting along with the strangers you meet in your day	Integrating practice into life outside your circle of family or friends
Identifying/ Solving problems	Work on the list above	Work on the list above	Identify problem(s) and plan solution. Put plan into action	Integrated, taking life as it comes

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Ideas for Occupational Therapy Interventions: Doing in the Day-To-Day World (continued)

OSA categories	Non-Doing intervention ideas	Half-Doing intervention ideas	Engaged-Doing intervention ideas	Absorbed-Doing intervention ideas
Relaxing/enjoying myself	Bring into your daily life objects or an activity that you enjoy and that relaxes you, e.g. soft blanket, music, etc	Do one activity per week which brings relaxation and enjoyment, for example use prior skills, e.g. knitting or walking in nature	Engaged in two regular weekly activities for enjoyment and relaxation, for example attend a pottery class	Absorbed by and potentially sharing with friends, or partner's activities that you enjoy and that relax you
Getting done what I need to do	Work on list above	Work on list above. Write down a daily 'need to do's plan'	Incorporate plans into a weekly diary. Prioritising tasks. Working through the list	No attention required using your diary. Getting things done and not stressing when you don't
Having a satisfying routine	Work on list above	Commit to doing one activity at a time with rests and rewarding yourself at the end of each day	Acting in the knowledge that routine is helping to make your daily life easier to manage	No conscious effort needed
Handling responsibility	Work on list above	Work on list above	Work on list above	
Being involved/student-worker-volunteer-family member	Work on list above	Work on list above	Set LT goals and ST steps to achieve them	Working with ST steps to achieve LT goals. Actively and patiently ticking off goals as they are achieved
Doing activities I like	Work on list above	Work on list above	Interest check list Set ST goals for one activity. Do chosen activities within a daily schedule Do one weekly activity you love	Actively involved and absorbed by activities you enjoy. Having the potential to share them with others
Working toward my goals	Work on list above	Work on list above	Work on list above	Work on list above
Make decisions based on what is important	You are in charge of the list above	You are in charge of the list above	You are in charge of the list above	You are in charge of the list above
Accomplishing what I set out to do	Work on list above	Work on list above	Notice accomplishments	Absorbed in finished product
Effectively using my abilities	Work on list above	Work on list above	Work on list above. Set goal to take on one new challenge	Absorbed in extend abilities to learn new skills

APPENDIX 2

To: General Practitioners in the North Shore area

The creation of a new service has been proposed to be involved in the treatment of clients in the North shore region with mild to moderate anxiety. A community mental health occupational therapist from WDHB has identified that clients with mild to moderate mental health issues who do not meet the criteria for being referred onto specialist mental health services do not receive adequate assistance.

Ministry of Health initiatives are now seeking to extend the scope of how mental health care is provided in the primary sector. According to the Guidelines for Assessing and Treating Anxiety written by the National Health Committee (1998), lifestyle changes may reduce the risk of anxiety disorder occurring, reoccurring or becoming more severe and relieve symptoms. Lifestyle changes which may help the person cope with stress include stress reduction, reducing alcohol and drug use, healthy eating habits, regular exercise, regular relaxation, assertiveness techniques, practical help such as budgeting, childcare and housing and taking part in meaningful activity.

The service proposed would include 6 individual sessions with the clients. The interventions used will focus on strategies which will empower the clients to make lifestyle changes which will enable them to better manage their anxiety. This programme would include using meaningful activities and daily occupations in order to manage their anxiety and promote health and wellbeing.

- If an occupational therapy service was able to provide the above mentioned program, do you think this would assist you in the treatment of these clients?
- Are there any other services available to clients with these conditions in this community which may provide similar services?
- If so, could you name them?
- Would the PHO be able to partly fund such a project?
- Would this be a good use of allocated funding in the PHO's?
- If this was implemented as a pilot study, would you be interested in referring to this group?

Yours sincerely
Occupational Therapist

Developing a Programme for Women Experiencing Homelessness in Auckland City

TESSA MANASE

Appendix Developer: Danielle Sciarone

Other Project Members: Anelle Brits, Julia Mason, Annabelle Shilton, Joanna Sykes, Michelle Van Lit

PAPER CO-ORDINATOR'S COMMENTARY

Lifewise is a part of the Methodist Mission Northern, one of the organisations that has for many years provided services to people who are homeless in Central Auckland. In the past the service has provided basic needs such as food, showers and clothing. However more recently new services have been developed that will enable service users to provide for their own needs with the goal of a life off the street. Lifewise already use meaningful occupations as a means to meet this goal such as developing life skills through involving service users in sport. This year the service manager requested that one team of students develop a programme for women who are homeless.

The strength of Tessa's proposal is a thorough and well structured literature review which gives a clear local context. She combines literature from a variety of very different sources to make very clear and strong points. Safety both for the women in this service and for staff is one of the keys to the success of this project and a point that Tessa covered more thoroughly than others. Despite a recommended separate entrance, all the students recommended this group take place in the same building which has for years been used predominately by homeless men. More thought needs to be given to whether this fact may keep some women away. What all members of this group excelled in as undergraduates was not only finding evidence based models of practice appropriate to this client group and setting but also demonstrating an in-depth critique and justification for how the models would be implemented.

EXECUTIVE SUMMARY

This chapter presents a proposed programme 'Ladies space' for women experiencing homelessness in Auckland that could be run at the Lifewise centre. The issues of women's homelessness is not adequately recognised and addressed in Auckland city. Homelessness is an issue that affects many women in Auckland; however they are often hidden from view thus forgotten in society. Due to restraints of being homeless, these women have become a marginalised population in society. Often they will be unable to engage in the everyday meaningful occupations that are valued by and available in today's communities, which fuels feelings of disempowerment. Addressing this issue of occupational deprivation is of high importance to occupational therapists. As a profession, occupational therapist believes that every person has the right to be supported to engage in occupations that are meaningful, participate in the community, and be included and valued as a member of society. Ladies space aims to address the identified issue of occupational deprivation, experienced by the targeted audience. The programme hopes to empower women experiencing homelessness, through a weekly group where they engage in meaningful activities of their choice. The programme will use the model of occupational empowerment (Fisher &

Hotchkiss, 2008) and the strengths model (Rapp, 1998). Partnerships with current organisations and services associated with Lifewise will be recommended for the development, promotion, and implementation of ladies space. Other stakeholders such as NZ Prostitute Collective and Women's Refuge may also be involved. Face-to-face conversations with attendees, individual outcome measurements as appropriate, and a mid-year steering committee will be used to guide programme evaluation.

