Job satisfaction: What are the factors influencing satisfaction for physical health Occupational Therapists working in rural New Zealand?

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Thesis Abstract

Background:

Rural occupational therapy practice is faced with many challenges such as travel, remoteness of communities, lack of resources and these issues may lead to lowered job satisfaction and occupational satisfaction for occupational therapists. Consequently, this may contribute to lower recruitment and retention in this important area of practice. The literature reviewed for this thesis suggests that key factors that influence job satisfaction include access to professional development opportunities, pay progression and colleague support. Decreased job satisfaction in turn negatively impacts job productivity, recruitment and retention. However, there is a dearth of published literature pertaining to this topic in NZ, creating a gap in our understanding of these issues. This research seeks to understand if these factors are present in occupational therapy practice in Aotearoa New Zealand, and specifically in rural practice. This has led to the proposed research question: What are the factors influencing satisfaction for physical health Occupational Therapists working in rural New Zealand?

Method

A mixed methods survey approach was used (qualitative and quantitative methods) for data collection, to gather both breadth and depth of information. An online survey was designed and implemented that avoided limitations of geographical barriers (i.e., associated with in-person interviews or onsite visits). The survey aimed to better understand the perspectives of a sample of occupational therapists in rural practice and to collect data about the factors affecting job satisfaction. This survey was kindly distributed by the OTBNZ to all Aotearoa New Zealand occupational therapists, with a final sample of 32. Analysis was completed using Qualtrics software and through thematic analysis.

Findings

The survey revealed time in a job, access to professional development, implementation and education of bi-cultural practice, hours worked, and salary were all important factors influencing job satisfaction for a sample of NZ occupational therapists based in rural practice. Therapists surveyed did not identify travel as a factor affecting job

satisfaction. Similar to published literature, defining rurality and identifying as a rural therapist was problematic. Also perceptions about job satisfaction and the factors that impact this varied amongst therapists. While this study has limitations (e.g., small scale survey), it contributes to the emerging literature on this topic in NZ and highlights the need for further research.

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Ehara taku toa I te toa takitahi engari he toa takimano

My strength is not that of an individual but that of the collective

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List of Abbreviations

Abbreviation	*Explanation*
ACC	Accident Compensation Corporation
A/NZ	Aotearoa/ New Zealand
APC	Annual Practising Certificate
DHB	District Health Board
MOH	Ministry of Health
OTBNZ	Occupational Therapy Board of New Zealand
OT	Occupational Therapist
PD	Professional Development

Chapter One: Introduction

This research project explores those factors which influence the satisfaction of occupational therapists working in physical health in rural Aotearoa New Zealand (NZ). It highlights the importance of occupational therapists who work in the field of rural physical health in Aotearoa New Zealand, and the need to understand their role/job satisfaction, and the impact role satisfaction could have on employee recruitment and retention. There has been limited Aotearoa New Zealand based published literature about rural whakaora ngangahau/occupational therapy (OT), the nature of their role, job satisfaction, and employment, and given NZ's diverse geography (e.g., Northland and Eastern Southland), a mixed-methods survey focused on occupational therapists working in rural physical health practice in Aotearoa NZ was constructed. This was in order to gain the occupational therapists' perspectives on the issues and gather quantitative data to inform the research question, identify areas for further research, and help guide policy related to this area of professional practice.

Statement of the problem

Job satisfaction is defined as the representation of "an affection or attitudinal reaction to the job" (Spector, 1985, p. 694). Based on evidence from published literature reviewed for this thesis, it is likely that individuals will generally remain in their current employment when satisfied and alternatively will be more likely to leave a position if they are dissatisfied (Mount, Illies & Johnson, 2006; Saari & Judge, 2004; Wegge, Schmidt, Parkes & can Dick, 2007). There is limited published research and literature about the factors that influence job satisfaction for rural health professionals in the physical-based field of occupational therapy field in NZ.

Several internationally sourced studies have highlighted the factors that influence job satisfaction for rural occupational therapists, and these reveal that access to professional development opportunities and pay progression are particularly salient (Randolph, 2005). However, this has not been explored in the published literature based in NZ. Given the limited range of research specific to NZ whakaora ngangahau/occupational therapy in the field of rural physical health, it is difficult to establish what are the factors that affect this group of therapists' job satisfaction, and if the international findings are relevant to the NZ context. Knowledge of these specific employment and role-related matters is vital to sustaining a happy, productive and effective workforce in this sector (Wegge, Schmidt, Parkes & can

Dick, 2007; Mount, Illies & Johnson, 2006; Saari). As a result, the focus of the research is about what factors influence rural physical health-based occupational therapists' job satisfaction. This can consequently better support those in this area of health care, informing both recruitment and retention policies, and practice in the provision of this vital service.

Personal Connection to the Topic

After completing a bachelor's in occupational therapy through the Otago Polytechnic the researcher worked in inpatient and community physical health positions in an urban setting that also covered rural areas. Having worked in areas of the primary health sector that include some rather geographically isolated areas in New Zealand (such as Otautau and Eastern Southland) she often reflected on the benefits/highlights and barriers associated with rural practice. Whilst working, the researcher began the process of a post-graduate diploma, where, through completing a paper in research for practice and reviewing relevant literature, her interest in this research topic was developed. Throughout this time, the researcher saw the ebbs and flows of retention and recruitment in practice with her colleagues and began to wonder about the factors which influence job satisfaction. Colleagues commonly reported, experiencing challenges to working in rural practice like accessing professional development opportunities. Having worked in rural areas, the researcher has experienced first-hand the challenges and opportunities of this type of work (such as working in isolation and the problem-solving skills required to do so competently). She was therefore interested in exploring through research if other occupational therapists had similar experiences, whether these were location-specific (i.e., rurally based) and what the factors were that contributed to their job satisfaction.

The scope of Practice for Occupational Therapists in Aotearoa New Zealand

Occupational therapists are registered health professionals who use processes of enabling occupation to optimise human activity and participation in all life domains across the lifespan and thus promote the health and well-being of individuals, groups, and communities. These life domains include learning and applying knowledge; general tasks and demands; communication; mobility; self-care; domestic life; interpersonal interaction and relationships; major life areas; and community, social and civic life. Enabling occupation incorporates the application of knowledge, principles, methods and procedures related to understanding, predicting, and ameliorating or influencing peoples' participation in occupations within these life domains (OTBNZ, n.d.). Such practice is evidence-based and undertaken following the Occupational Therapy Board of New Zealand's (OTBNZ) prescribed Competencies and Code

of Ethics, and completed based on the individual therapist's area and level of expertise (Occupational Therapy Board of New Zealand/Te Poari Whakaora Ngangahau o Aotearoa [OTBNZ], 2016.).

According to New Zealand's regulatory board (OTBNZ), occupational therapists must hold an occupational therapy bachelor's degree from an accredited institution, or qualifications and experience assessed by the Board as appropriate. An individual must also hold an annual practising certificate through the OTBNZ, and to gain registration must engage satisfactorily in their OTBNZ e-portfolio. The e-portfolio is an online process where therapists identify self-assessments about areas of their practice aligned to OTBNZ competencies they want to develop, develop relevant goals, and complete necessary associated activities to achieve these outcomes. The OTBNZ also outlines the legal obligations of engaging in supervision as required by the therapist (e.g., weekly for new graduates). New graduates, overseas trained therapists, and therapists returning to employment must pass through a review process, that helps to determine their competency to have any conditions on their scope of practice removed (e.g., the conditions under which they must practise occupational therapy). The OTBNZ and its regulations ensure that therapists abide by the Health Practitioners Competence Assurance Act 2003, thus helping to ensure that clients of health and disability services, that are provided by occupational therapists, are of high quality, effective and safe.

History and Context

Health and Occupational Therapy

The World Health Organisation (WHO) defines health as a state of "complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO, 2006), p.1). WHO defines wellbeing as "a state in which an individual can realise their own potential, cope with normal stresses, work productively, and contribute to their community" (WHO, 2001, p.1).

Whakaora ngangahau/occupational therapists working in physical health-based roles work alongside individuals from a range of age, gender, ethnic, cultural and social backgrounds who present with a variety of diagnoses, either in an acute hospital setting (e.g., a medical or surgical ward), or in rehabilitative-based hospital and community settings (e.g., urban and rural locations) typically involving chronic/long-term conditions such a cerebrovascular disease/stroke, cardiovascular and pulmonary diseases (e.g., heart disease, chronic obstructive pulmonary disease), degenerative neurological diseases such as multiple

sclerosis, or musculoskeletal conditions such as rheumatoid or osteoarthritis. This results in a diversity of health conditions and personal backgrounds of clients or people that the occupational therapist works with and requires a broad range of occupational therapy and health-related knowledge and skills, and specialist training (Donnelly, Donnelly, Brenchley, Crawford, & Letts, 2014).

Occupational therapy's key focus is to facilitate and promote participation in meaningful occupations such as activities of daily living, leisure, education/employment (un/paid roles) (Law, 2002). One of occupational therapy's core beliefs is in the benefit of meaningful occupation to sustain and promote health and well-being in all its forms (e.g., physical, mental, social) (American Journal of Occupational Therapy, n.d.). Occupational Therapy utilises practice models such as the Canadian Model of Occupational Performance and Engagement (CMOP-E), and the Model of Human Occupation (MOHO) to promote wellbeing through knowledge and skills that facilitate engagement in occupations and positively influence the health and well-being of individuals, whānau and wider communities (Reitz, Scaffa, Commission on Practice, & Dorsey, 2020).

As of 2018, Aotearoa NZ had 49% of its OT workforce registered and employed in District Health Boards (DHBs) typically in hospital and community-based and government-funded health facility settings, and 23% worked in private practice (i.e., providing ACC-funded interventions). The remaining 28% worked in non-governmental organisations (NGOs), government agencies, education providers (e.g., schools), private rest homes and hospitals. Approximately half (i.e., 58%) of the occupational therapists employed by DHBs work in physical health roles, with 42% in mental health roles. Almost two thirds (i.e., 67%) of the therapists employed in private practice work with physical health conditions. The majority of occupational therapists are employed in the densely populated areas of New Zealand, however, around 14% of New Zealand's population live in rural areas. Currently, there is no published data that quantifies the number of OTs who work rurally (OTBNZ, 2018).

With an ageing population, health concerns and comorbidities often increase. For example, osteoarthritis, stroke. OT plays a key role in facilitating independence for individuals with these diagnoses with the provision of equipment, education, and the promotion of aging well strategies (e.g. Installation of rails, connecting with community organisations, and fear-of-falling advice). Research shows small changes, such as environmental adaptations (i.e., removing rugs, installing rails) promote independence and engagement in occupations such as showering and meal preparation (Johansson & Björklund,

2015). Therefore the role of occupational therapists in physical health is crucial in the promotion and facilitation of health.

Aotearoa New Zealand Physical Health Context

In Aotearoa New Zealand, there are inequities between the health of urban dwellers, and rural dwellers, with higher rates of morbidity and mortality in rural areas (Marek, Wiki, Campbell, Kingham, Sabel, Tomintz, & Hobbs, 2020). The factors that influence this vary, however, generally the rural population are older, at times participate in activities not conducive to health (e.g., heavy farm work), and are living in more isolated regions of the country that present barriers to accessing healthcare and health-related services (Ministry of Health, 2007). For example, rural-dwelling individuals are less likely to have seen their general practitioner (GP) in the past year and less likely to have received immunisations/vaccinations. Rural dwelling males, in particular, are more likely to have accessed their GP for injury or poisoning than those living in urban settings. Although access to public and private hospitals does not significantly vary between locations, or based on gender, rural-dwelling females utilise public hospitals more frequently than men, and their urban counterparts (Ministry of Health, 2007). This data highlights the health discrepancies in access to healthcare for the rural population.

Clarifying Terminology

Rural Practice

It is generally understood that there is no agreed definition of rural (Ricketts, Savitz et al., 1994; Litchfield, 2002; London, 2002; Janes, 2006). The concepts of rurality are tied to a variety of factors including geography, demographics and history. This image of rurality is echoed by the discrepancy between individuals who access rural healthcare in Aotearoa New Zealand, and the individuals who fit with the NZ Stats definitions of what rurality is, meaning, those who access rural health care are not necessarily defined as rural individuals. As shown in Table 1, the urban/rural population concept as defined by the Ministry of Health. According to the Ministry of Health (2007), 40% of rural health service users are technically classified as ‘urban’ dwellers, whereas 20% who are defined as rural dwellers access urban services. (Refer to Table 2, census data about urban/rural population NZ.) As a result, it is challenging for researchers or practitioners to differentiate between definitions of urban and rural and boundaries that delineate dwellers and thus their access to services (Fearnley, Lawrenson & Nixon, 2016). As highlighted in Figure1, classification of NZ urban-rural boundaries. Although significantly more individuals reside in urban areas within New

Zealand, as evidenced in Table 2, according to the OTBNZ (2018) report, approximately 14% of New Zealand's population is reported to reside in rural areas. However, at present, there is no evidence detailing the number of occupational therapists who cover/work in these areas.

Table 1

Definition of urban and rural areas (Ministry of Health, 2007).

Main Urban	Towns and cities with a minimum population of 30,000 people
Secondary Urban	Towns with a population between 10,000 and 29,999 people.
Main Urban	Towns and cities with a minimum population of 30,000 people
Minor Urban	Towns with a population between 1000 and 9999 people.
Rural Centre	Population between 300 and 999 people.
True Rural	Population less than 300 people.

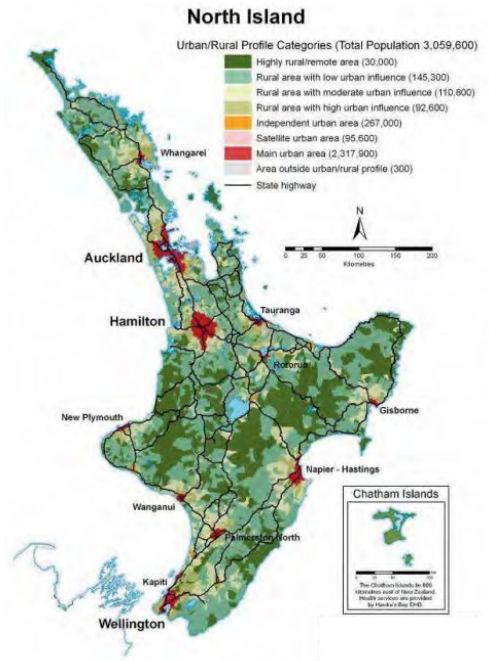
Table 2

Populations by Urban/Rural area type (Ministry of Health, 2007).

Main Urban	71% total New Zealand population
Secondary Urban	6.3% of the total New Zealand population
Minor Urban	8.3% of the total New Zealand population
Rural Centre	2.1% of the total New Zealand population
True Rural	11.7% of the total New Zealand population

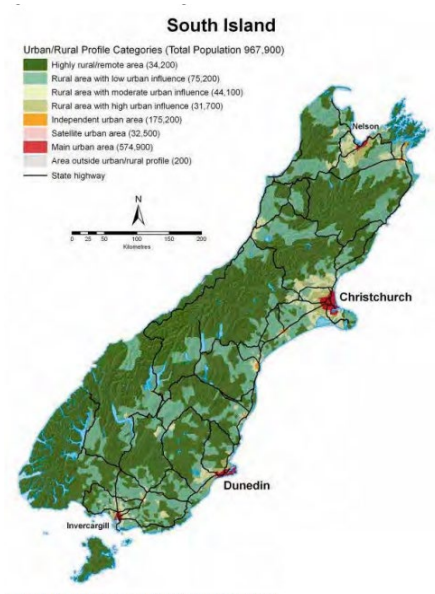
Figure 1:

Urban/Rural Profile categories for the North Island, New Zealand, 2006



Note: Population figures have been rounded to the nearest 100.