INTRODUCTION

Homelessness is not just about 'rooflessness'. Crisis (2009) illustrates how a home is not just a physical space but, "provides roots, identity, security, a sense of belonging, and a place of emotional wellbeing. Homelessness is about the loss of these" (p. 1). Statistics New Zealand (2009) recently put out the proposed final draft of the New Zealand definition of homelessness. This defines 'homelessness' in terms of peoples living situations, and encompasses individuals who are 'living rough', in temporary shelter, sharing another households home or living in substandard housing (Statistics New Zealand, 2009).

At present there are limited options available for women in Auckland who do not have a permanent, safe, or secure housing (S. McLukie, personal communication, September 29, 2009). A woman may become homeless due to a variety of reasons; however once homeless, issues of personal vulnerability arise intensifying their situation. This pushes them further towards the borders of society, where they become stranded as part of a highly stigmatised group (Bukowski, 2009; Hodgetts, Radlet, Chamberlain, & Hodgetts, 2007; Larson, Poortinga, & Hurdle, 2004).

Lifewise, formally the Northern Methodist Mission, offers both emergency and temporary services for people experiencing homelessness. This organisation is the leading providers of specialist services that turn the lives around of individuals and families in our community. They work with all homeless people and are committed to making positive changes for these individuals (Lifewise, 2009). It is estimated that women make up around 15-20% of the homeless population accessing the service (S. McLukie, personal communication, September 29, 2009). However, the service manager of the Lifewise centre has identified a gap in their current service provision to women in Auckland who are homeless. He has requested a programme proposal of a group specifically for this target population to be developed.

LADIES SPACE

Ladies space is the proposed name the project team gave to the group for women who are experiencing homelessness in Auckland City. It uses meaningful occupation as a mechanism for helping women find empowerment, belonging and hope.

Overall Aim

To empower women experiencing homelessness through a weekly group where they engage in meaningful activities of their choice.

Objectives

- To provide a sustainable member-driven group run on a weekly basis.
- To create a safe and supportive environment where women feel a sense of belonging and hope.
- To provide opportunities for women to identify their needs and goals for working towards positive change.
- To facilitate engagement in meaningful group activities of the women's choice.

NEEDS ANALYSIS

For women, the way in which they relate to the world and interact in society is different to men. Research shows that “women and men experience homelessness differently” (Hagen, 1987, p. 316). Thus the needs of a woman who are homeless will be different to the needs of a man. The issues of women's homelessness is not adequately recognised and addressed in Auckland city. Major injustice include: marginalisation, occupational deprivation and disempowerment.

Marginalisation

Homeless women are a marginalised population in the community (Bukowski, 2009; Fisher & Hotchkiss, 2008). They are often unable to take advantage of social and economic opportunities which surround them, due to the complexities of being homeless. Bukowski described homelessness being a journey that for many women “takes them further and further towards the margins of society” (p. 1).

Occupational Deprivation

Due the restraints of homelessness this marginalised group often experience the injustice of occupational deprivation (Bukowski, 2009; Fisher & Hotchkiss, 2008; Jones & Pleace, 2005). This is described as “a state in which people are precluded from opportunities to engage in occupations valued in our communities” (Whiteford, 2000, p. 200). Contrary to common societal beliefs, most homeless women want the opportunity to engage in the everyday occupations available to community citizens, but do not have the resources or support to do so (Bukowski, 2009). For example with regards to travel, hobbies, employment, having a stable family life, education, and being a home owner.

Disempowerment

Disempowerment often occurs when women who are homeless do not get the chance to access meaningful life opportunities. A recent study of women's homelessness in Auckland revealed there is feeling of total disempowerment with this population group (Bukowski, 2009). The women the study sampled expressed that social and institutional barriers existing in society hindered their ability to be active members within the community. This exclusion from being able to participate in the community meant they were unable to gain a sense of connectedness, respect, protection and belonging that comes from being a citizen. The impact of disempowering environments on women who are homeless include: low self esteem, loss of hope and ability to achieve

things in the future, and the development of poor behaviour patterns that become very hard to break, otherwise known as 'learned helplessness' (Bukowski; Fisher & Hotchkiss, 2008).

Causes

Research shows that for the majority of homeless women, 'homelessness' is not a personal choice (Christian, 2003; Pascale, as cited in Bukowski, 2009). Relationship breakdowns, domestic violence and financial difficulty are among the common contributing factors leading to women's homelessness (Calay, as cited in Bulowski; Rota-Bartelink & Lipmann, 2007; Sev'er, 2002). Other factors include teenage pregnancy, drug or alcohol abuse, and mental illness (Burt & Cohen, 1989; Ralston, as cited in Bukowski; Rota-Bartelink & Lipmann, 2007; Sev'er).

Prevalence

There is limited research and published literature on homelessness in NZ, the majority of this focused predominantly on young men who are homeless (Bukowski, 2009). Women who are homeless in NZ are often overlooked, thus there is little known about the exact extent of women's homelessness in Auckland city (Al-Alnasrallah et al., 2005; Amore, 2007; Ellis & Holt, 2007; Hodgetts et al., 2007; Laurenson, 2005; Leggart-Cook, 2007; Richards, 2008; Smith, Robinson, & AtkinRead, as cited in Bukowski). Part of the problem is that the male population is more visible to society, with homeless women commonly found in inadequate or transitional housing rather than on the streets 'hidden away from view' (Bukowski). The latest street count found 76 people "sleeping rough" in streets, parks and makeshift shelters within 3 km of the Sky Tower (NZ Herald, 2009, p. 1). Of these 76 individuals 10 were women. This homeless census found a further 587 people living in boarding houses and other insecure accommodation (NZ Herald, 2009). It is estimated 25-30% of the homeless population living in temporary shelters are women (S. McLukie, personal communication, September 29, 2009).

Severity

Homelessness has significant impacts on health and wellbeing. Living in marginalised housing poses specific risks to women. "Because women are a minority population in mixed-gender accommodation, they are at particular risk of sexual violence and intimidation and, even if violence is not perpetrated against them, they experience fear and a lack of safety" (Murray, 2009). Bukowski's (2009) research findings show women in insecure and unsafe housing become trapped, without the resources or options to improve their housing

situation, and that many of whom have children to care for. Other implications of homelessness for women include an increased risk of "disease, physical or sexual violence, and a sense of fear and difficulty reintegrating into society" (Hodgetts et al., 2007; Stein et al., as cited in Bukowski).

Available services

Investigations for this proposal revealed there are no current services in the Auckland district that cater specifically for the needs of homeless women, and the Auckland City Council's Homeless Action Plan does not include any specific points in relation to issues of women's homeless (Bukowski, 2009). This is a concern as Auckland's CBD is one of the fastest growing residential areas in the Auckland region (Auckland City Council, 2007) and houses a high level of homeless people, as well as a lack of affordable housing (Laurenson, as cited in Bukowski, 2009). This highlights the need and sense of urgency to establish a programme that will address issues of women's homelessness, and support their participation in fulfilling meaningful occupations.

Evidence base to support meaningful occupation as a mechanism to stimulate empowerment and change in the women's lives

Bukowski (2009) stresses the importance of empowering the women experiencing homelessness. "Women need to be helped to find the power and mana within themselves and feel empowered... a woman is the full circle. Within her is the power to create, nurture and transform" (p. 71).

It is important to have the opportunity to engage in meaningful activity, and suggested that the mastery of these experiences is the most effective way of creating a strong sense of self efficacy (Bandura, 1995). Jones and Pleace's (2005) study on daytime homelessness found the engagement in meaningful occupations was important in helping to promote health and well-being of individuals who are homeless. "There is a misconception that people who have lived on the street solely need food and medical services – but they need meaningful occupation as well – it is very important that people can see the ways in which they can change" (Jones & Pleace, p. 42). These findings suggest engagement in purposeful activity could assist women who are homeless in Auckland city start to take control of their lives, develop a sense of hope and plan for a positive future.

Occupational therapists recognise the importance of being able to participate in occupations that are meaningful. Being able to participate in chosen occupations will "foster hope,

generate motivation, offer meaning and satisfaction, create a driving vision of life, promote health, enable empowerment, and otherwise address quality of life” (Townsend, 2002, p. 182). The World federation of Occupational therapists state it is the right of every person to be supported to engage in occupations that are meaningful, participate in the community, and be included and valued as a member of society (World Federation of Occupational Therapists, 2006).

Summary

Barriers to engaging in meaningful everyday occupations appear to be the major issue for women who are homeless and leads to feelings of disempowerment and learned helplessness. Through this needs analysis it has been identified that these women need to have a place where they can come and feel safe, supported, and be together: to have the space to look forward to their futures with hope. We know that empowerment belonging and hope can be elicited through engagement in meaningful occupation. Thus the focus for ladies space must be providing these opportunities and giving support so that they feel they can take up those opportunities and become empowered.

MAPPING SIMILAR PROJECTS

In New Zealand there are very limited options available for women who “do not have permanent, safe or secure housing, this is particularly the case for single women, women who have drug and alcohol issues, women with mental illness and transgender women” (Bukowski, 2009, p. 1). At present there are no services in Auckland that cater specifically for the unique needs of homeless women. In the past Lifewise has trialled a women’s group within their centre. This was run by the drug and alcohol counsellor from Community Alcohol and Drug Services (CADS) who works alongside Lifewise. However, unfortunately this group was unsuccessful. This was due to a number of contributing factors being concerns around confidentiality, inconsistent numbers and the content of the group not always meeting individual needs.

The City Mission is a non-governmental organisation that similar to Lifewise in that it provides short term solutions such as food and shelter as well as support for people wishing to make lifestyle changes and exit homelessness. There was a recent women’s group being run at the City Mission (S. McLukie, personal communication, September 29, 2009). However, it was not sustained.

The Salvation Army is an organisation that offers only emergency services for people experiencing homelessness. However they do run a number of other community services which can be utilised by ladies space such as the Bethany centre, court and prison services, job skill courses, budgeting advise, early childhood centres and drug and alcohol counselling.

PARTNERSHIP ARRANGEMENTS

Currently Lifewise partners with organisations including the Auckland City Mission, the Salvation Army, Housing New Zealand, Work and Income New Zealand, Te Atea Marino/CADS, The Taylor Centre (ADHB), and probation services. Each of these organisations will be invited to take part in the steering group for Ladies space. Research shows that word of mouth is the most effective way to distribute information with this target population (Bukowski, 2009). Thus, Lifewise will also collaborate with these organisations to advertise and promote the group.

Other important stakeholders that will be invited to join the steering committee may include the NZ Prostitute Collective, the ‘houseworks’ women’s action group, women’s refuge, Auckland Women’s centre, and tangata whenua from Nga Wau Horotiu Marae as it is located nearby Lifewise on the corner of St Paul’s and Wellesley street.

Ladies space will be coordinated so that it links up with other services that already visit the centre. For example CADS/ Te Atea Marino, counselors from the Taylor centre Probation services, Work and Income New Zealand (WINZ), and Housing NZ. CADS are a substance abuse organisation run by Waitemata District health board (WDHB) and Te Atea Marino is the Maori arm of this. A female counselor visits from this service visits the centre every Monday morning; The Taylor centre is part of Auckland DHB and there are currently two female staff members in this part of the service; Housing NZ are available at Lifewise centre on Tuesday and Thursday mornings on arranged appointment.

Local community businesses will be invited to sponsor the group. This could include but is not limited to The Body Shop, Jeans West, and Subway. These would be important partners for the group in terms of supporting the women in the community, and providing resources.

SERVICE USERS’ VIEWS ON THE PROJECT

This programme hopes to establish a group that is run for the women, by the women. It is recognized that having service user input is invaluable. This insight is crucial to ensuring the group is successful in meeting these women’s needs, becoming self sustaining. For women who are experiencing homelessness, they have been stripped of their opportunities to make choices, and have ended up feeling disempowered as a result (Fisher & Hotchkiss, 2009). Thus the level of service user participation most appropriate for this group is ‘empowerment’. The goal of ‘empowerment’ is to place the final decision-making in the hands of the women. It promises that what they decide will be implemented, and ensures their opinions and the voices will be incorporated throughout this member-driven group (International Association for Public Participation, 2007).

IMPLEMENTATION PLAN

Ladies space will be based at the Lifewise centre with group sessions run weekly at a regular time. This will be held in a women’s only room with a separate access from the main entrance for the women to use. This group is for women experiencing occupational deprivation and often have low self esteem, feelings of total disempowerment, and a loss of hope as a result. Following the model of occupational empowerment (Fisher & Hotchkiss, 2008) and the Strengths model (Rapp, 1998), this group aims to allow engagement in meaningful occupations through which these women can find a place for empowerment, belonging and hope. These models are congruent with the philosophy which has begun to move away from using just a charity based model, and is now establishing programmes that work with people who are homeless towards achieving long term solutions (Lifewise, 2009).