Figure 2:



Note: Population figures have been rounded to the nearest 100.

Note: Urban/Rural Profile: Experimental classification. Census of Population and Dwellings, 2006. Reprinted from *Rural Health Challenges of Distance Opportunities for Innovation* by National Health Committee, 2010, National Health Committee.

Job Satisfaction

Job satisfaction as already identified explains an individual's positive attitude towards their profession (Weiss, 2002). There have been large amounts of research published about job satisfaction and the relationship between its effects on productivity levels and retention within the health profession generally (e.g., physiotherapy, social work, nursing) (Mount, Illies & Johnson, 2006; Saari & Judge, 2004; Wegge, Schmidt, Parkes & can Dick, 2007). Thus highlighting the importance of improving job satisfaction for occupational therapists in order to sustain employee performance, reduce staff turnover and to help ensure stability in the place of employment. There is currently no data capturing the factors influencing satisfaction for occupational therapists working in rural, physical health practice context in NZ.

Rationale for Study

As job satisfaction is one of the most compelling issues facing the profession of OT (Mertala, Kanste, Keskitalo-Leskinen, Juntunen, & Kaakinen, 2022) these factors must be explored further. Health professionals are more likely to resign when dissatisfied with their jobs, which has a flow-on effect concerning the loss of institutional knowledge, increased training costs for the organisation, and reduced continuity of care for clients/patients (Jones, 2004; Ray, Wong, White & Heaslip, 2013; Woltmann et al., 2008).

As New Zealand is a sparse country, with the majority being classed as remote or as having low urban accessibility, except for the six major urban areas (Statistics NZ, 2020) there are likely to be many therapists practising in rural environments. Rural practice brings its own set of strengths and challenges, where therapists may need to travel long distances to see service users and work in generalist roles where they are more professionally isolated (Occupational Therapy Board of New Zealand [OTBNZ], 2018). This study aimed to identify the factors influencing the satisfaction of occupational therapists working in physical health in rural New Zealand.

Thesis Structure

This thesis consists of five chapters. Chapter one is an introduction outlining the context of whakaora ngangahau/occupational therapy practice in Aotearoa New Zealand, specifically the physical health field of OT. The researcher outlines her connection to the

project and rationale for selecting the research topic. The researcher also discusses key terms relating to the research including specifically rurality, and job satisfaction.

Chapter 2 provides the results of a literature review conducted as part of this thesis, exploring evidence-based information relating to rural practice, job satisfaction, and OT based physical health practice. The literature review included searches using keywords related to the topics discussed (i.e., job satisfaction, rural practice), was originally limited to 1990 with earlier keystone research being included, published in English, and drew from a range of databases (e.g. ProQuest and CINAHL). Literature that related specifically to the research topic, but was concerned with other areas of OT practice, were selectively included on a limited basis in the review (e.g., due to high specificity to the research question). Although the focus was on these practice topics in Aotearoa NZ, literature from other countries was included in the search. Also, while the search was about Occupational Therapy literature, due to the limited range of published articles found and in order to broaden the review, published literature from nursing and allied health practices were included to provide an inclusive range of perspectives on the issues explored.

Chapter three provides details of the underpinning theory and assumptions, research methodology (i.e., mixed-methods approach to survey research), the key data gathering method (i.e., mixed methods online survey), recruitment and data gathering processes, analytical methods used (i.e., crosstabs, thematic analysis), and ethical and cultural considerations in conducting this study.

Chapter four presents the results of the survey involving both quantitative data and qualitative information. Data relating to participants' levels of satisfaction are explored, including factors influencing satisfaction, and pertinent demographic information. The aim being to present these fs results in a format consisting of key themes arising from the data analysis process. This involves both excerpts from participant's reports and quantitative data constructed in numerical, tabular or graphical-based forms. Utilising Qualtrics, a web-based survey and data analysis tool, the researcher presents findings from both a statistical and narrative perspective.

The final chapter, five, integrates the thematic findings from the survey with key information gleaned from the literature review, drawing on published findings both nationally (Aotearoa NZ) and globally. Key factors influencing job satisfaction for whakaora nganghau-/occupational therapists working in rural physical health fields are discussed in terms of recruitment and retention in these roles and implications for practice and policy. The findings

are compared and contrasted with the published literature and theory related to the topic. Suggestions for further research, that can build on this master's level survey, are also considered.

Chapter Two: Literature Review

The following literature review discusses significant concepts and relevant literature that pertain to the research question: What are the factors influencing satisfaction for physical health Occupational Therapists working in rural New Zealand. The literature review primarily focused on finding and examining peer-reviewed, published literature relating to the job satisfaction of kaiwhakaora ngangahau/occupational therapists working in physical health practice in rural Aotearoa New Zealand. Several studies have been completed that relate to the job satisfaction of physical health occupational therapists, but only a few are specific to rural practice. The analysis of literature relevant to the job satisfaction of occupational therapists working in rural physical health practice settings ensures that the research question, research design and the analysis of findings was informed by evidence. This chapter will discuss the current available literature relating to job satisfaction in occupational therapy, whilst exploring specific concepts, such as rurality and New Zealand practice.

The Structure of this Literature Review

This literature review will explore:

- Definitions of satisfaction, recruitment, retention, rurality, and occupational therapy theory and practice.
- What the literature tells us about rural role/job satisfaction,
- Factors influencing rural role/job satisfaction,
- The relationship between gender and role/job satisfaction,
- Health inequities in rural practice,
- The current New Zealand occupational therapy workforce,
- Factors influencing job satisfaction in rural practice,
- Summarising the key messages from the literature,

- Limitations of literature review,
- Exploring the gaps in current literature related to the research question.

Literature Review Method

Literature was identified through online research electronic databases 'ProQuest,' 'Cumulative Index of Nursing and Allied Health Literature' (CINAHL Complete) and via the Otago Polytechnic library database. Key search terms included but were not limited to; 'occupational therapy,' 'physical health,' 'satisfaction' and 'rural.' Boolean Operators (i.e., AND, OR, NOT) were utilised to provide a more focused search, and to limit unrelated literature.

Initially, literature from before the 1990s was omitted, to ensure that literature was relevant to the current time and therefore up to date evidence was accessed to support effective decision making throughout this thesis (Tam, Lo, Khalechelvan, Seah & Goh, 2017). However, during the initial review of the literature, it was identified that some literature dated before the 1990s (i.e., seminal works) provided some significant background information, key ideas and concepts that aligned with the research question and met the search requirements. The literature included in the review which dated prior to the 1990s was limited to data that demonstrated relevance to a key concept/s or confirmed data and themes from more recent literature.

Inclusion Criteria

In the completion of background literature searches, it was identified that some of the studies related to satisfaction did not relate to physical health whakaora ngangahau/occupational therapy practice. However, the researcher included this literature to add depth and understanding of the issues that were also identified in the literature specifically related to physical health occupational therapy. As a result, the literature review was widened to include job satisfaction and occupational therapy generally.

Occupational therapists are included in the allied health professional group, including physiotherapists and social workers, among others. Initially the literature review was limited to include the published literature on occupational therapist experiences only. However, the decision was made, in consultation with my supervisors, to broaden the search to include literature relating to role satisfaction of other allied health professionals in order to

add breadth and depth to the literature review, and to be able to compare with findings that were identified in the OT specific literature.

Other inclusion criteria included.

- Key search terms: ‘occupational therapy,’ ‘physical health,’ ‘satisfaction’ and ‘rural’,
- Relating to occupational therapy and other health professions (nursing, physiotherapy among others),
- Literature reviews, peer-reviewed journal articles, books, and thesis’,
- English language, or research translated into English,
- Research less than 10 years old (unless keystone/seminal research).

Key Terms Used in the Research Question

Defining Role/Job Satisfaction

Satisfaction is defined by the Macmillan Dictionary (n.d.), as “The feeling of pleasure that you get when you achieve or obtain something that you want”. Occupational satisfaction is widely documented as a core concept of our profession (Schultz & Schkade, 1997; Morgan, 2010). It is defined as being satisfied with one’s occupational performance or ability to engage in a meaningful and purposeful activity (Sewpersadh et al., 2016). The term occupational satisfaction is similar to job satisfaction when applied to one's work, as job satisfaction can be defined as a feeling of positivity towards a specific position, job, or aspects within the role (Panchasharam & Jahrami, 2010). According to Weiss, (2002) job satisfaction is defined as a worker's attitude towards their profession. In preparation for this study, both terms have been researched in the literature.

Defining Rurality

Rural practice necessitates practitioners have a larger skill base to cope with the diversity of caseloads and demands with larger settings often having more specialised wards (e.g., wards specific to respiratory, cardiology). There is a large body of evidence that validates the complex demands of rural settings on occupational therapists, which contradicts the historical belief that rural practice is less skilled than urban specialised practice and tends to undermine the value of rural OT practice (Michetti & Dieleman,

2014). Adding to this is the unresolved issues of isolation (e.g., therapists spending periods working alone) and the related dissatisfaction that many therapists experience has been found to increase the likelihood that occupational therapists will leave rural practice (Lannin & Longland, 2003).

Rural allied health practice presents its unique challenges, demanding an extensive general knowledge-base and skills, in order to meet the demands of diversity and the requirements of clients in an environment that is limited in resources and support. Rural settings have different geography, demography and social contexts compared to urban areas, with higher morbidity and mortality rates than those residing in urban settings. This is linked to the limited availability of health services, and inadequate numbers of health practitioners in rural areas, where service users and health professionals need to consider distance and travel in order to provide health services (Paliadelis, Parmenter, Parker, Giles, Higgins, 2017). New Zealand District Health Boards have identified difficulty with sourcing experienced therapists to fill generalist roles in rural settings. Often new graduates are applying for their first role in these areas, however, there is often a lack of experienced occupational therapists to provide supervision and support in these rural settings (Valentine, McLean & Rahiman, 2017).

Occupational Therapy Theory and Practice

What the Literature Tells us About Rural Occupational Therapy Job/Role Satisfaction

There have been international studies related to the job/role satisfaction of rural occupational therapists (Bailey, 1990a; Freda, 1992; Mills & Millsteed, 2002; Moore, Cruickshank, & Haas, 2006). However, it is acknowledged that rural settings present different challenges in practice for rural therapists compared to their urban counterparts, such as isolation, workload, and career progression (Christiansen & Baum

1997). Moore, Cruikshank, and Haas, (2006) completed their hermeneutical phenomenological study that identified autonomy and diversity in role and caseload (i.e., working with a variety of diagnosis's), and success/achievement in working with individuals on their health and occupational issues to be crucial for the job satisfaction of rural occupational therapists. However, they also found that occupational therapists in this study had difficulty explaining their role and felt undervalued by other health professionals, which contributed to lower job satisfaction. In a more recent peer-reviewed literature review completed by Hayes et al., (2008) occupational therapists who reported feeling satisfied with their current employment, also identified that time pressures negatively impacted on their

role/job satisfaction. Findings by Scanlan and Hazelton, (2010) identified that occupational therapists working in the mental health field in Sydney, Australia, a lack of respect from other health professionals as a key contributor to lower job satisfaction.

The challenges of rural occupational therapy practice specifically in Aotearoa New Zealand are considered to be: time spent travelling, working outside of their scope of practice (i.e., completing tasks they are not comfortable with/ trained in), lack of support and access to supervision, isolated practice, limited professional development, and limited career progression (Occupational Therapy Board of New Zealand, 2018). However, this does not inform about whether these factors reduced job satisfaction, retention, and recruitment. Therefore, there is a lack of information on this topic in rural New Zealand. The following section will explore the key factors that influence job satisfaction based on the international literature.

Factors Affecting Job Satisfaction: Recruitment and Retention

There are substantial amounts of literature relating to satisfaction and its effects on productivity levels and retention within occupational therapy (Mount, Illies & Johnson, 2006; Saari & Judge, 2004; Wegge, Schmidt, Parkes & Van Dick, 2007). Sweden (Eklund & Hallberg, 2000), America (Randolph, 2005) and Australia (Meade, Brown & Hawke, 2005; Moore, Cruickshank & Haas, 2006; Simon, 2006) have widely researched the job satisfaction of occupational therapists. The key findings from this literature have identified communication, team cooperation, managerial feedback and caseloads as key factors influencing job satisfaction of occupational therapists. However, these findings are not specific to rural practice or the climate of the occupational therapy profession in New Zealand.

One article discussed the job satisfaction for occupational therapists working in mental health in Bahrain (Panchasharam & Jahrami, 2010). Most of the occupational therapists identified they were moderately satisfied with their jobs, the nature of their work and rewards. However, salary was identified as the highest contributing factor to job/role dissatisfaction (Panchasharam & Jahrami, 2010). This might suggest that role satisfaction and the contributing factors might vary from country to country, given the different context settings or each country/ area.

There have been several studies examining role satisfaction among occupational therapists from various viewpoints, including settings (i.e. inpatient and community), extrinsic factors (external to the individual such as salary, career progression) and intrinsic

factors (feeling valued, personal development, and diversity of practice) (Randolph, 2005). Hellickson, Knapp, Ritter, & Martin (2000) used a self-administered questionnaire (n=54) to obtain information regarding the level of job satisfaction of Wisconsin-based occupational therapists working in a school setting or non-school-based (including hospital, nursing facility, mental health, private practice, home health, and early intervention) practice settings. The survey utilised Likert scales, closed (yes/no) questions, multiple-choice, item ranking, and a qualitative open-ended question. The study identified that occupational therapists working in the school-based setting had higher levels of job satisfaction than occupational therapists who did not work in school-based settings (Hellickson et al., 2000) citing healthcare policies (e.g., Medicare) for non-school based therapists may have contributed to differences in overall satisfaction ratings.

Survey research completed by Eklund & Hallberg (2000) in an in-patient Swedish psychiatric setting involving occupational therapists, identified high levels of satisfaction for most of the occupational therapists employed. This study showed that key positive influencers on job satisfaction for occupational therapists in this setting included general satisfaction with work, team environment and feedback from managers (Eklund & Hallberg (2000). A survey conducted of health professionals working in mental health settings in Australia (N=19), including occupational therapists and social workers, found work stressors to include minimal resources, conflicts/team dynamics, high caseloads, and the occupational therapists' self-doubt around their practice (Lloyd & King, 2004).

The satisfaction of health professionals, including occupational therapists, was researched in a cross-sectional study by way of a telephone survey by Randolph, (2005). Intrinsic factors of feeling valued, professional development opportunities, assisting clients to get well, and the diversity of roles were found to have the greatest impact on job satisfaction compared with extrinsic factors such as salary, the flexibility of time, and the clinical ladder (Randolph, 2005). Although definitive conclusions could not be made with cross-sectional designs, results may assist in highlighting strategies for promoting positive situations of the health professionals included.

Both Jenkins (1991) and Madill et al., (1987) identified the relationship between job satisfaction, and the ability to retain occupational therapists, in that therapists who are satisfied with their work are less likely to resign. This highlights that there is a need to ensure organisations employing occupational therapists have the knowledge of techniques and strategies for increasing role satisfaction. As retention has been identified as paramount to

ensure that Occupational Therapy continues as a viable profession, providing a range of services and innovative care' (Sutton & Griffin, 2000).