The model of occupational empowerment was developed from grounded theory research, and emerged from work at a homeless shelter for women and children (Fisher &

Hotchkiss, 2008, p. 55). The model starts with *disempowering environments* which encompass the negative impact the environment can have on a person, for example the limited access to resources such as education and housing associated with enduring poverty. This then leads to the second point which is *occupational deprivation* as discussed previously in the needs analysis. Occupational deprivation and disempowering environments result in the model’s third point, *learned helplessness*. This can be described as poor behaviour patterns that become very hard to break, consequently promoting homelessness. For example, patterns of behaviour that make it difficult for a person to maintain work and education, which will eventually decrease health and well-being. The fourth point is the intervention step. The model uses *occupational empowerment* as the mechanism for helping individuals develop a positive self identity and feelings of competence, which leads to *occupational change*. This is the final step in the model whereby, with support and engagement in an activity that is meaningful, self-initiative develops as well as independence, healthy routines, increased self-fulfilment and well-being.

The strengths model will be used in collaboration with the empowerment model to help move the focus from learned helplessness to utilising their strengths. The strengths model will be used to help build a programme that will enable the women to identify, utilise and develop their existing strengths rather than focus on their weaknesses and issues. Research with this population highlights the importance of incorporating the strengths of each individual into interventions and client goals in order for them to be successful and a sense of mastery in their endeavours gained (Schultz-Krohn, Dernek, & Powell, 2006). Through this programme we aim to replace these women’s imagery of deficits with imagery of strength and resilience in order for them to gain hope, confidence in themselves, and their ability to identify and work toward achieving their chosen goals. Following principles of this, the group work will aim to achieve three main things, that the women experience support and affirmation, ideas and learning.

Table 5.1: Implementation Plan

Time frames	Implementation steps	Actioned by whom
Week 0-5	Research into occupational therapy models and literature evidence to support our proposal. Develop the idea for the ladies group and compile a list of possible group activity ideas that can be used as a resource to provide inspiration for activities in the early stages of the groups (Appendix A)	AUT students

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Table 5.1: Implementation Plan (continued)

Time frames	Implementation steps	Actioned by whom
Week 4-5	Develop an outline plan for the 'kick off' event to open ladies space and the initial group session (Appendices B & C)	AUT students
Week 5	Design a marketing package and plan for the group	AUT students
Week 6	Present Ladies space proposal to Lifewise	AUT students
Week 7-17	Form a steering group: with stakeholders for example past/ current service users, Lifewise staff, group coordinator, the city mission and the salvation army. Source funding, resources, and staff	Lifewise Service Manager
Week 18-20	Advertise 'kick off' event using the marketing package	<ul style="list-style-type: none"> • Group coordinator • Lifewise staff/volunteers • Partnering organisations
Week 21	'Kick off' event	Group coordinator
Week 22	First group meeting Set ground rules for group	<ul style="list-style-type: none"> • Group attendees • Group coordinator
Week 23-26	Group makes the space 'their own' Opportunity for group to further develop/ rebrand Ladies space	<ul style="list-style-type: none"> • Group attendees • Group coordinator
Week 27	Monthly group activities ideas forum initiated	<ul style="list-style-type: none"> • Group attendees • Group coordinator
Week 27-49	Group implemented as per monthly ideas forum Quarterly steering group meeting	<ul style="list-style-type: none"> • Group attendees • Group coordinator • Steering group
Week 50-51	Programme evaluation	<ul style="list-style-type: none"> • Group attendees • Group coordinator • Steering group

Table 5.2: Project Evaluation

Objectives	Success criteria and outcome measures	Time line
1: To create a safe and supportive environment where women feel a sense of belonging and hope.	<ul style="list-style-type: none"> • Obtain a room at the LIFEWISE Centre with its own entrance for 'women's only space' • Women participate in decorating and furnishing the room to make it their own • Have a core regular attendance • In face-to-face conversations women report feelings of belonging, hope, and safety at group 	<p>Achieved/Ongoing</p> <p>Assessed at week 27</p> <p>Recorded weekly, evaluated at quarterly steering meeting</p> <p>Ongoing ; programme evaluation week 50-51</p>
2: To provide a sustainable, member-driven group run on a weekly basis.	<ul style="list-style-type: none"> • Weekly group is sustained. • 6 idea forums; Have moved towards all activities being chosen by women • At least one service user (past or current) represented on steering group 	<p>Ongoing ; programme evaluation week 50-51</p> <p>Ongoing ; programme evaluation week 50-51</p> <p>1st steering group meeting and quarterly thereafter.</p>

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Table 5.2: Project Evaluation (continued)

Objectives	Success criteria and outcome measures	Time line
3: Provide opportunities and support for women to identify their needs and goals for working towards positive change.	<ul style="list-style-type: none"> Goals identified by women are recorded and progress monitored with them using an appropriate outcome measure – e.g. outcome star In semi-structured face-to-face conversations women reflect feeling as if they have been provided opportunities to identify and work towards their needs/goals 	<p>Ongoing; programme evaluation week 50-51</p> <p>Ongoing; programme evaluation week 50-51</p>
4: To facilitate engagement in meaningful group activities of the women's choice	Each weekly session will involve meaningful activities chosen by the women - in the previous ideas forum.	Monthly at the ideas forum & at the programme evaluation

MONITORING ARRANGEMENTS

Monitoring confidentiality and safety

Group norms: During the first session members will decide upon what they want or consider the group norms and expectations to be. This could be printed and laminated to put up on the wall as a positive reminder of what the group is about and can be referred to if group members or the coordinator feels in some way these are being breached. Any arising issues will be discussed in the group or individually if this is preferred by the member or else deemed not appropriate by either party. In this case the co-ordinator will arrange to meet after the group or later during the week. If the coordinator feels unsafe, inadequate or unable to provide the help required for the member they will be referred to a relevant service that can.

Panic buttons & alarms: will help ensure the members and the facilitators are and feel safe in the group. The co-ordinator and any visiting guests (i.e. hair dresser for a pamper group session) will be given a panic button that they can keep on themselves at all times during the group. It is recommended that safety alarms also be installed on the walls within the room in case of an emergency where help is required for staff or a member. A member of the Lifewise staff will also be on sight at the centre during group session if such emergency occurs and a quick response is needed.