Gender Factors Influencing Job Satisfaction

The gender of occupational therapists has also been considered as a potential contributing factor to levels of job satisfaction. A collective case study utilising semi-structured interview questions in telephone interviews with 16 occupational therapy managers was completed by Meade et al. (2005). Meade et al. found no significant differences in job satisfaction relating to client contact, client success, and relationships within the team between female or male occupational therapists. Whereas factors leading to increased job dissatisfaction for those who identified as male included limited earnings and recognition, in contrast to those identifying as women who reported respect from others as an important factor (Meade et al., 2005). In a survey conducted by Turgeon and Hay (1994), with male occupational therapists, (N=55) it was found that those with less than 7 years of practice had lower job satisfaction compared with their senior colleagues (i.e., more than 7 years in practice). A survey distributed by Watson (1983, as cited in Brown, 1995) stated that occupational therapists who identified as male had higher satisfaction in the areas of co-worker relationships, promoting independence, job variety, client contact and work fulfilment. Factors that led to greater job dissatisfaction included the potential to earn a higher income, reduced opportunities to progress in the profession, limited awareness of the diversity in occupational therapy roles, and a low public recognition about the profession (Parish, Carr, Swinski, & Rees, 1990).

Literature that has explored the factors influencing job satisfaction for female occupational therapists has identified job flexibility and salary (Okerlund, Jackson, Parsons, & Comsa, 1995), positive interaction with colleagues, professional development, and appropriate staffing levels, (Jenkins, 1991), autonomy, the occupational therapy role itself (Davis & Bordieri, 1988), and job security (Nordholm & Westbrook,1982) as key factors. Whereas issues that lead to greater job dissatisfaction for female occupational therapists related to limited support from an organisational level, limited professional development opportunities and unsatisfactory working conditions (Davis & Bordieri, 1988), poor pay, and limited constructive feedback (Nordholm & Westbrook, 1982). The literature on gender identified several common factors, where satisfaction was influenced by both intrinsic and extrinsic factors (salary, professional development, working

relationships, diversity of caseload) however, the significance of these in relation to their importance varied between the genders.

Health Inequities: Rural Compared to Urban Regions

Health inequities exist between rural and urban populations in Aotearoa NZ. Proportionally, rural populations in NZ experience lower health status compared with urban communities primarily due to the inability to provide reliable, accessible services (Millsteed, 2009). While at the same time, population growth in rural areas is expected to grow faster than urban areas, with an increase of 100,000 individuals over the next 20 years (Health and Disability System review, 2019). According to the National Health Committee report, (2010) life expectancy was similar for rural and urban populations, but with the life expectancy of Māori residing rurally being slightly lower than their urban counterparts. Recent literature found inequalities in disease rates, service access (e.g. appointments) and health outcomes (e.g., increased mortality rates) of rural-dwelling individuals compared to urban dwellers (Fearnley, Lawrenson, & Nixon, 2016). Key factors that result in reduced access to health for those residing rurally, and likely contribute to these health inequities include higher rates of socioeconomic deprivation, geographical and distance-related barriers, transport difficulties, telecommunication restrictions (e.g., lower cell phone and internet coverage), and the cost of accessing health services.

Attention ought to be paid to factors affecting job satisfaction for occupational therapists, which will, in turn, impact recruitment and retention in the rural sector, given the relationship between satisfaction and retention (therapists are less likely to resign if they are satisfied in their roles). Despite the studies identified, little is known about rural occupational therapy practice in Aotearoa New Zealand, and the researcher has not found any New Zealand literature that examines specifically the role/job satisfaction of rural occupational therapists working in physical health practice in NZ. Limited access to appropriate health professions across all disciplines in many communities contributes to the poor health status of individuals in rural communities (Comer & Mueller, 1995). Unfortunately, difficulty with retention and recruitment in rural communities is not limited to occupational therapists, with nursing, physiotherapy, and OT, among others, citing difficulties (Elliot-Schmidt & Strong, 1995; Wolfenden, 1996).

The Structure of the Aotearoa New Zealand Occupational Therapy Workforce

The profession's size in Aotearoa New Zealand is relatively small, with only 3,219 occupational therapists holding a current practising certificate (Occupational Therapy Board New Zealand [OTBNZ], 2021). Compared to other allied health professional groups in NZ, there are significantly greater numbers of professionals registered, such as 5,133 registered physiotherapists (Reid & Dixon, 2018) and 8,019 registered social workers (Stats NZ, 2018). The OTBNZ releases a report annually detailing the structure of the occupational therapy profession, with these details outlined below. However, in the literature reviewed there is a lack of data pertaining to rural occupational therapy practitioners in New Zealand.

Factors Influencing Job Satisfaction in Rural Practice

Professional Development

The accessibility of professional development is identified as a significant and key challenge impacting practice for rural clinicians (OTBNZ, 2018). Studies have also shown that a lack of access to professional development (e.g., courses, workshops) is a leading reason for difficulties in retaining health professionals, including allied health professionals, and has been found to be strongly linked to an individual's job satisfaction (Paliadelis, Parmenter, Parker, Giles, & Higgins, 2017). The National Rural Health Group of the Australian Physiotherapy Association (APA) (1996) highlighted the need for broad professional development opportunities and stated,

[I]n isolated rural or remote Australia, there are two fundamental levels of knowledge required for the delivery of effective services for consumers. The first...is the domain of the specific profession; that is clinical and practical therapy skills. The second involves the essential knowledge required to effectively deliver these clinical and professional skills to clients and communities; that is contextual service delivery skills which enable a therapist to be optimally effective in a remote area as opposed to a metropolitan setting (p.3).

Peer Support and Networking

Shared work practices, such as in-services, joint home visits and local networking have been identified as helping to meet the peer support and networking needs of rural practitioners (Sheppard, 1995). With the development of technology such as video calling, professional development is more accessible than it was historically. Video conferencing for health professionals is considered a beneficial tool for promoting information sharing, clinical

reflection, and professional development opportunities in remote communities (Sen Gupta et al., 2012). Videoconferencing is also beneficial from a resource perspective for employers, where there is limited travel and time required to participate, compared to paying training fees and travelling costs to attend a course typically in an urban setting (Valentine, McLean & Rahiman, 2017; Frueh, Grubaugh, Egede, & Elhai, 2009). However, as technology continues to develop, this is an area requiring continued review and analysis regarding its utilisation in rural practice.

Resources

The literature reviewed identified accessing resources for the provision of health services as a challenge for rural health professionals (Lloyd & King, 2004). Challenges with limited availability of treatment tools, assessment tools, and equipment were identified as impacting negatively on people's jobs (Tariah, Hamed, Alheresh, Abu-Dahab, & Al-Oraibi, 2011). Evidenced specifically by the impact of an equipment management system (Accessable) utilised by some New Zealand occupational therapists, in which the frustrations of use were found to contribute to lower levels of job satisfaction (Valentine, McLean & Rahiman, 2017).

Summary and Key Messages

Job satisfaction can be defined by the positive feeling towards one's position of employment, the position overall, and the aspects within it and the degree to which an individual likes their work (Panchasharam & Jahrami, 2010). Both intrinsic and extrinsic factors were found to influence satisfaction within the literature explored. Autonomy, diversity in roles and caseload, and the feeling of achievement all contribute to the job satisfaction for occupational therapists, regardless of setting type (Moore et al. 2006; Eklund & Hallberg, 2000). The primary factor for job dissatisfaction of occupational therapists is the misunderstanding of what the occupational therapy role entails, by both fellow health professionals, and service users. Many therapists also reported the issue was prevalent in the managerial understanding of the occupational therapy profession, particularly in managers not understanding how occupational therapists interacted with their clients/service users (Moore et al., 2006). Later research, completed by Scanlan et al. (2010) mirrored many of these findings, however, interestingly, therapists were found to report their managers had a clear understanding of their role and respected their service. Stress and burnout also contribute to job dissatisfaction, performance, and quality of practice (Bassett & Lloyd, 2001).

Limitations of the literature review

The literature came from a variety of sources, primarily metropolitan areas, or large rural settings (such as Australia, and Canada). Literature specific to New Zealand was limited, making it difficult to generalise findings from overseas literature to the current professional climate of occupational therapy in New Zealand. Particularly difficult as contexts and sample sizes are vastly different to New Zealand, (e.g., rural Australia compared to rural New Zealand). However, the reviewed literature provides a basis and foundation to understand the New Zealand context.

Gaps in the literature

While there was a notable amount of literature pertaining to the job/role satisfaction of occupational therapists, there was an absence of literature found that explored the satisfaction of occupational therapists in physical health in Aotearoa New Zealand, specifically of therapists working in rural health. With the exception of the Webster, (2017) study exploring the issue in mental health practice. While some articles briefly identified satisfaction, it was incidental or, minor findings in the literature of other topics, such as retention and recruitment. Many of the articles and literature reviewed were older (i.e., published more than 10 years ago), thus not highlighting the current experience of therapists. Many of the studies available were from Australia, Canada, and the United States, all of which have social, cultural, institutional, and political differences to Aotearoa NZ. There was a dearth of Occupational Therapy literature on the topic international and none found in NZ. Therefore, supporting the need for further research on this topic being completed in NZ. Furthermore, there is limited understanding of the culture of physical occupational therapy and how this influences job satisfaction.

This literature review has identified a gap in the available published literature related to NZ occupational therapy, rural, physical health practice. Limited variety in literature makes it challenging to make conclusions about an issue based on such an absence of evidence. For example, much of the literature about job satisfaction for occupational therapists was based on large metropolitan areas, therefore not necessarily relatable to rural settings and rural practitioners. This gap highlighted the need for further understanding and was instrumental in the researcher's decision to explore this area further.

New Zealand has unique characteristics and history that impact on the culture of the individuals and the wider occupational group, with significant differences to the countries

included in the international literature reviewed. A study into the role satisfaction of occupational therapists in rural New Zealand would assist in identifying and addressing relevant issues that have influence on the future of occupational therapists working in physical health and their services to their clients. It can also start the discussions with management and professional bodies regarding the progression of the rurally-based Occupational Therapy profession in New Zealand.

Summary

Upon the review and analysis completed in this literature review, the researcher's conclusions are whether research completed in New Zealand would mirror factors identified in research conducted overseas. Specifically, relating to the role satisfaction of physical health occupational therapists working in rural Aotearoa New Zealand. The researcher identified a gap in the literature relating to job satisfaction and hopes this project will provide a snapshot of the current professional environment in NZ, and may further identify areas for future research. The identified gaps in the literature related to the research question have helped to provide a rationale and basis for this planned research and how the survey questions can be constructed.

Chapter Three: Methodology

Introduction

In this chapter, the research design will be outlined providing details about the mixed-method research approach used in this study. This research design was deemed to be a suitable way to answer the research question:

What are the factors that impact job/role satisfaction of rural occupational therapists working in physical health roles in Aotearoa New Zealand?

The rationale for the use and development of a mixed-methods designed survey (the method used) will be identified, along with the choice and rationale for the survey questions. An account of the piloting of survey questions, inclusion and exclusion criteria, the subsequent sample, recruitment method, the analytical techniques used, and the ethical and cultural considerations involved in designing this research will be discussed.

Research Methodology and Underpinning Theoretical Approach

Research relating to health often utilises a combination of qualitative and quantitative methods within a single study, and this is termed mixed-methods research where utilisation of the two paradigms allows for the exploration of the phenomena in different ways (Tariq & Woodman, 2013). This is evidenced by the idea that quantitative methods are unable to access data such as lived experience and personal perceptions, that health researchers are often interested in (Sale, Lohfeld & Brazil, 2002). Alternatively, quantitative data collection methods can achieve what qualitative methods can not, which is the measurement and analysis of phenomena and the correlation between relationships.

Quantitative research approaches are based on the positivism paradigm, meaning that phenomena can be examined using quantitative research methods (e.g., statistical analysis), and based on a belief that there is a verifiable truth - (Guba and Lincoln, 1994). Quantitative research allows a large amount of data to be collected, whilst qualitative components facilitate the opportunities to develop a more detailed narrative. Therefore, components of both methods were utilised, to gather both breadth and depth of information (Tariq & Woodman, 2013). An online survey was designed and implemented to provide a snapshot of the current professional climate, without the limitation of geographical barriers, whilst also allowing for a larger participant population, thus facilitating a larger body of data.

In quantitative research, there is no relationship between the researcher and the participants, as both are considered separate entities, with the ideology that "inquiry takes place as through a one-way mirror" (Guba and Lincoln, 1994, p.110). Therefore, the researcher can study the specific phenomenon, through quantitative research methods and scientific protocols (e.g., valid and reliable research methods, able to be repeated) that will not influence/bias the result/outcome. The goal of quantitative research is to discover the truth about phenomena being examined, through scientific measurement and analysis methods that explore the correlation or relationships between variables being studied and can provide evidence for causations (Denzin and Lincoln, 1994). A survey research method is one form of quantitative research data collection.

In comparison, qualitative research is based on the general premise that truth/s are constructed and there are varying ways to understand reality. Qualitative research considers that there are multiple truths, based on the individual's ever-changing reality. The focus of

qualitative research is on meaning and personal experience. There are several approaches in quantitative research such as interpretivism (individuals shape society) (Secker et al., 1995) and constructivism (knowledge is constructed from experience) (Guba and Lincoln, 1994), critical inquiry and post-modernism (values subject options of an individual) (Crotty, 1998). Generally, techniques utilised in qualitative research involve observation and/or interviews. Participant numbers are limited as the focus is on small, specific samples, which provide in-depth information about the phenomena being studied (Vasileiou, Barnett, Thorpe, & Young, 2018).

In quantitative research, a survey is one type of data collection utilised to gather statistical information relating to the research topic. In descriptive quantitative research, a survey is also a common and effective tool to gather data (Singleton & Straits, 2009). The opportunity for respondents to give more in-depth accounts and experiences is provided with the use of open-ended questions within the survey. The questions for this study were informed by the literature relating to the topic of job satisfaction for occupational therapists (e.g. the use of open-ended questions).

It is generally accepted that qualitative and quantitative methods can be utilised in combination. Namely, that both concepts share the same goal of further understanding the world in which we live (Tariq & Woodman, 2013). Raven, Doran, Kostrowski, Gillespie, and Elbel, (2011) stated that a combination of quantitative and qualitative research is beneficial in health, where, at times, the complexity of the topic requires data from a large population. There are several noted reasons for the combination of methods, one of which is to gain a more complete understanding of the topic, another, to achieve complementary results utilising the strength of one method to reinforce the other (Raven, Doran, Kostrowski, Gillespie, and Elbel, (2011).

Combining qualitative and quantitative components to a research survey was selected for this research project, based on the above considerations of mixed-method research. By utilising the strengths from both methodologies, the researcher was able to gather numerical survey questions (e.g., number of therapists in each age bracket). Depth can be added to results from the survey by providing an opportunity for participants to share more details in their answers to survey questions (e.g., ‘what was your reason for leaving your previous role?). Thus, gaining insights into the participants' perspectives on the topic of interest in this study. The implementation of mixed methods research design allowed for a survey that would glean both quantitative and qualitative data that would provide a richer, more fully informed response to the research question.

Survey Design, Development, and Methods

Data was collected using various survey question formats. These included multiple-choice, text answers, rating scales and matrix design questions. Thus, ensuring the data collected was appropriate for the questions asked. Several of the survey questions required the participants to rate their experiences. Some questions allowed for further discussion, for example, the rationale for leaving previous employment. Other questions asked for statements therapists wished to make regarding satisfaction, allowing for a more in-depth understanding of the current environment from the therapist's perspective, and adding experiences to quantitative data.

The mix of the different types of survey questions facilitated the gathering of the superficial level of data and more in-depth information. The variety and focus of the questions the researcher utilised were in part determined by what had been included in previous studies, this was not limited to occupational therapy specific practice, in order to increase rigour in this study. Participants were asked to identify their satisfaction relating to specific aspects as identified in the research literature, such as their current satisfaction, potential factors e.g., perks, staff relationships. Survey participants were also asked about previous employment and about what factors contributed to them leaving these roles. Thus, highlighting potential retention issues, without making it the sole focus of the survey. By basing some of the questions on existing literature relating to concepts similar to satisfaction from a variety of overseas and local literature it was anticipated that this could provide opportunities for comparison between Aotearoa and overseas contexts.

Closed questions were used alongside open-ended questions, or 'other' options to provide an opportunity for a more in-depth narrative of the participants' views (Marcinowicz, Chlabicz & Grębowski, 2007; Ponto, 2015). The reason for using open and closed type questions was to reflect the mixed methods methodology chosen and thus to provide both quantitative and qualitative data/responses to fully inform the research question. The survey also gathered general demographic information such as gender, age, location, area of employment. In total, the survey consisted of 46 questions and averaged around 20 minutes to complete (Refer to Appendix B).

Creating an online survey that was accessible nationwide, to all registered occupational therapists was chosen as it provided the opportunity to ensure that the survey had the greatest geographical distribution of participants (Sue & Ritter, 2012). Surveys are a low-cost option, with no administration fees or postage (De Vaus, 2002),

and provide the opportunity for honest feedback without time restraints in travelling to meet with participants or other researcher pressures. Thus, meeting the requirements of the researcher and the completion of a small (or 60-point) master's thesis project.

Although there are challenges of an online survey (computer and technology needs/ misplacing survey link) the researcher considered that an online survey was the most appropriate form of information gathering for this research project hence the choice to use this method of data gathering. These challenges were likely rectified in that computer access is essential in current practice, and that lost/deleted emails can be recovered. Analysis of online surveys is clear and straightforward, with the ability to import data directly, appropriate data saved, and the removal of non-related information or data. As a result, the survey questions, and the content of the survey are a direct reflection of the information identified in the literature review.

The researcher elected to use 'Qualtrics', an online survey development software system, because of its user-friendly nature of the development process (step by step instruction of survey development) and the flexibility of question design allowed, which was considered important given the longer nature of the survey. Using an online survey required ensuring that the survey was aesthetically pleasing, ordered logically, and clearly formatted, all factors that are considered to increase the response rate (Dillman et al., 2014). These were all features that appeared to be offered by the Qualtrics platform, in addition to the ability to uniquely arrange and format the structure of the survey. So, the design of the survey could include the selection of the number of questions per page and thus allowing for ease of viewing, and the ability to link questions so that respondents did not have to answer questions not relevant to them (see Appendix C for screenshots of the survey format). Qualtrics also allows for ease of collection, all survey responses are automatically available on the Qualtrics system under data and analysis once a submission is made. When all respondents have made their submissions, the researcher can export all the data into excel spreadsheets to assist with data analysis. This simplicity of accessing and organizing the data was considered crucial by the researcher in the identification of available and appropriate survey platforms. Qualtrics was also supported by the technical department of the institution, should any support be required during the development, implementation, or analysis phases.

Survey monkey was considered as an option, however, due to challenges importing data, and the limitation on the type and design of several survey questions, it was decided against its use (Waclawski, 2012). The researcher firstly used tools such as Google and YouTube to troubleshoot any development issues and then the institution's technical

services were consulted about specific formatting queries that the researcher was unable to answer. For example, the formulation of a 'submit' button as opposed to a 'next' button on previous questions and including skip logic formatting (the ability to change the flow of the survey/questions asked based on answers provided) relating to specific questions.

Piloting of the Survey

Initially, the survey was reviewed by 1 occupational therapist as a paper version for piloting. The occupational therapist was identified as an individual who works in a large metropolitan area, thus, would not be eligible to participate in the final survey. Their feedback was utilised to raise any concepts the researcher may not have considered and to identify potential issues with syntax. The survey was inputted onto the online survey platform “Qualtrics”. The researcher’s two supervisors completed a run-through/test of the finalised draft survey format, online through Qualtrics, with final feedback on comments such as adjusting the syntax on some questions. These were incorporated into the final survey form. The online survey took approximately 20 minutes to participate in and the feedback from the pilot was primarily related to the formatting of the survey, such as question numbers, the unclear syntax of ‘question 35’, and the inability to select multiple choice answers in a multiple-choice question. The finalised survey design and questions were adapted to reflect the statements and suggestions from the pilot. In which question locations were changed, with demographic questions moved towards the end of the survey, to potentially increase engagement by building trust and rapport for participants, within the survey. The table in which participants are asked to rate their satisfaction against specific factors was separated into categories. Thus, visually reducing the size of the table and potential to visually overwhelm participants, which would have been off-putting and thus may have reduced the number of individuals who completed the question.

Research collected over an extended period of time was generally more affected by the participants' experiences (Allen, 2017). This survey was available for completion for 2 weeks, to ensure a snapshot of data and to motivate engagement of participants, as participants may become less motivated the longer the study was open.

Data Collection

Participants and Inclusion/ Exclusion Criteria

All occupational therapists working in Aotearoa New Zealand (NZ) are required to be registered with the Occupational Therapy Board of New Zealand (OTBNZ). Therefore,

therapists are unable to practice without registration and thus would be unable to answer questions regarding their current practice in this survey. As the researcher was interested in the experiences of rural occupational therapists in physical health, it was important that these individuals were the focus of the survey. As the focus was on the current environment of the profession in NZ, participation was limited to individuals who are currently practising as occupational therapists.

Rural is generally a challenging concept to define, with all available research defining it as a specific statistical number (Litchfield 2002). However, areas covered do not necessarily have a specific number of inhabitants, or therapists may be based in urban settings yet cover rural areas. Therefore, inclusion criteria gave a general term for 'rural' and gave space for therapists to identify why they considered themselves to be rural practitioner. Participants currently practising in physical health were identified in the inclusion criteria, as health is ever-evolving, and therapists who are not currently practising in a physical health setting may not be able to identify the current environment as it stands. Therefore, individuals were required to identify if they worked in physical health.

Inclusion and exclusion criteria were identified from the literature reviewed, (based on inclusion and exclusion criteria for other research) therefore providing an opportunity to give information on the topic relating to NZ research. The inclusion and exclusion criteria were located within the initial stages of the survey format to ensure that the data collected was from the individuals who would best answer the research question. This structure was implemented in both the pilot study and the finalised survey. Any individuals who answered 'no' to the following inclusion criteria questions were not able to proceed with the survey.

The key inclusion criteria were:

1. Required to be registered with the OTBNZ and have a current APC (annual practising certificate),
2. Currently practising in a physical health role,
3. Identify if they were worked covering a rural setting (but allowed for those who worked in both rural and urban roles/settings).

The only exclusion criteria, were if participants answered 'no' to any of the inclusion criterion above. The survey automatically withdrew participants from the study when a 'no' answer was provided to any of these screening questions in the initial part of the survey. (Refer to copy of the survey in Appendix B.)

Recruitment Method

The OTBNZ was approached with the request of circulating the survey after the researcher identified the OTBNZ as the preferred distributor due to their ability to circulate anonymous links to therapists consenting to research, and the ability to reach a wide audience. The participant information with a survey link was emailed to the OTBNZ requesting they distribute it to the appropriate therapists (from those who selected they are happy to participate in research when they completed their annual registration process). (Refer to Appendix B for a master copy of the online survey. Appendix F for a copy of the participant information. Appendix G for a copy of the recruitment email.)

The aim of the survey was for it to be sent to all registered occupational therapists in Aotearoa New Zealand, then to exclude ineligible participants, therefore helping to ensure a larger sample size. The primary purpose of the survey research was to obtain information from a large sample size in a shorter time frame, thus giving a snapshot into the current environment at the time of the survey's distribution. A survey was utilised to ensure a large population of therapists were provided with the opportunity to engage. Surveys allow for flexibility in administration (by self or by a third party) and more recently are often completed using online platforms, facilitating reduced geographical barriers to engagement. Landreneau, (2009) stated that it is impossible to measure an entire population, it is a sample that is studied, therefore the survey sample must represent the entire population. This was achieved by distributing the survey to occupational therapists throughout NZ, with all levels of experience and in a variety of settings. This is best achieved through providing survey access to a wide number of individuals, with the awareness that not all individuals invited to participate in the research will do so (Landreneau, 2009).

As of March 2018, there were 3,219 registered occupational therapists in New Zealand (OTBNZ, 2021). Participant information and a survey link were sent to occupational therapists registered with the OTBNZ who identified they are happy to receive research opportunities (opting in when applying for the annual practising certificate). As per the OTBNZ policy on distributing opportunities for research involvement. The participant information sheet (Appendix F) advised participants that their responses are anonymous and unidentifiable, thus they will not be personally identifiable at any stage of the research process, including data analysis, or presentation of results.

Data analysis

Data analysis is the process of identifying patterns from data collected, with the aim of summarising these observations (Tolich & Davidson, 2018). It is about making sense of the research data (Bradley, Curry, & Devers, 2007). The design of collection utilised the same online platform as the data analysis, therefore, data did not require alternative storing or moving between platforms for collection and analysis. Data is easily accessible on the Qualtrics system under the 'data and analysis' section, allowing for management and review of data submitted. Qualtrics data selection allows for classification, merging, importing and analysis of data. There are several different tools within the Qualtrics system that allow for the analysis of a variety of data types. These include; text section, Stats IQ and Crosstabs. Text selection allows for text entered (such as 'other') to tag a text entry with specific topics for analysis. Stats IQ facilitates the analysis of trends and can be used in predictive modelling. Crosstabs allows for multivariate analysis of more than one variable at a time which may be more relevant to more measurable data. The utilisation of Crosstabs and the text section allowed for the collection of numerical data (Crosstabs allowing for data comparison, e.g., establishing the potential relationship between experience and overall satisfaction) whilst the text section allowed for participants to further explain their experiences in the depth they felt required.

Ethical and Cultural Considerations

> *"Ethics is about values, and ethical behaviour reflects values held by people at large. For Māori, ethics is about 'tikanga'- for tikanga reflects our values, our beliefs and the way we view the world." (Te Ara Tika, n.d.).*

This research project was granted ethical approval following an ethics application to the Otago Polytechnic Ethics Committee (approval number 877), (See appendix D) and the Ngai Tahu Research Consultation Committee (see Appendix E). Furthermore, the researcher is a New Zealand-registered Occupational Therapist with a current practising certificate, thus meeting the requirements of the Health Practitioners Competence Assurance Act 2003.

Within descriptive quantitative research, there is potential for institutional harm, due to the confidentiality and autonomy of the data gathering method. Individuals may have been forced to reflect on aspects of their jobs and employment where they have the potential for an emotional response. Particularly, in response to reflection caused

by the nature of the research questions (Tolich & Davidson, 2018). This potential harm was considered and the provision of services and networks in which the participant can seek support if they feel required, such as management, union representatives, and Māori Health kaumatua. Participants were encouraged to seek guidance, advice, or support if when completing the survey there arose any issues they were concerned about. Although no remuneration was provided to participants the survey was concluded by a message thanking participants for their involvement in the survey and adding to the growing body of occupational therapy literature.

Informed consent

Informed consent details the risks, benefits, and alternatives that are critical to the individual in the decision-making process (Spatz, Krumholz, Moulton, 2016).
To ensure informed consent, it was important that survey participants volunteer their participation, and were aware of the ability to withdraw at any time before submission of survey results. Participants were fully informed of the survey process and how the information would be stored. Before commencing participation in the survey, survey participants were provided with a participant information sheet located in the email invitation. The participant information sheet explained the rationale for the research, information about the researcher, project aims, and types of participants sought, generalised information about the survey, examples of survey questions, average completion time, and the anonymity of the survey. It highlighted that participants could withdraw at any time before survey submission. Participants were provided with the contact information of the researcher and research supervisor should they wish to question or clarify any part of the research process (Appendix F).

Due to the potentially sensitive topic of job/role satisfaction (e.g. individuals identifying issues specific to their setting), and the potential institutional harm to an individual, if their results were known by colleagues, an anonymous survey was a key factor in promoting participant response. Surveys facilitate secure and anonymous data gathering, thus reducing occupational harm and increasing participation levels (Sue & Ritter, 2012). The first page of the survey requested participants click ‘yes I consent’ or ‘no I do not consent to participate in the survey’.
Those who clicked ‘No, I do not consent’, were not able to continue their survey participation, with the survey automatically screening ‘no’ answers and skipping to the end of the survey. The consent question was programmed to require an answer, and participants

were unable to continue if a 'no' answer was provided. Participants could choose to cease their involvement at any time prior to the final submission of survey questions. However, they were advised once the survey was submitted, their results were unable to be withdrawn, given that there was no identifying information that could connect results with the participant.

Anonymity and confidentiality

Anonymity is "the degree to which the identity of a message source is unknown and unspecified; thus, the less knowledge one has about the source and the harder it is to specify who the source is among possible options, the more anonymity exists" (Scott, 2005, p. 243). To ensure anonymity, all identifying information (if any) was removed by a third party (master's supervisor) prior to access by the researcher. Thus, ensuring no identifying information had been inputted by the survey participant, specifically, where the participants were provided with the opportunity to type answers. Therefore, ensuring the confidentiality and anonymity of survey participants, whilst also ensuring the researcher was not privy to participant-specific information. Particularly given the size of the professional body and the likelihood of knowing participants. However, this was not required as no participants included specific or identifying information.

Ensuring compliance with the Privacy Act 1993 and the Health Information Privacy Code, all identifying information is either not collected, or removed at the time of submission of the completed survey. The data was securely stored electronically, and password-protected, to ensure only those involved in the research process could access it, as per the institution's processes.

A summary of the survey results was sent to participants in the months following the close-off of the survey and was sent in the same forum that the survey itself was sent (to those who answered 'yes' to being included in research). Participants were advised that research findings and data may be used in conference presentations or discussed in academic and/or professional journals. As per Otago Polytechnic requirements, all data will be stored under password protection for 5 years, after which time it will be deleted.

Māori Consultation

Consultation with the Kaitohutohu (KTO) office at the Otago Polytechnic was completed as all research undertaken in Aotearoa New Zealand, regardless of its focus, is of interest to Māori. According to the Royal Commission on Social Policy (1988), the Te Tiriti o

Waitangi/Treaty of Waitangi identifies that rangatiratanga (researchers, iwi, and Māori communities) work together to ensure rights are respected, that Māori are involved in the design and implementation of research, and that research actively protects Māori, Māori data, Māori culture, cultural concepts, and values in the research process. As a researcher who identifies as Māori, and Kai Tahu whakapapa, completing research that may potentially include participants who identify as Māori, it was important to participate in the consultation process to ensure the research was culturally safe and all avenues had been considered (Royal Commission on Social Policy, 1988). The KTO was contacted for feedback on the researcher's research proposal and was approved 24.09.2020 by the Kaitohutohu Māori Research Office. One point of feedback from the KTO was to anonymously ask survey participants if they had Māori whakapapa. To assist in providing feedback relating specifically to the satisfaction of Māori occupational therapists. Thus, concepts could also be used as survey questions, to explore the sociocultural realities of occupational therapy practitioners and their satisfaction levels in this profession. These recommendations were implemented within the survey, in which the researcher asked participants to identify their ethnicity, and asked specifically relating to bi-cultural practice and cultural safety. With the use of Qualtrics, the researcher was able to identify participants who identify as Māori and cross analyse this data, whilst maintaining anonymity. KTO (See Appendix E for full KTO feedback).