Debriefs and supervision: will provide support for facilitators of the group. Before the initiation of the group, the facilitator will establish a support system including: weekly supervision (with an identified supervisor) and

debriefings at the end of each group (this could be a co-staff worker at Lifewise or an outside individual).

Protocol and procedures: All staff will be educated in Lifewise's protocols and procedures to follow in the case of a crisis. This will include how to act in a controversial situation where staff may feel they need to break confidentiality for legal purposes or the health and safety of the client or other individuals.

Monitoring structure

The steering group: will monitor the direction of the group programme, and help evaluate its successfulness, whether it is achieving targeted outcomes, and meeting the needs of these women. Steering committees are ideally made up of key representatives of each stakeholder group partners, supporter 'suppliers' and 'users' (Dwyer, Stanton, & Thiessen, 2009). Suppliers will be able to monitor the costs and feasibility of the group, while the 'users' will focus on the purpose and quality of the group. Many of the existing services are miss-matched to this population's needs, as the women are not being fully involved in the service development (Bokowski, 2009). The steering committee will convene before the initiation of the group and meet quarterly thereafter.

Project Champion: has the ultimate responsibility of monitoring the group programme and financial budgets (Dwyer, Stanton & Thiessen, 2009). Thus, in relation to this proposed women's group, these tasks will be taken on by Corrie Haddock, Service Manager of Lifewise.

Monitoring targets

Programme objectives will be measured using both qualitative and quantitative methods as described previously in the outcome measures of objectives.

Programme evaluation

This will be guided by:

- Face-to-face conversations with attendees
- Individual outcome measurements as appropriate
- Mid-year steering group meeting

If it is found that the group is successful, group branching and development may be considered as an option to ensure the evolving needs are being met.

PERSONNEL, EQUIPMENT AND RESOURCES**Physical**

- Space: Women's only room with separate access, area for children (with toys), access to kitchen and bathroom facilities.
- Room furnishings: Couches or seating, tables, storage, décor, electricity sources, cleaning products, computer and a phone connection.
- Activity supplies and Incidentals

Cultural

Culture that hopes and dreams can become realities; each woman has strengths that can be used to facilitate positive life changes; developing strong and lasting friendship bonds through groups; women supporting and encouraging each other in the community.

Social

Staff: Female group coordinator and volunteers. It is necessary to have a qualified group facilitator that has experience working with people who are homeless and preferable women due to the sensitive nature of this group. A female facilitator is crucial to the development of establishing trusting and therapeutic relationships, because many of the targeted population will have experienced abuse or domestic violence in some form.

Institutional

- Funding for group
- Partnerships with other services and organisations involved in the development, implementation or monitoring of the group.

Possible avenues for funding

- Supplies and services from local businesses
- Lifewise
- Fundraising by the ladies space group
- Funding information service (2009): Fundview <http://www.fis.org.nz/index.php?page=Fundview> Lifewise may want to consider using 'Fundview' as an avenue to search for group funding especially in terms of one-off costs, for example funding for the initial set up of the room. Fundview is an internet database which provides information on funding for community groups and non-profit organisations.

APPENDIX A

DEVELOPED BY DANIELLE SCJARONE

Ideas for Group Activities for Ladies Space

This is a resource to provide ideas and inspiration to those getting the group off the ground. Once the group is running, the group members should have full control over the direction of the group activities.

1. Women contribute stories to Lifewise newsletter

The women could put together items about their lives to be published in the Lifewise community newsletter (as proposed in a submission to the Auckland City Council in 2008). Often women who are homeless have never had the opportunity to share about their life experiences. Women in a study by Vanliet, Starrett, and Crowe (2006) reported telling others their stories made them feel recognised in society, and enabled them to envision how they wanted life to be.

2. Pampering session

Every woman deserves to be looked after and most women enjoy a bit of pampering. A recent study found women who are homeless can feel they do not have the time, resources or the motivation to spend time on their appearance, resulting in them feeling down and having low self esteem (Van Liet, Starrett & Crowe, 2006). The Body Shop or similar organisations may be willing to donate services and resources for a pamper day. This idea is suggested in the literature (Fisher & Hotchkiss, 2008; Fleming Cottrell, 2000).

3. Art and crafts

Art often provides an avenue to explore one's own culture and identity and can create a sense of achievement having made something. Groups could involve jewellery

and bag/ belt making; making and mailing cards to send to people the women care about; painting, weaving, or sewing. Selling art is a good way of fundraising, which gives a sense of giving back to the community and being industrious as well as providing funds for more resources. A craft oriented group previously ran at the Auckland City Mission was responded to well.

4. Performing arts

Many of the women may have hidden talents or an interest in performing arts. Activities could be centred on listening to music, playing instruments, writing music, singing, or watching/acting out plays.

5. 'One-Stop-Shop' days

Difficulty accessing social welfare services is a well recognised occupational issue for women who are homeless (Finlayson, Baker, Rodman, & Herzberg, 2002; Marsh, 2006; Neale, 1997). At these meetings women could access services such as WINZ, Housing NZ, and CYFS, at one place, in an environment where they feel safe and supported. A 'One-Stop-Shop' has identified as a need both by Lifewise and homeless women themselves (Bukowski, 2009).

6. Just chilling

A session where the women could just share refreshments and "be with" each other. Van Liet, Starrett and Crowe (2006) found that the homeless women in their study discussed the importance of having friends to be a top priority.

7. Reading/ book club session

Van Liet and colleagues (2006) studied the occupational goals and concerns of homeless women and found that women spoke about the "unmet need to exercise, relax and read" (p. 55). Possible sponsors for this may include Whitcoulls, Dimmocks or another leading book store.

8. Walking group

In a study by Smith (2005), homeless women identified exercise as one of their health promoting needs. A 6 week walking class implemented by the women allowed the women to understand how commitment impacts on their likelihood of participation. It also allowed these women to take leadership roles throughout the study.

9. Gardening

The women could contribute their services to a

community garden. This activity has been successfully implemented with people who are homeless overseas. People involved in this project noted: "The gardens are both therapeutic and rehabilitative" - Paul Lee (Founder). "We create community and a safe place off the streets. The garden provides meaningful labor in a safe and beautiful environment," (Jane Freedman (Director), as cited in Montgomery, 1994).