Summary

This chapter has described the justification in the use of mixed methods survey methodology used in this project, in particular, the use of mixed-method to establish breadth and depth of survey data, thus, providing a snapshot of the current professional environment. A detailed description was provided about the research design and implementation of the survey. An in-depth overview of ethics and cultural considerations was provided, ensuring the guiding principles were adhered to, thus safeguarding the quality, integrity, and reliability of this research project. The following chapter will identify the results of the data collected from the survey, and thus, will highlight potential areas of interest and themes from the data to inform the research question.

Chapter Four: Results Chapter

The following chapter will detail the findings of the survey, highlighting potential themes and quantitative data results. Initially, 61 individuals started to complete the survey, but as they did not meet the inclusion criteria (as detailed in the methodology chapter, such as; working in a metropolitan area, not currently practising) or not completing/finalising the survey, the total respondent rate was N= 32 individuals. As of March 2021, there were 3,219kaiwhakaora ngangahau/occupational therapists employed in Aotearoa New Zealand (Occupational Therapy Board of New Zealand, 2021). In that same year, 49% of registered and employed occupational therapists were identified as working in physical health (n=1454). The exact figure/number of 'rural' occupational therapists is not known, but is expected to be significantly less than this figure. The survey invitation identified that the data was to be gathered from rural occupational therapists. Therefore, it is expected that the number of therapists who met the inclusion criteria, and who would be able to participate, would be significantly less than the total number working in physical health roles.

Of the 61 who commenced the survey a number did not meet inclusion criteria;

- Two individuals identified that they did not currently work in a physical health role.
- Four individuals selected 'no' to working in/covering a rural area.
- Individuals who selected 'no' were those who worked in a large city area, or those who worked on an inpatient ward. Four individuals selected 'not sure' relating to working in/covering a rural area. These individuals were included in the survey findings as their opinions on why they are not sure as to if they are rural, are of interest. In particular, given rural occupational therapy in New Zealand is challenging to define.
- The four individuals who selected 'not sure' all identified working in a Ministry of Health (MOH) defined urban setting, yet often covering rural areas and working with rural individuals. Six individuals did not meet the inclusion criteria so using skip logic (the ability to change the flow of the survey/questions asked based on answers provided), were taken to the final page of the survey and provided with a 'Thank-you' message for their participation.
- All remaining individuals did not complete for unknown reasons, therefore data was not recorded.

All questions were required to be completed by the participant to be considered as a completed survey response. Participants who chose not to answer a question were unable to move on to the next question and were presented with a text feature advising them to select a response. This response option was to indicate 'I prefer not to say', which was available for all questions, except the consent question, which was mandatory. The final, total number of survey respondents who completed the survey was N=32.

The researcher utilised Qualtrics to compare a range of factors/questions that were asked in the survey, primarily against overall role satisfaction. Findings will be outlined in this results chapter, with significant findings, or findings of interest which will be discussed in more depth in the following discussion chapter.

Participants: Demographic Data

Geographic Location

Due to the nature of this nationwide survey, geographic location and demographics were collected, in order to identify any location-specific issues. Given the possibility of some geographic locations containing a low number of respondents, (For example, specific District Health Boards (DHBs) or towns such as small, rural locations such as Gore or Queenstown, with low numbers of practising occupational therapists) were expanded into larger geographical regions, encompassing general geographical borders, such as 'Southland' or 'East coast of the North Island'.

Southland had the highest number of responses, or n=12 (29% of total respondents), followed by Otago, n=7 (17%). Refer to Table 4.1, below for full details on geographical location and response numbers.

Table 3

Q2 - In which geographical location are you based?

Geographical location	Number of participants	Percentage	Average satisfaction rating (1-9)

Auckland	3	7%	6.7
Bay of Plenty	2	5%	6
Canterbury	2	5%	7.5
East Coast (North Island)	2	5%	7.5
Hawkes Bay	0	0%	n/a
Manawatu/Wanganui	2	5%	6.5
Nelson/Marlborough	0	0%	n/a
Otago	7	17%	6.1
Prefer not to say	2	5%	8.0
Southland	12	29%	6.0
Taranaki	0	0%	n/a
Waikato	5	12%	7.4
Wellington	2	5%	5.0
West Coast (South Island)	3	7%	5.7

Note: Average satisfaction rating (1= very dissatisfied, 9= very satisfied).

According to OTBNZ (2018), Auckland has the largest number of practising occupational therapists, with just over one-quarter of the total NZ practising occupational therapists working within the Auckland region. These numbers echo the population demand, in that Auckland is NZ's largest large metropolitan city. Canterbury is the second largest region, with 15% of the workforce, followed by Wellington, Otago and Waikato, with each region having approximately 10% of the occupational therapist workforce. The regions with the smallest number of occupational therapists in practice are the West Coast (1%), Southland and Taranaki (2% each), followed by Nelson, Tasman and Marlborough and Northland (4%).

Of note, Southland had the highest number of respondents identifying as rural occupational therapists, however; Taranaki, Nelson and Marlborough (with Northland omitted in error) had no respondents to the survey. Given the overall sample size (N=32) this is likely an appropriate response rate that reflects the relatively low number of practising therapists in these regions. It is likely these regions can be considered 'more rural' than other

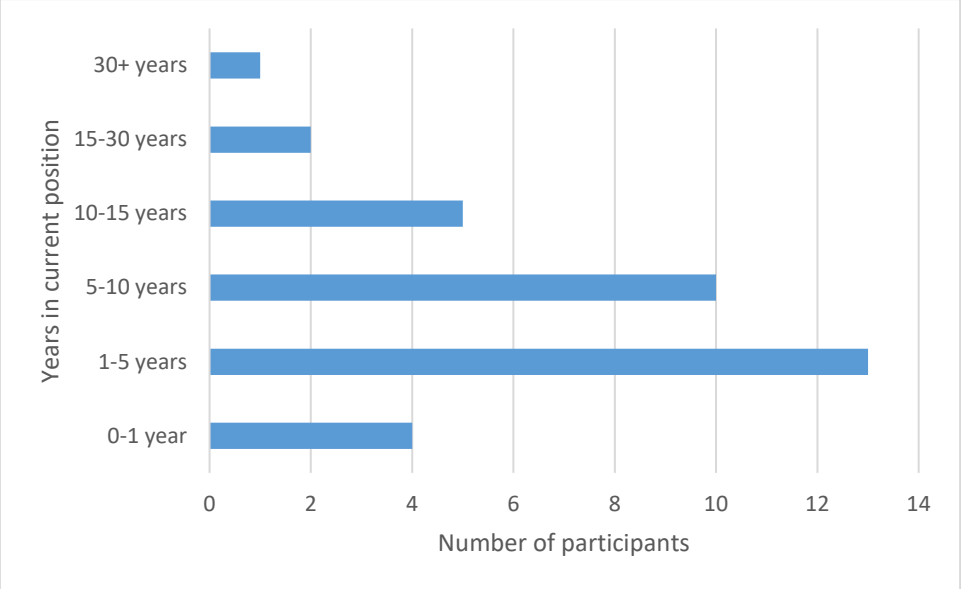
areas given the sparse geographical nature of the regions (Refer Figure 1: Urban/Rural geographical locations in NZ, Chapter 1).

Participant Age

The largest number of survey participants were aged 45-50 years old (18.75% of total participants, n=6). As seen in Figure 4.1, there is a steady increase of occupational therapists aged up to 45-50 years old, with declining figures after this age. This is similar to the OTBNZ, (2021) report identifying that the average age of occupational therapists in New Zealand is 41.

Figure 3 –

Q24. Which age group are you in?

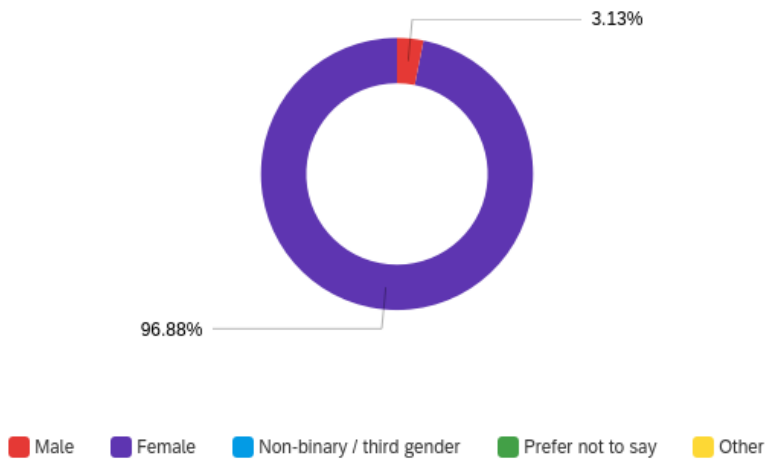


Participant Gender

Thirty one (31) respondents (97% of total participants) identified as female and 1 (3%) identified as male (Refer to Figure 4.2, a graph showing participants by gender). The survey results approximately align with the current composition, based on gender, in the NZ occupational therapy workforce (e.g. 90% female and 10% male) (OTBNZ, 2018).

Figure 4

Gender(s) of participants



Participant Ethnicity

Participants were asked to identify which ethnicities they most strongly identify with and were able to select more than one. The majority of participants identified as New Zealand European, n=24 (or 61% of total participants), followed by 4 participants (or 10%) as NZ Māori (See Table 4.2, for full numbers). All 4 participants who identified as Māori also identified as New Zealand European. No other participants answered as identifying as more than 1 ethnicity, and no other ethnicities were identified. This likely represents the current ethnic composition of NZ practising occupational therapists, with the majority being European/Pakeha, and under 10% of other ethnicities such as Māori, Pacific, Asian, other (OTBNZ, 2018). While ethnicity was not an initial key feature of this research, recruiting and retaining Māori into the profession is vital. Although "there has been a steady growth in the number of Māori and Pacific Island kaiwakaora ngangahau ... they remain less than 8% of the occupational therapy workforce of Aotearoa" (OTBNZ, 2021, p.25).

Table 4

Q23 - What ethnicities do you identify with? Select all that apply

Ethnicity	Number of participants	Percentage
New Zealand European. Pakeha	24	62%
New Zealand Māori	4	10%

Pacifica	1	3%
New Zealand (other)	2	5%
Other (please specify)	7	18%
Prefer not to say	1	3%

Responses by Categories and Job Satisfaction

Responses by Ethnicity: Job Satisfaction.

When a Crosstabs analysis (cross analysing two survey questions and the responses) was completed, it is observed that there were differences in responses to key questions such as about job satisfaction.

Table 5

Ethnicity and overall role satisfaction rating

Ethnicity	Likert scale of overall role satisfaction
New Zealand European/Pākehā	6.6
New Zealand Māori	6.5

A tentative conclusion (given sample size and no statistical analysis completed) is that there is no significant difference in satisfaction between identified ethnicities.

Participants were asked: "Are you satisfied with the implementation of bi-cultural practice within occupational therapy in New Zealand? Seven (21%) New Zealand European/Pakeha participants stated, 'yes' and 8 (25%) stated 'no'. Compared to all Māori, and Pacifika participants reporting they were not satisfied with the implementation of bi-cultural practice. The results highlight that New Zealand European, Māori and Pacifika occupational therapists all feel more work is required regarding the implementation of bi-cultural practice.

However, several participants made comments relating to not being satisfied with bi-culturalism in practice, stating:

> *Still a lot of implementation work required…Many therapists still learning about bicultural practice let alone implementing it...Work area is very European based, medical model often…Few Māori clients referred... I believe OTs are not educated enough about and how to specifically relate to our learning... not actively developing*

cultural participation i.e. no powhiri to welcome new staff...I feel it is over emphasised...rather than freely exercised and becoming a natural part of engaging with clients and in practice. Selection of quotes from survey participants.

58% of Pākehā, 67% of Māori, 100% of Pacifika, 100% of 'other' (Asian, Australian) responded to the question that asked if they thought 'cultural satisfaction to be important in their job satisfaction they have for their role', and stated:

Concerned that [I] have limited Māori client referrals…Of course, inequalities lead to poorer health outcomes and thus affecting access to services, health and mortality rates…I want to [be] more inclusive, aware and fair in my therapy to all involved in my caseload. Selection of quotes from survey participants.

In response to the question 'Is your cultural satisfaction important to you in the satisfaction you have within your role?' 20.8% of Pākehā stated 'no' cultural satisfaction is not important within their role, with 33.3% of Māori, 28.6% of 'other' and 100% of 'prefer not to say', and stated:

I consider myself to be demonstrating cultural safety in my work... I consider it an important part of delivering a quality service... I would like to continue developing my implementation of appropriate bi-cultural practice…Able to relate...but lacking in language and retention of cultural characteristics. (Selection of quotes from survey participants.)

In terms of response to the question about the importance of cultural satisfaction in relation to their role 54.3% of Pākehā, 33.3% of Māori, 0% of Pacifika, 71.4% of the others' reported that cultural satisfaction is important in the satisfaction they have within their role. 20.8% of Pākehā, 0% of Māori, 100% of Pacifika and 100% of 'prefer not to say' reported that they do not feel satisfied with the cultural safety in their role.

Participants were then asked if they were satisfied with cultural safety within their role. 25.0% of Pakeha, 66.7% of Māori, 28% of 'other' identified they were not sure if they were satisfied with cultural safety in their role. The relatively high rates of individuals identifying they were unsure about the importance of cultural safety in their role.

Thus, potentially highlighting that more work is required relating to what cultural safety is, and how this could be incorporated into practice.

Responses by Age: Job Satisfaction.

The researcher was interested to establish if there was an association between the age of occupational therapists and average overall job satisfaction. Due to an error in the survey relating to the specified age bracket of the 40-45 age category not being provided as an option to select, this may have led to participants in that bracket selecting the age bracket on either side that they most closely identify with. Using analysis based on the participant responses, when cross analysed with overall satisfaction (Likert 1-9 scale) there does not appear to be a trend between the two. (Refer to Table 5, table providing data on age linked with satisfaction, and Figure 5, showing no association between these topics as represented in a line graph.). The findings appear to reflect occupational therapy OTBNZ professional portfolios (goals to meet competencies) identified by the OTBNZ in annual reports.

Table 6

Age comparative to overall satisfaction rating

Age	20-25	25-30	30-35	35-40	45-50	50-55	55-60	60-65
Average overall satisfaction rating	7.5	6.3	5.8	7.6	5.7	6.5	6.5	6.8

Responses by Gender: Job satisfaction.