10. Guest speakers

There are many people in the community willing to speak to groups about their topic of expertise. Depending on what the women want to hear/learn about this may be a local celebrity, politician, chef, business woman or maybe someone who has overcome serious hardships.

11. Music appreciation

The women may want to bring music to play at the group. A study on a group for homeless people found that music provided an opportunity for the group facilitator to establish relationships with people who did often do not initiate contact. It promoted relaxation and interaction with others and was observed to decrease loneliness and isolation. "The music programme was effective in fostering a sense of well-being and allowing the participants to join together in a meaningful activity" (Penden, 1993).

12. Outings

Outings are a great way for people to explore their environment and 'escape'. This could be a trip to the beach for a picnic, or simply a trip to the library to sit on a soft couch and read some books/ magazines.

13. DVDs

Watching a movie together enhances the sense of belonging and companionship within the group in a non-confrontational way. This session could be a good one to facilitate early on in the programme, to build rapport, friendship and feelings of equality between the group members. Possible sponsors include Video Ezy or Village 8 cinemas.

14. Cooking/baking

This is an activity that many women enjoy, are good at, and may not have had the opportunity to do recently. The women can be involved in all aspects of the activity from planning what will be cooked, looking at recipes, writing a shopping list, shopping, cooking, eating etc.

APPENDIX B

Ladies Space Opening Event

Where: At Lifewise in the proposed ladies space room.

2 Airedale Street
Auckland City Central

When: 12.00 – 3.00pm (Week 21 Thursday/ Friday)

What: Welcome event for women experiencing homelessness in Auckland to promote the beginning of Ladies Space. Lifewise will be closed for the event between these hours.

Free lunch and drinks will be provided by Lifewise to encourage social interaction. This event aims to provide women with the opportunity to familiarise themselves with the environment, people within the organisation, and other homeless women.

Welcoming event

- Aims to create a sense of excitement and anticipation for first session
- We will advertise gift incentive for attending session one
- Inviting environment – Outside and inside, i.e. attractive entrance at church, decorated inside (balloons, party food, streamers, furnishings, cushions)
- Meet and greet
- Pamphlets given out/posters on wall advertising ladies space
- Music

APPENDIX C

First Ladies Space Meeting: Session Outline

Introduction:

- Offer karakia
- Facilitator and group members introduce themselves to each other
- Warm-up/ ice breaker
- Facilitator to explain purpose of group clearly – what are the benefits?
- Group attendees and facilitator discuss and from ground rules
- Orientation to Lifewise centre (toilets etc)

Brief description of activity

- -Brainstorm ideas for room furnishing/decoration
- -Meaningful activity e.g. flax weave flowers for room decoration/gifts

Supplies and equipment needed

- Sound system, refreshments, welcome gift pack (distributed at end of session).

Goals of the group

- Build rapport and trust within the group, between members and facilitators.
- Women to begin to create a space where they feel safe and comfortable.

Questions for discussion

- How do group members feel about the experience, the leader and each other? Careful consideration needs to be taken as to how this happens. Perhaps facilitator can discuss this with each member individually?
- Generalisations are made by the facilitator about how the group went, how the members of the group felt about the session and what they want from future sessions etc.

Points of summary

- Review goals, the content and process of the group,
- Discuss direction of group for next week.

Developing a Parenting Programme for Year 7 and 8 Students

TANYA WARREN

Other Project Members: Bobbie Munday, Bonnie Lee, Hayley Blackburn, Kirsten Noakes, Rebekah Keasberry, Swen Brandsma

PAPER CO-ORDINATOR'S COMMENTARY

In this project students worked with the principal of a decile one South Auckland Primary School. This school is already well known for implementing innovative projects to involve students in occupations and skills based learning they normally wouldn't have access to. Staff at the school had noted that a significant number of pupils were having their own children within a few years of leaving primary school. The principal asked that we look at designing a programme that challenged his students on the occupational choices they make for their futures including what it might be like to become a parent.

This proposal demonstrates need through good community mapping and statistics. Tanya's proposal shows that this group of students worked hard to understand the community context of this population group. They identified like services who could be useful consultants or partners in this project, whilst still making it very clear there was a gap in services to this age group. They also identified theories that will be useful in developing and shaping this programme. Another strength of this proposal is that thought has been given to how programme leaders could gain information from these children in an age appropriate way which would measure whether the programme was successful or not. The Maori and Fonafale models of health are described but would benefit from more detail on how they could be incorporated into this programme.

What is not included with this proposal is an extensive resource pack for the school that the students developed. It included detailed group plans for each week of the programme which are as follows:

1. *Introduction: Making a collage of hopes and dreams*
2. *Happy and Healthy Relationships*
3. *Positive Parenting*
4. *Practical Session: Observing preschoolers*
5. *Realities of Parenting (to be run with Plunket)*
6. *Practical Session: Preschool playtime*
7. *Feelings & Emotions*
8. *Natural Highs*
9. *The World is your Oyster*
10. *Final session: Revisit collage of hopes and dreams – what has changed?*

EXECUTIVE SUMMARY

The target population for this programme proposal named “Horizons... Building whole people for tomorrow, today” are thirty-six year seven and eight students of mixed gender attending a primary school in South Auckland. The primary school in this proposal is a decile 1A school in a low socio-economic area, and its students are disadvantaged in terms of economic, cultural and physical life due to lack of resources, a deficit of positive role models, familial welfare dependency, and a strong drug/gang culture in the area surrounding the school (Nicholls, personal communication, September 22, 2009).

The purpose of this proposal is to shape students to become “whole” people. This will entail education on a variety of topics so that students may be empowered to live a life with more occupational choice than their environment and other external factors have thus far allowed.

This proposal will be implemented through a programme consisting of ten weekly sessions which will be executed at school (within school hours) and run by school staff. Sessions will be of ninety minutes duration and will use strategies such as informal discussion, interactive visits from outsourced experts, role play, activities, and a relationship

with children at an adjacent pre-school to encourage empathy and educate as to the needs of younger children. The programme will be evaluated by means of quizzes, discussion, observation, and a follow-up session the next term to access written feedback from participants.

Health promotion programmes such as “Horizons” greatly benefit from occupational therapy input, due to the professions’ expertise in enabling occupation and the potential to alter a person’s “sense of meaning, physical and mental performance (Townsend, Beagan, Kumas-Tan, Versnel, Iwama, Landry et al, 2007, p.94). Dahlin-Ivanoff (2004) further finds that “the goal of occupational therapy in health promotion is to prevent occupational dysfunction in order to improve health” (p. 33).