As of March 2018 90%, of occupational therapists in New Zealand identified as female, and 10% as male (OTBNZ, 2019). There was no data available relating to any other gender identification (e.g., transgender, non-binary). Given there was only one male who responded, a very small sample, it is unlikely any meaningful conclusions can be drawn relating to gender differences in terms of job satisfaction. However, a study by Maxim and Rice, (2018) found that gender did not much impact on occupational therapist's role satisfaction. Research completed by Meade et al. (2005) regarding occupational therapy managers considered a relationship between gender and overall role satisfaction. Utilising a standardised job satisfaction tool, they found no significant differences in job satisfaction between female and male occupational therapists. Given the small sample size of male

participants in this research, the authors were unable to draw any solid conclusions relating to gender and role satisfaction in New Zealand.

Responses: Time Spent in the Profession and Job Satisfaction

Length of Time (Years) Working as an Occupational Therapist: In total, how Long Have You Been Working as an Occupational Therapist? (Q27.) The rationale for identifying the length of time therapists worked in a position, is to establish if there is a relationship between levels of satisfaction and length of time in a position. Thirteen (13) participants (40% of the total sample) had been employed as occupational therapists for between 15-30 years. Followed by 7 participants who had been working 1-5 years (21%), 6 working 5-10 years (18%), 4 (12%) working 30+ years, and with 1 participant (3%) preferring not to answer this question.

Table 7

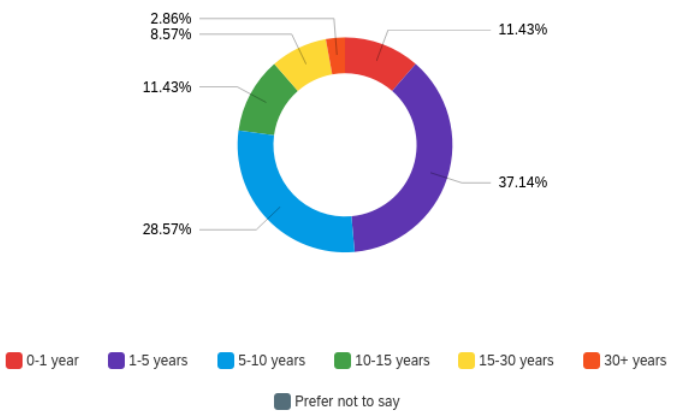
Correlation between length of time working as an occupational therapist and overall satisfaction rating.

Length of time working as an occupational therapist	Overall satisfaction rating (1-9)
0-1 years	5.0
1-5 years	6.0
5-10 years	6.7
15-30 years	6.5
30+ years	7.5
Prefer not to say	7

Length of Time (Years) in Current Position: How Long Have You Been in Your Current Position? (Q20.) Thirteen (13) participants (37% of the total sample) had spent 1-5 years in their current position, followed by 10 (29%) having spent 5-10 years (Refer to Figure 7 for full details on participants' time in current position.) Interestingly 62% of participants reported being satisfied in their current position, with 34% reporting they were not satisfied, and 2% preferring not to say when cross analysed with overall satisfaction rating (Q.3. On a scale of 1-9, with 9 being very satisfied and 1 being very dissatisfied).

Figure 5

Q20 - How long have you been in your current position?



There appears to be a steady increase in overall role satisfaction with increased time spent working as an occupational therapist. Average satisfaction peaked for individuals who have worked as occupational therapists for 30+ years (Refer to figure 8). This is of note particularly in consideration to retention, in that those individuals with 0-1 years working as occupational therapists are least satisfied (averaging 5 on Liken scale) compared to any other group.

Figure 6

Average rating of satisfaction compared to length of time in current position

Working in Physical Health Q21 - Did you work in a physical health setting prior to your current position?

Twenty-five (25) participants (71%) had worked in physical health prior to their current role, with 10 (28%) who had not. Reasons for not working in physical health prior to their current role included being a new graduate, change in career and relocating to a different location in NZ.

Current Role and Job Satisfaction.

With the use of skip logic (the ability to change survey flow depending on the answers a participant gives) participants who answered no to Q17 (I am content in my current position and have no desire to leave my current position. If no, why?) Were asked to then answer the question "I often think about quitting my job. If yes, why?" (Q.18). Of note, 12 (92%) of respondents identified they had often thought about resigning, far more than had identified as being unsatisfied in their current role (refer to figure 7,). Participants were provided with the opportunity to comment on this further, with five choosing to do so. Two of these respondents identified stress and burnout as a leading course in wanting to resign. Other comments included:

- "Due to stress and pressure"
- "Stress & burnout. Excessive workload and expectations"
- "No clinical support, management making decisions without consultation"

Figure 7

Q17 - I am content in my current position and have no desire to leave my current position. If no, why?

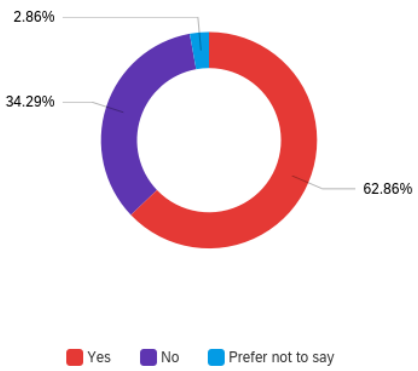
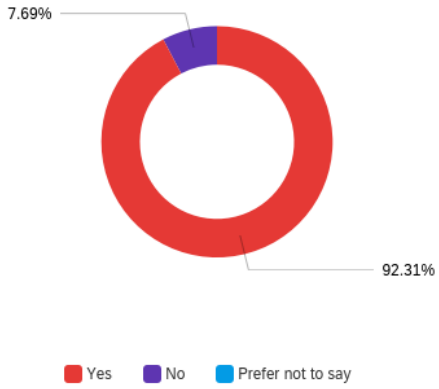


Figure 8

Q18 - I often think about quitting my job. If yes, why?



Using skip logic, participants who reported they often thought about quitting were prompted to answer the question: "Q19 - As soon as I find another job I will quit. If yes, why?" of the eligible participants in answering this question (n=12), 9 (or 50% of the total sample) identified that they would not resign if another employment opportunity arose. However, 4 participants (or 33% of the total sample) reported that they would find another employment opportunity. Participants were provided with an opportunity to comment regarding both 'yes' and 'no' in responses to Q.19. Reporting that seeking reduction of , relationships with colleagues, other roles of interest and general role support would lead to seeking other employment.

Responses: Client Demographics and Job Satisfaction

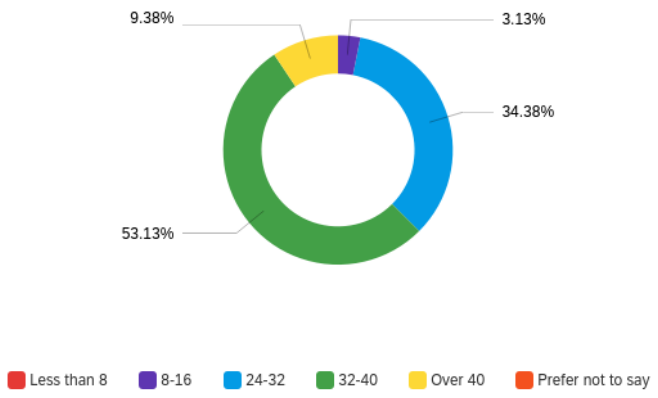
Client demographics were included in the survey in order to gain a snapshot of the client/patient related dynamics and working environment for participants in this survey. Participants were asked to identify the range of client age groups they worked with and were able to select more than 1 age group. This resulted in 239 responses to this question. 30 participants identified they worked with individuals aged between 55-64 (12.55%), which was followed closely by 29 therapists who worked with both 35–44 year-olds and 45–54-year-olds, both of which equated to 12.13% respectively.

Responses: Employment/Setting and Job Satisfaction

Hours Worked Per Week by Participants. The majority of participants (N=17, or 53% of the total sample) worked between 32 and 40 hours per week. Thus, most survey participants are employed on a full-time basis. N=11 of participants (34% of the total sample) worked between 24-32 hours per week. Of note, 9% of participants work over 40 hours per week, and thus, over full time or engaged in 'over-time' work. (Refer to figure 11 pie graph identifying percentages of hours worked).

Figure 9

Q31 - In terms of paid working hours, how many hours a week do you generally work?



When cross analysed, the number of hours worked was associated with overall satisfaction rating for participants with Q.3, Overall role satisfaction on a Likert scale of 1-9).

Table 8

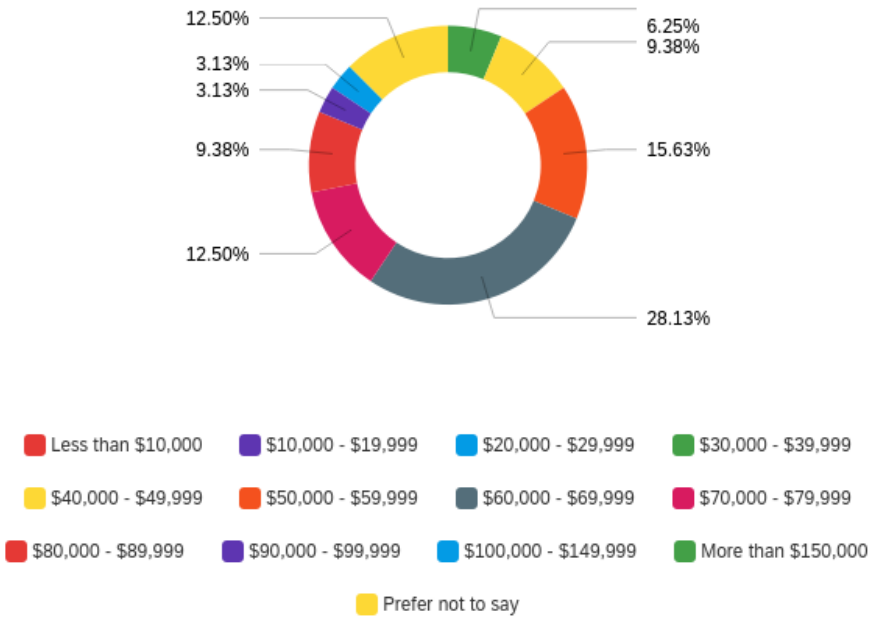
Hours worked and average role satisfaction

Hours worked – per week	Role satisfaction rating on Likert scale (1-9)
8-16 hours	4
24-32 hours	6.7
32-40 hours	6.2
40 + hours	8

Pay Range. Of the 32 people who responded to the gross annual salary range question (Q. 32 - what is your gross annual salary range?), the majority of participants (9 or 28% of the total sample) earned between $60,000 – $69,000 a year, 5 respondents (16% of the total sample) identified as earning $50,000 – $59,000, followed by 4 (13% of the total sample) earning $70,000 – $79,000. Followed by 3 respondents (9% of the total sample) for both income bands of $40,000-$49,000 and $80,000-$89,000 (Refer to figure 12).

Figure 10

Q. 32 - what is your gross annual salary range?



Job Satisfaction and Categories

Access to Resources and Job Satisfaction

In question 7 of the survey, participants were asked to rate their level of satisfaction relating to access to resources. 24% of the participants (9 respondents) identified being very satisfied with access to resources for work purposes (e.g., cars, computers, phones) and 24% (9 respondents) identified being satisfied with access to resources. 18% (7 respondents) were somewhat satisfied, 18% (7 respondents) were somewhat dissatisfied, 5% (2 respondents) reported being very dissatisfied and 5% (2 respondents) reported being very dissatisfied. 30% of participants (12 respondents) reported being satisfied with their access to resources required to implement interventions (e.g., adequate rooms, availability of rooms, equipment. 20% (8 respondents) reported being somewhat dissatisfied, 17% (7 respondents) reported being dissatisfied, 12% (5 respondents) reported being somewhat satisfied, 7% (3 respondents) reported being very satisfied, 7% (3 respondents) reported being very dissatisfied and 2% (1 respondent) preferred not to say.

42% (16 respondents) reported being satisfied with access to required IT systems for work purposes. 31% (12 respondents) reported being somewhat satisfied, 15% (6 respondents) reported being somewhat dissatisfied, 7% (3 respondents) reported being very satisfied, and 2% (1 respondent) reported they are very dissatisfied with access to IT systems. Given the development of IT systems and the use of these within OT practice, it is important to consider the role they may play in terms of the job satisfaction for therapists.

Management Factors and Job Satisfaction

Using the same Likert scale (1-6, with a 'prefer not to say option') in question 8 of the survey, participants were asked to identify their level of satisfaction relating to the following management factors. (Refer to figure 13)

- Availability of your manager
- Management style
- Feeling valued by your manager/s
- Concerns are addressed by your manager/s

Availability of Manager:

Participants were asked to rate their satisfaction with the availability of their manager. 25% of participants (10 respondents) reported being very satisfied with the availability of their

manager, 30% of participants (12 respondents) reported being satisfied, 15% of participants (6 respondents) somewhat satisfied, 8% of participants (3 respondents) somewhat dissatisfied, 10% of participants (4 respondents) dissatisfied, and 13% of participants (5 respondents) were very dissatisfied.

Management Style.

Participants were asked to rate their satisfaction with management style. 21% of participants (8 respondents) reported being very satisfied with management style, 26% of participants (10 respondents) reported being satisfied, 21% of participants (8 respondents) being somewhat satisfied, 10% of participants (4 respondents) being somewhat dissatisfied, 15% of participants (6 respondents) being dissatisfied, and 8% of participants (3 respondents) being very dissatisfied with the management style.

Feeling Valued by Manager/s.

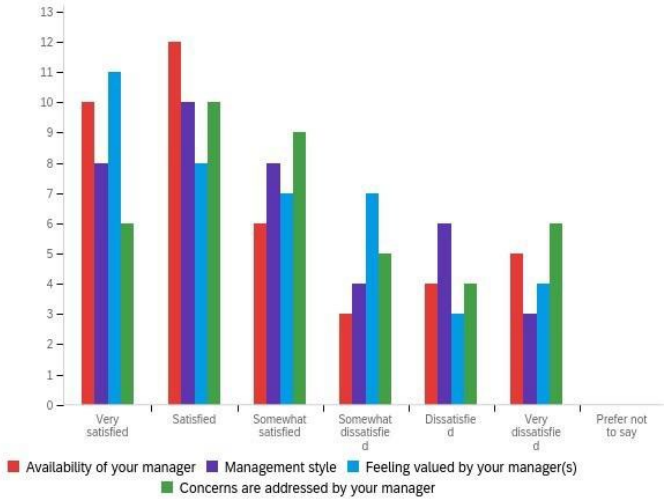
Participants were asked to rate their satisfaction with feeling valued by their manager. 28% of participants (11 respondents) reported being very satisfied, 20% of participants (8 respondents) reported feeling satisfied, 20% of participants (8 respondents) reported being satisfied, 18% of participants (7 respondents) reported being somewhat satisfied, 18% of participants (7 respondents) reported being somewhat dissatisfied, 8% of participants (3 respondents) reported being dissatisfied), and 10% of participants (4 respondents) reported being very dissatisfied with feeling valued by their manager/s.

Concerns Addressed by Manager/s.

Participants were asked to rate their satisfaction relating to concerns being addressed by their manager. 15% (6 respondents) were very satisfied, 25% (10 respondents) were satisfied, 23% (9 respondents) were somewhat satisfied, 13% (5 respondents) were somewhat dissatisfied, 10% (4 respondents) were dissatisfied, and 15% (6 respondents) were very dissatisfied. Thus, demonstrating that overall, respondents were satisfied with all management factors.

Figure 11

Q8 - Please rate your level of satisfaction relating to the following management factors



Role Factors and Job Satisfaction

Participants were asked to rate their level of satisfaction relating to the following role factors (Q9):

- Caseload management
- Pay progression opportunities
- Diversity of work
- Flexibility of working hours
- Work-life balance
- Client-contact to paperwork ratio
- Job security
- Appropriate staffing levels
- Autonomy
- Access to annual leave
- Access to staff discounts (retail stores and services).

Caseload Management Factors.

Participants were then asked to rate their satisfaction of caseload management where 31% participants (13 respondents) reported being somewhat satisfied, 24% (10 respondents) report being satisfied, 17% (7 respondents) dissatisfied, 14% (6 respondents) somewhat dissatisfied, 7% (3 respondents) very satisfied and 4% (2 respondents) report being very dissatisfied with caseload management.

Pay Progression.

When asked to rate satisfaction with pay progression 29% (12 respondents) report being somewhat satisfied with pay progression with 19% (8 respondents) satisfied, 17% (7 respondents) somewhat satisfied, 9% (4 respondents) somewhat satisfied, and 7% (3 respondents) report being very satisfied.

Diversity in Work.

Participants were asked to rate satisfaction with diversity in their work.
Majority, 48% (20 respondents) report being satisfied with the diversity of their work. With 29% (12 respondents) being very satisfied, 9% (4 respondents) being somewhat dissatisfied, 7% (3 respondents) somewhat satisfied and 4% (2 respondents) being very dissatisfied.
Flexibility of work hours:
31% (13 respondents) report being somewhat satisfied with the flexibility of working hours. 26% (11 respondents) report being somewhat satisfied, 24% being satisfied, 4% (2 respondents) somewhat satisfied, 4% (2 respondents) report being dissatisfied and 2% (1 respondent) report being very dissatisfied.
Work Life Balance:
36% (15) report being somewhat satisfied with work life balance. 34% (14) state satisfied, 9% (4) are very satisfied, 9% (4) are very dissatisfied, 4% (2) somewhat dissatisfied and 4% (2) report being dissatisfied.

Client contact to paperwork ratio:

Participants were asked to rate their satisfaction with client to paperwork ration. 24% (10 respondents) report being somewhat satisfied with the client contact to paperwork ratio. 19% (8 respondents) report being satisfied, 21% (9 respondents) feel somewhat dissatisfied, 19% (8 respondents) report being dissatisfied, 12% (5 respondents) feel very satisfied and 2% (1 respondents) feel very satisfied.

Job security:

Participants were asked to rate their satisfaction relating to job security. Majority, 13% and 13% (13 respondents) report being very satisfied or satisfied with their job security, 26% (11 respondents) report being somewhat satisfied and 7% (3 respondents) somewhat satisfied, 3% (1 respondent) reporting 'not applicable'.

Staffing levels:

Participants were asked to rate their satisfaction with staffing levels. Majority, 29% (12 respondents) feel somewhat satisfied with appropriate staffing levels. 21% (9 respondents) feel satisfied, 19% (8 respondents) somewhat satisfied, 12% (5 respondents) very dissatisfied, 7% (3 respondents) and 7% (3 respondents) report being very satisfied and dissatisfied.

Level of autonomy in role:

Participants were asked to rate their satisfaction relating to autonomy within their role. 39% (16 respondents) feel satisfied with the level of autonomy they have in their role. 31% (13 respondents) feel very satisfied, 21% (9 respondents) feel somewhat satisfied, 2% (1 respondent) and 2% (1 respondent) feel somewhat dissatisfied and dissatisfied.

Access to annual leave:

Participants were then asked to rate their satisfaction relating to their access to annual leave. 43% (18 respondents) feel satisfied with access to annual leave, 26% (11 respondents) feel very satisfied, 14% (6 respondents) somewhat satisfied, 4% (2 respondents) somewhat dissatisfied and 2% (1 respondent) feel dissatisfied.

Access to staff discounts:

Finally participants were asked to rate their satisfaction relating to access to staff discounts. 39% (16 respondents) feel somewhat satisfied with access to staff discounts, 12% (5 respondents) and 12% (5 respondents) report being satisfied and somewhat dissatisfied, 9% (4 respondents) feel very satisfied, 4% (2 respondents) very dissatisfied and 2% (1 respondent) reported being dissatisfied. Interestingly, 19% (8 respondents) identified 'not applicable', implying they do not receive access to staff discounts as part of their employment.

Overall, there were no significant outliers relating to role factors and participants satisfaction. It is noteworthy that 8 respondents reported they do not receive staff discounts, which are typically seen as a 'perk' for many therapists in this roles and evidence has linked this to improved job satisfaction.

Colleague factors and Job Satisfaction

Using the same Likert scale (1-6, with a 'prefer not to say option') in question 10 of the survey, participants were asked to identify their level of satisfaction relating to the following colleague factors (Refer to figure 14).
These factors included:

- Support from occupational therapy colleagues
- Support from other health professionals
- Colleagues having a clear understanding of your role
- Feeling valued by your colleagues and clients.

Support from Occupational Therapy Colleagues.

Participants were asked to rate their level of satisfaction with the support received from occupational therapy colleagues. 46% (19 respondents) feel very satisfied with the support received from colleagues, with 24% (10 respondents) being satisfied, 19% (8 respondents) somewhat satisfied, 4% (2 respondents) and 4% (2 respondents) being somewhat dissatisfied and dissatisfied.

Support from other health professionals:

Participants were asked to rate their level of satisfaction with the support received from other health professionals. 36% (15 respondents) feel satisfied with support from other health professionals, 29% (12 respondents) feel very satisfied, 21% (9 respondents) somewhat satisfied, 7% (3 respondents) somewhat dissatisfied and 2% (1 respondent) reported being dissatisfied.

Colleagues have a clear understanding of your role:

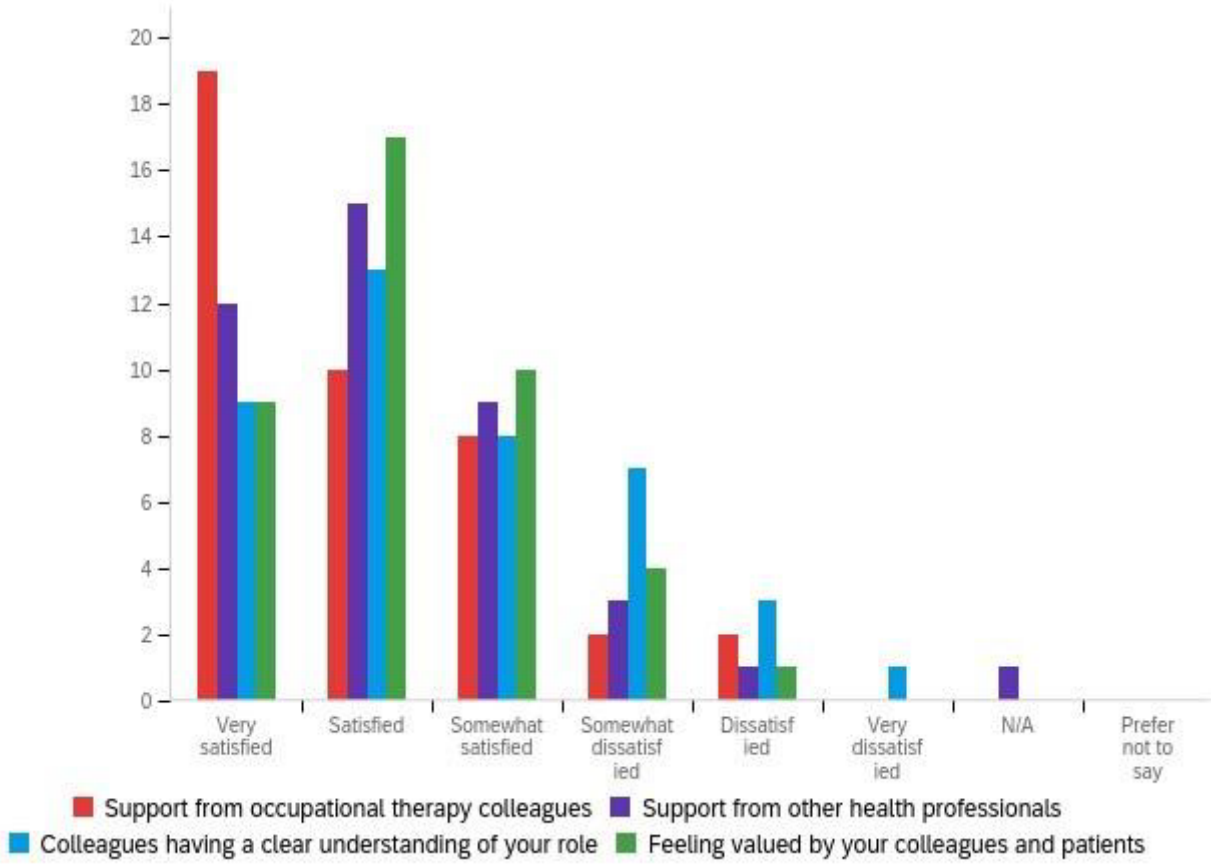
Participants were asked to rate their level of satisfaction with colleagues having a clear understanding of their role. 31% (13 respondents) feel satisfied that colleagues have a clear understanding of the OT role. 21% (9 respondents) feel very satisfied, 19% (8 respondents) somewhat satisfied, 17% (7 respondents) somewhat dissatisfied, 7% (3 respondents) dissatisfied, 2% (1 respondent) feeling very dissatisfied.

Feeling valued by colleagues and clients:

Participants were asked to rate their level of satisfaction with the feeling of being valued by their colleagues and clients. 41% (17 respondents) feel satisfied with feeling valued by colleagues and patients with 24% being somewhat satisfied, 21% (9 respondents) being very satisfied, 9% (4 respondents) being somewhat dissatisfied, and 2%
(1 respondent) being dissatisfied.

Figure 12

Q10 - Please rate your level of satisfaction relating to the following colleague factors.



Travel and Job Satisfaction

Using the same Likert scale (1-6, with a 'prefer not to say option') participants were asked to identify their level of satisfaction relating to the following travel factors (Q11).

- Travel times (to get to your place of employment)
- Travel times (to see your patients)
- Travel times (to access workshops, trainings).

Travel Times (to get to Your Place of Employment).

Participants were asked to rate their satisfaction with the travel times to get to their place of employment. 43% (17 respondents) feel very satisfied with the travel times to get to their place of employment, with 30% (12 respondents) feeling satisfied, 10% (4 respondents) somewhat satisfied, 7% (3 respondents) somewhat satisfied and 2% (1 respondent) being dissatisfied.

Travel times (to see your patients)

Participants were asked to rate their satisfaction with the travel times to see their patients. 43% (17 respondents) report feeling satisfied with travel times to see patients, with 23% (9 respondents) being somewhat satisfied, 15% (6 respondents) very satisfied, 10% (4 respondents) somewhat dissatisfied and 2% (1 respondent) being dissatisfied.

Travel times (to access workshops, trainings etc.)

33% report being satisfied with travel times to access workshops and training, 25% (10 respondents) being somewhat satisfied, 15% (6 respondents) somewhat dissatisfied, 10% (4 respondents) dissatisfied, 7% (3 respondents) very dissatisfied and 2% (1 respondent) being very satisfied.

Supervision and Job Satisfaction

Participants were asked to rate their satisfaction with supervision factors (Q12). These factors include:

- Access to an appropriate supervisor
- Access to supervision training
- Ability to participate in supervision.

Access to an appropriate supervisor:

Participants were asked to rate their satisfaction relating to access to an appropriate supervisor. 38% (15 respondents) feel satisfied with the access to an appropriate supervisor, 25% (10 respondents) very satisfied, 15% (6 respondents) somewhat satisfied, 10% (4 respondents) somewhat dissatisfied, 7% (3 respondents) feel dissatisfied.

Access to supervision training:

Participants were asked to rate their satisfaction relating to access to supervision training. 30% (12 respondents) of participants feel satisfied with access to supervision training, 23% (9 respondents) feel somewhat satisfied, 17% (7 respondents) very satisfied, 15% (6 respondents) somewhat satisfied, 5 % (2 respondents) dissatisfied and 2% (1 respondent) very dissatisfied.

Ability to participate in supervision:

Participants were asked to rate their satisfaction relating to ability to participate in supervision. 56% (22 respondents) feel satisfied with their ability to participate in supervision, 23% (9 respondents) very satisfied, 10% (4 respondents) and 10% (4 respondents) are somewhat satisfied and somewhat dissatisfied.
Overall, survey participants were satisfied with their ability to access and participate in supervision and supervision training, despite the potential challenges that rurality could offer.

Perks/Benefits of Current Position and Job Satisfaction

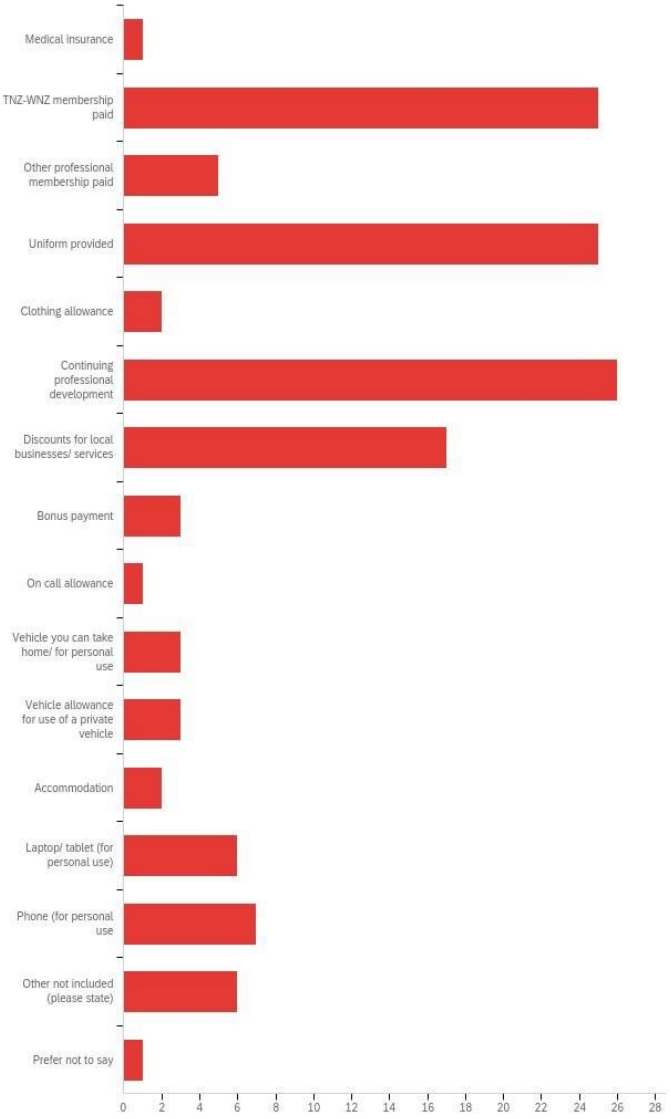
Survey participants were asked to select from a list of benefits/ perks they had as part of their employment (Q.4). These included (uniform provision, Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa (OTNZ-WNA) membership paid, discounts for services) individuals were encouraged to select 'other' and type their responses if these were not listed. Of the 32 participants, most selected multiple perks, resulting in 133 responses.

The top perks and benefits identified as:

- 19% (26 respondents) Continuing professional development,
- 19% (26 respondents) uniform being provided
- 18% (25 respondents) OTNZ-WNZ membership paid.

Figure 13

Q4 - What benefits/ perks do you have as part of your employment? Please select as many as applicable.