INTRODUCTION

Ridge, as cited in Sutton (2008), recognises that young people living in a lower socio-economic area - such as school students in this proposal- are likely to experience difficulties participating in their wider community. Australian research indicates that those from a lower socio-economic background have approximately half the probability of engaging in tertiary education compared to individuals from higher socio-economic groups (James, 2002). There is also a recognised connection between adolescent pregnancy and socio-economic deprivation in the majority of developed countries (Smith & Elander, 2006). In keeping with this literature, the school principal states that historically, the school has a high rate of past students becoming parents during adolescence (Nicholls, personal communication, September 22, 2009).

In terms of occupational health, these students are experiencing occupational deprivation, a state which precludes a person from engaging in “occupational choice and diversity because of circumstances beyond the control of individuals and communities” (Wilcock, 2006, p. 343). This issue must be addressed as it is a potential antecedent to occupational dysfunction, which results in inadequate health and welfare (Wilcock, as cited in Fazio, 2008).

Our programme focuses on this concern, while being guided by occupational-based theory such as the Model of Human Occupation (MOHO) (Kielhofner, 2002). In addition, the Maori Model (Te Whare Tapa Wha) and the Fonofale Model (Durie, 2003; Ministry of Health, 2008) will be used to promote health. Erikson’s theory will be used to address

stage of development, and Strategies for Kids – Information for Parents (SKIP) will be employed to address constructive parenting (Berk, 2007; Family & Community Services, n. d).

OVERALL AIM

To deliver a programme that equips primary school students to make positive occupational choices that will open opportunities.

Objectives:

- Students are to identify and develop short and long term goals within the 10 week programme.
- Students will be educated on healthy relationships and the impacts of teenage parenthood during the 10 week programme.
- Students will be educated on the short and long term effects of drugs and alcohol on themselves and others during the 10 week programme.
- Students will be equipped with the internal resources to make positive life choices and consider the consequences of their decisions and actions by the end of the 10 week programme.

NEED FOR THE PROGRAMME

Measurement of the programme need requires consideration of the school location. The area where the school is located is an area that is classed as having huge social concerns in need of intervention (Orsman, 2009). The district has a higher than usual rate of socio-economic deprivation; in 2004, Plunket statistics indicated that in the area, nearly three babies in ten were dwelling in the most deprived regions of New Zealand (Family and Community Services Northern Region, 2006). This area also has a family violence figure that is twice the national average, and in addition has an unemployment rate that stands at 7.0 percent for those 15 years and over, compared to 5.1 percent for other New Zealanders (Family and Community Services Northern Region, 2006; X District Council, 2004).

Between 2000 and 2004, adolescents gave birth to ten percent of babies in this area, in contrast to the national figure of seven percent, indicating a pattern of younger than average child-bearing (Family and Community Services Northern Region, 2006). While physically early child-bearing is of no detriment to either mother or child, teen pregnancy is a social issue as it has been found to notably limit the life

opportunities for those implicated; it increases the chance of intergenerational welfare dependency as well as the risk of educational underachievement for the children born (Smith & Elander, 2006; Woodward, Fergusson, & Horwood 2001). Furthermore, many fathers involved in teenage pregnancies do not fully engage in the parental role (Moore, McGlinchey, & Carr, 2002).

Richter, Erhart, Vereecken, Zambon, Boyce and Gabhainn (2009), state the need for prevention programmes (such as that of our proposal) to address detrimental behaviour of young people “from lower socio-economic groups to help prevent life course disadvantages in terms of health and social inequalities” (p. 396). In the prevention of teenage pregnancy, Card (1999) endorses programs that intercede at an early stage of a child’s life, and encompass elements such as the encouragement of goal-setting and the child’s consideration of a positive future.

Our programme is committed to assisting young people from marginalised environments to consider different ways to live so that they may not only formulate and realise goals but also increase their societal engagement through occupation.

Erikson’s theory of development supports the need of enabling occupation and empowering students to make positive choices to increase their potential, as our target population is on the cusp of the “self-identity versus role diffusion” stage. This is the period where an individual will trial different identity patterns until a perception of their future is obtained and societal roles are established, meaning current intervention is necessary to prevent future maladaptive behaviour (Hinojosa, Kramer, & Pratt, 1996). The Model of Human Occupation (MOHO) provides further evidence for the need of the Horizons programme, with Kielhofner (2002) explaining that enabling occupational choice plays a major role in determining future roles, lifestyle and health.

Due to the fact that the school serves “a predominantly Maori and significantly increasing Pacific Island community” (Safe Communities Foundation NZ, 2007, p. 1), The Maori Model (Te Whare Tapa Wha) and Fonafale Model will be used to ensure that the holistic needs of the Maori and Pacific Island population are considered at all times, in keeping with culturally safe practice (Durie, 2003; Ministry of Health, 2008). Principles of “Strategies with Kids, Information for Parents,” (SKIP) will be employed to govern programme sessions that address ways to parent in a positive manner,

should pregnancy occur (Family and Community Services, n. d.).

MAPPING SIMILAR PROJECTS

A variety of existing providers such as the Parent Trust, Plunket and the Parents Centre run a range of parenting programmes specific to the area where the primary school is located. These programmes address issues such as forging connections, children’s needs, relationships, and the reduction of parenthood myths (Parent Trust, 2009; Plunket, n. d.; Parent’s Centre, 2009). In addition, Family Planning offers a health promotion service in the form of parenting programmes and education on sexuality (Family Planning, 2007). A near-by Whanau Centre also runs parenting programmes. This organisation is comprised of a team of professional social workers who concentrate on child and family work - one of which is contracted to the school that this proposal is for (Whanau Centre, 2009; personal communication, October 15, 2009).

In terms of similar projects that cover a more comprehensive range of topics, “Attitude”, (an organisation that travels to educate young people) seems to come the closest to sharing the vision of our programme, as it has the aim of encouraging youth to choose lifestyles that pave the way for a better future (Parents Incorporated, 2008). However, while covering similar areas to our programme such as drugs/alcohol and relationships, “Attitude” presentations have more of an emphasis on mental health issues and sex education than our programme. Another vital difference is that “Attitude” only caters to secondary school students as opposed to those attending primary school (our target population), meaning their programme is not duplicated by our project.

Occupational therapy is essential to augment existing programmes through its unique viewpoint that engagement in meaningful occupations sustains well-being and leads to a fruitful and significant life (Scaffa, Van Slyke, & Brownson, 2008). This recognition will enable occupational therapists to decrease the students’ risk of occupational dysfunction through education regarding occupational role balance and performance (Scaffa, Van Slyke, & Brownson, 2008).

PARTNERSHIP ARRANGEMENTS

The likely partners that have been identified are the pre-school adjacent to the school, Family Planning, and the Whanau Centre. The pre-school, (once operational), will facilitate and permit older students to enter the grounds in order to learn about younger children and develop empathy. Family Planning has been established as a partner, due to their shared vision with our programme of having a holistic perspective of health and well-being, and the aim of reducing health inequities. Their knowledge base will also be used to train programme leaders (International Family Planning, 2008).

The Whanau Centre will be a partner due to the fact that they currently contract one of their social workers to the school, and have a focus on helping address the problems faced by families in the area (Whanau Centre, 2009). All partners have the responsibility of ensuring student safety, in accordance with the school's admittance in the Safe School Community International Accreditation Programme (SSCIAP) (Safe Communities Foundation NZ, 2007).

SERVICE USERS' VIEWS

As the service users of our programme technically include both staff and students, we will be using the consult level of participation (with elements of inform) for both parties. This level commits to keeping the public informed, while acknowledging the importance of obtaining public feedback throughout the project (International Association for Public Participation, 2007). Through interviews with the school principal and social worker, expert opinion as to the characteristics of the student population has been sought in order to devise a programme that is in keeping with the ethos of the school. Once running, our programme also utilises measures such as feedback forms completed by students, discussion between facilitators, and collaboration with the school board and staff in order to encourage bi-directional relationships concerning decisions on future project content and direction.

Table 6.1: Implementation Plan

Time frames	Implementation steps	Actioned by whom
5 months preceding programme	Obtain consent from the school board to initiate programme planning	Principal
4 months preceding the programme	Initiate committee to organise programme Appointment of facilitators for each session Make contact with external organisations (including pre-school) to access outsourced experts Deliberation around resources and location/classroom availability	Principal Programme committee Programme committee Programme committee
3 months preceding programme	Brief school board on planning progress - obtain approval to proceed	Principal
2 months preceding programme	Finalisation of necessary resources Identification of possible student participants Staff training and education	Appointed committee member Principal, Teachers & Social Worker
6 weeks preceding programme	Seek consent for pre-schooler/student participation from parents – post permission forms	Programme committee & Teachers
Onset	Programme commences	Programme committee, Principal, Facilitators
At end of each session	Debrief between programme facilitators to discuss group climate and considerations for next session	Facilitators

...continued next page

Table 6.1: Implementation Plan (continued)

Time frames	Implementation steps	Actioned by whom
Midway through programme	Review of programme success so far and report to school board	Principal
Conclusion of programme	Evaluation of programme success and written report sent to school board	Facilitators, Principal & Programme committee

Table 6.2: Success criteria and outcome measures

Objectives	Success criteria and outcome measures	Time line
1: Students are to identify and develop short and long term goals within the 10 week programme.	Students will be encouraged to formulate goals through the visual medium of a collage (where they will create a picture of their imagined future), to be completed at the beginning and end of the programme. Collection and subsequent comparison of the collages will indicate any change in terms of both visions of the future and goal-setting.	During weeks 1, 9, and 10 of the programme
2: Students will be educated on healthy relationships and the impacts of teenage parenthood during the ten week programme.	This objective will be met through the student's participation in the sessions - the success rate of the objectives will be gauged through the level of interaction between students and programme leaders. The worksheet completed after the pre-school observation session will indicate how closely students observed the complexities of pre-school child behaviour. Informal/fun quizzes at the end of other sessions will further indicate the level of student understanding, and observation of student reactions will give information as to their comprehension.	By the end of weeks 2, 3, 4, 5 and 6 of the programme
3: The school's students will be educated on the short and long term affects of drugs and alcohol on themselves and others within the ten week programme.	This will be again be determined through student participation and their evidence of learning throughout the session. This will be ascertained through a multi-choice quiz as to the effects of these substances. The quiz will not be a pass/fail exercise, but results will be collated in order to assess the "pitch" of the session and general level of student knowledge, in keeping with the objective.	By the end of session 8
4: Students will be equipped with the internal resources to make positive life choices and consider the consequences of their decisions and actions throughout the ten week programme.	This objective will be addressed through all of the sessions in the programme, and will be measured by observation of student interaction during sessions, and the responses to the various fun quizzes completed. The final collage will give a visual indication at the programmes end as to whether positive life choices are being envisioned.	Addressed throughout programme, starting with session 1, concluding with session 10

MONITORING ARRANGEMENTS

Monitoring will be managed through the presence of the school social worker, who will sit in on sessions due to the fact he has built up a rapport with the children over time – this will address the tendency of students to be wary of “outsiders” (Whanau centre, personal communication, October 15, 2009). Meetings will be scheduled as needed for programme leaders to debrief the school principal as to the development of the programme. Programme leaders will also fill out an evaluation form for each session for the principal’s perusal. The school’s Health and Safety Committee (which facilitates communication between school staff and the Board of Trustees) is available for consultation should any difficulties need to be discussed immediately (Safe Communities Foundation NZ, 2007).

FUNDING AND RESOURCES

Resources used will be: a whiteboard, markers, art supplies, paper, pens, magazines, a classroom, tables, chairs, and human resources (staff).

It is envisioned that some funding may be available through the Ministry of Social Development, particularly via the Family and Community Services division and its “Supporting Stronger Families” scheme; this focuses on the provision of early-stage prevention programmes to support vulnerable children and decrease the chance of future social issues. This scheme is currently involved with the “Roots of Empathy” programme run at the school, a classroom-based course aiming to address behavioural issues (Ministry of Social Development, n. d.).

The Ministry of Education may fund some of the programme as its “Promoting Healthy Lifestyles” initiative includes a focus on student well-being (Ministry of Education, n. d.), while the Ministry of Health promotes employing robust programmes to deal with teen pregnancy and further states that “public health initiatives should be focused at the community level to influence the determinants of teen pregnancy” (Ministry of Health, 2004, p. 96).

Counties Manukau District Health Board (CMDHB) may be a funding source due to their vested interest in the well-being and health of young people in the community. CMDHB-funded services are stated to include “specific school-based health services... and community-based youth specific programmes” (Counties Manukau District Health Board, 2006, p. 1).

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