Most Rewarding/Positive Aspects of Current Position and Job Satisfaction

Participants were asked to rate the most rewarding/positive aspects of their jobs (Q.13). 63% of survey participants identified that the most rewarding part of their job is direct client contact. 44% rated the nature of their caseload as the second most rewarding part of their caseload. Programme development (22%) was 3rd. The full ranking is outlined in the table below refer to Table 5.

Table 9

Participants ranking of most rewarding/ positive aspect of their current position (descending order).

Ranking	Positive/ rewarding aspect of role
1	Direct client contact
2	Nature of caseload
3	Programme development
4	Staff supervision
5	Relationship with team/peers
6	Participation in service activities
7	Professional development opportunities
8	Team/colleague opinion of occupational therapy
9	Management responsibilities
10	Holiday time/annual leave
11	Salary/pay
12	Management /management style
13	Career development /promotion
14	Clinical research
15	Flexibility of hours
16	Work-life balance
17	Childcare availability
18	Other

Past Position: Leaving or Quitting and Job Satisfaction

Individuals were asked "Did you work in a physical health setting prior to your current position? (Q22). 35 individuals responded. 25 (71%) selected 'yes', 10 (29%) selected no. Individuals who selected 'yes' were taken to a subsequent question:
"What was your reason for leaving your previous role?" (Q22). Individuals who did not answer yes to the previous question skipped this question with the survey logic function. 5 individuals made comments as to "What was your reason for leaving your previous role?" 2 of which responded that they were a new graduate, therefore had not worked previously, and 'to become an occupational therapist' therefore these answers were omitted.

The remaining respondents stated:

- "A change in management (affecting organisational culture)"
- "Wanting a change and opportunity for skill development"
- "To move back to New Zealand (family)"
- "Isolation and minimal professional development."

Frames of Reference and Job Satisfaction

Occupational Therapy Frames of Reference/Models Used in Practice

Survey participants were asked to identify if they consciously used an occupational therapy frame of reference, conceptual model or framework (Q34). 50% (16/32) participants identified 'yes' they consistently used a specific practice model, 43% (14/32) stated 'no' they did not and 6% (2/32) preferred 'not to say'. Participants who answered yes to consistently using an occupational therapy frame of reference were then asked to select from a list of common models/frameworks. They were able to select from the list of models that applied to their practice. This question was included in the survey to identify if the use of profession-specific models was a factor that influenced job satisfaction for rural occupational therapists.

1. Person Occupation and Engagement model: 41% (16) of participants reported regular use of this model.
2. Canadian Model of Occupational Performance and Engagement (CMOP-E): 26% (10) of participants reported regular use of this model.
3. Model of Human Occupation (MOHO): 15% (6) of participants reported regular use of this model.
4. Kawa Model: 5% (2) of participants reported regular use of this model.
5. Other: 12% (5) of participants reported regular use of another model not otherwise specific.

Participants who selected 'other' were provided with an opportunity to comment. 4 participants made note of the following models;

1. Canadian Practice Process Framework (CPPF) a model using visual metaphor to show the therapist-client relationship and client-centred enablement, the process for CMOP-E.

2. Biomedical model – not an occupational therapy model, but taught as a key theory in undergraduate occupational therapy education.
3. International Classification of Functioning, Disability and Health (ICF) – not an occupational therapy model, but taught as a key theory in undergraduate occupational therapy education.
4. Te Whare Tapa Wha – not an occupational therapy model, but taught as a key theory in undergraduate occupational therapy education.

Practice Models

Participants were then asked, "Do you use non-occupational therapy models to guide your current practice? If so, please specify" (Q.36). 11 (35%) participants selected 'yes' and 20 (64%) selected 'no'. Five participants elected to comment further on this question.
The identified practice models they used included:

1. ACT (Acceptance and commitment therapy)
2. Motivational Interviewing
3. CBT (Cognitive behavioural therapy)
4. Solutions focused therapy
5. Te Whare Tapa Wha
6. ICF (International Classification of Functioning, Disability and Health)
7. Holistic models depending on clients.

Conclusion

This chapter discussed the data analysis and findings and presented them in tabular and graphical format, and in verbatim quotes from participants. Where appropriate, literature was drawn upon to compare or contrast to survey findings in terms of demographics and composition of the occupational therapy workforce or other factors influencing job satisfaction for rural, physical health-based occupational therapists. These survey findings are somewhat limited by the rate of response (i.e., 32 participants out of the total possible rural occupational therapists in practice), only 1 male therapist responded, and lower numbers of ethnicities other than European and Māori. The data collection of 32 questionnaires revealed an average overall satisfaction level on par with other research, whilst in particular highlighting concerns regarding role satisfaction of occupational therapists with less experience.

Chapter 5 will conclude the research findings, and will discuss themes and hypotheses in more detail whilst making recommendations for practice and further research based on the data.

Chapter Five: Discussion

The literature review outlined a gap in available data relating to job satisfaction of rural occupational therapists in Aotearoa New Zealand. This lack of information has important implications for informing the profession and key stakeholders (e.g., employers such as DHBs) about what factors influence job satisfaction and the impact this can have on recruitment and retention in the profession, especially in the specialised field of rural, physically-based health practice. From what literature is available and based on practice-based information there are low retention rates for rural therapists and inconsistent staffing numbers in rural practice contexts. Such employment-related issues can have a significant bearing on the delivery of health care services for clients in rural areas of NZ and may be contributing to poorer health outcomes for this population (Fearnley, Lawrenson, & Nixon 2016).

This study aimed to better understand the factors that influence or sustain job satisfaction from the perspectives of rurally-based occupational therapists who are currently in practice in Aotearoa New Zealand. This project-based master's thesis used a mixed-methods survey methodology including quantitative and qualitative data drawn from the participants' responses. The discussion chapter has brought together the results from the survey and the evidence from the literature review completed for the study, to help answer the research question: *What are the factors influencing satisfaction for physical health occupational therapists working in rural New Zealand?* Overall, the results of this study show how a variety of interrelated factors affect rural job satisfaction for occupational therapists. The survey highlighted difficulty with defining rurality, the impact of job experience and hours on satisfaction, and the importance of continued learning and its application to practice, especially relating to the important area of bicultural practice. The researcher utilised Qualtrics data analysis tools and identified key themes based on the data provided from the survey responses. This is presented alongside the key findings from the literature review conducted.

Rurality

Based on the survey conducted the concept of rural/rurality appeared to be a difficult term for the occupational therapists to define. When therapists identified that they were not sure as to if they were rural therapists, they often stated that they worked with rural patients in an urban setting, such as an acute ward. Thus,

highlighting that it should be considered that a 'rural' identity is tied with an occupational therapist's own experiences, and as such rural can be associated with many factors for example with travel and geographical isolation and the effect these are considered to have on both the therapist and the client. Therefore, as much as rurality is based on the experiences of clients, and therapists who identify that they have rural clients, the concept of rurality could differ depending on the experiences of the individual. As a result, the frustrations, strengths, and experiences of job satisfaction as a rural occupational therapist may vary depending on the therapist. It is possible that self-identification of rurality isn't determined by the client type alone, rather, the setting and the experiences of the therapist.

Although there were several reasons given, this uncertainty of rural identity primarily focused on the problems that the therapists perceived that their clients experienced (e.g., isolation, and geographical distance) hindering their clients' ability to maintain their occupational identity and/or access services or support. Thus, highlighting that the occupational therapists who responded tended to have mixed views in how they described themselves as rural practitioners. For example, some responses indicated the participants were aware of the numerically-based population definition or that they served both rural and urban populations and may work or reside outside rural settings.

The survey highlighted that there are potentially many therapists who are not sure as to if they would be defined as a rural practitioner by others, but who identified and considered themselves to be rural practitioners and therefore participated in this research. As a result, making it challenging to capture the number of those who could be defined as rural therapists, thus creating implications for the definition. Consequently, it could be concluded, based on this sample, that therapists in Aotearoa NZ do not make a clear definition between being an urban versus rural practitioner.

As evidenced when participants had the opportunity to identify their thoughts regarding their rural identity:

> *I work in an urban area, however [I] cover rural areas and complete home/site visits in rural communities...I work in a hospital which attends to many people from rural settings but I don't actively go to rural settings...The town I live in has 5000...I cover*

towns that are more than 1000 people but have some very rurally isolated people. Selection of quotes from survey participants.

The literature reviewed highlighted the general understanding that the concept of rurality is challenging to define, unlike the intersection of geographical location, demographics, and history (Litchfield 2002; London 2002). This research also showed that the personal perceptions of rurality, or what individuals considered to be rural, was apparent and this poses challenges in defining rural roles.

The results of this study would suggest that the term rural is not a measurable, numerical concept, but rather is based on the individual perceptions and experiences of occupational therapists and their narratives of the world they live in. For example, therapists who have an experience in urban settings only, versus therapists who have worked in large metropolitan areas, urban and rural settings. Therefore, individuals may struggle with the concept of rurality, as they compare their narrative of the term with what they perceive may be the narrative of others. This differs from the widely utilised Ministry of Health definition, which states rural consists of a region with less than 999 individuals residing there. This is purely a numerically based definition, that takes little account of other cultural or environmental aspects (e.g., distance from access to services/urban area).

Participant: Years Practising/Experience

Based on the findings of this survey, qualitative data suggests therapists who have been practising for longer are generally more satisfied in their role, with those working over 30 years the most satisfied. However, Hellickson, Knapp, Ritter, & Martin, Peggy, (2000) highlighted that occupational therapists, irrelevant of rural or urban roles, with more than 7 years' experience tended to be more satisfied with their role compared with their less experienced colleagues. Similarly, other research (based on both rural and urban practice contexts) found that occupational therapists with increased years of experience showed they valued all aspects of their job (Freda, 1992). Potentially because they have found a role they enjoy (over time) or because there is more enjoyment relating to the increased experience within the role.

Given the survey findings match the literature, it may be that this phenomenon is not specific to rural practice, or the New Zealand context, rather, it appears to be a global phenomenon. Due to the small scale of this survey, there was not an opportunity to

explore in more depth this apparent association between job satisfaction and the length of time spent in the role as an occupational therapist. However, it was a suitable starting point that can inform future research focusing on this topic. For example; therapists who have been practising for an extended period of time have had the opportunity to develop institutional knowledge, require less time to complete tasks, draw on past experiences, and are more confident in their approach to occupational therapy interventions and are more likely to feel valued in their role, have developed solid working relationships over time, and have improved clinical reasoning based on experiences (Mitchell & Unsworth, 2005; Britton, Rosenwax, & McNamara, 2015). Therefore, each day feels less 'unknown' as day-to-day practice is more predictable with variance in cases and challenges more manageable because of their experience. It is also possible that more experienced therapists feel greater security in their role as occupational therapists and are therefore happy to meet challenges/uncertainty, with the variety of the role providing satisfaction and enjoyment (Robertson, 2009). It is not apparent as to if this is as a result of satisfied therapists remaining in their jobs, and unsatisfied therapists leaving, or if this is related to length of time in a position and experience.

Of note, participants with 0-1 year's experience (new graduates) were the least satisfied of all groups. These findings are supported by the research that found that new graduates face challenges when transitioning from a student role to a therapist role (Fortune, Ryan, & Adamson, 2013). New graduates often experience reduced confidence, difficulty meeting demands of documentation, limited experience, difficulty accessing a senior mentor, and face challenges with both role justification and conflict resolution (Robertson & Griffiths, 2009). All of which highlights that there appears to be a steady increase in overall role satisfaction with increased time spent working as an occupational therapist. Given the relationship between satisfaction and retention, it is important that role satisfaction, and being able to adapt to the demands of entering the profession as a new graduate occupational therapist is explored in future research.

Geographical Location/Travel

Occupational therapists in the regions of Canterbury and the East Coast of the North Island identified that they were more satisfied in their roles compared with those from other geographical locations. The results of this survey would suggest that it is not necessarily the number of occupational therapists working in a geographical area that contributed to increased satisfaction. Nor, the geographical area that contributed to

satisfaction, but more of what was available to therapists in these regions (resources, professional development). Previous research has highlighted that there are several reasons job satisfaction could vary depending on geographical location. These factors include but are not limited to setting culture, access to resources, colleague support, supportive management, or individual perception. Interestingly, when researching various other health professions, O'Sullivan, McGrail, & Russell, (2017) and Kobza & Syrkiewicz-Świtała, (2018) both found that geographical/physical location had no impact on satisfaction. The majority of findings explored in the literature review highlighted concerns about the geographical location of the rural practice (access to professional development, travel time) however, this is not necessarily reflective of the satisfaction of occupational therapists in rural New Zealand identified in this survey, a strength of practice in Aotearoa.

Travel is a concept intricately linked to the concept of rurality, given the geographical isolation away from urban settings, it forms part of many therapists' everyday work. Overseas research highlights that costs, distance, and time, all linked to longer travel for therapists to access their clients, and are barriers to healthcare access for clients, all of which come into play for individuals residing rurally (Dirnberger & Waisbren, 2020; Powell et al., 2017). Based on the results of this survey, therapists/participants were generally very satisfied-satisfied with travel times to see patients (86% of total respondents) with 33% reporting being satisfied with travel times to access workshops and training. This may be due to travel being an expected component in a rural role, with travel being seen as a perk of the role, and the travel contributing to caseload interest (diversity in caseload). Seeing travel as a benefit is at odds with what is more commonly associated with negative aspects in international literature, such as access, opportunity, and resources (Paliadelis, Parmenter, Parker, Giles, & Higgins, 2017).

Whilst this result shows minimal concern for travel times to access clients, in this sample of NZ, rural, physical health-based occupational therapists, it is an interesting finding as it contrasts with internationally published findings, it was based on a small sample size. However, it is a unique finding and one that indicates the need for further research to understand this phenomenon in more depth.

Hours worked

A key finding from the survey amongst rural occupational therapy was the association between the number of hours an Occupational Therapist worked and their self-identified

satisfaction in their role. Based on the sample in this survey, OTs who worked more than 40 hours a week were more satisfied than those who worked less than full time. This finding echoes those of Bartoll, Cortès, and Artazcoz, (2014) who suggested that low job satisfaction and poorer health status was more common among individuals who worked part-time. However, in contrast, Vasilevski, Sweet, Smith & Dell (2020) reported midwives were more satisfied in their roles when they worked on a part-time basis. This highlights that the relationship between hours and satisfaction is likely multifactorial, varying based on the individual, and their personal and professional contexts.

The findings here contribute to the research related to hours of work and job satisfaction and warrant further investigation, especially in the context of rurally-based occupational therapists in NZ. Understanding the reasons for increased job satisfaction and longer work hours would be of interest to employers as this may support efforts in terms of job retention and considerations about how jobs are advertised e.g. full-time equivalent (fte) roles. The literature reviewed on the topic revealed health workers tend to work longer hours (due to time pressures, caseloads) (Peetz et al 2003) but these reasons would not suggest satisfaction, indeed quite the opposite.

Models of Practice

Survey participants were asked to identify if they consciously used an occupational therapy frame of reference, conceptual models or frameworks. Approximately, 50% of the participants (16/32) identified they consistently used an occupational therapy specific practice model. Participants who answered yes to consistently using an occupational therapy frame of reference were then asked to select from a list of common models/ frameworks. One theme that came from the survey findings was that therapists who utilised a non-OT specific model of practice had higher role satisfaction than their peers who do not use such profession-specific models (overall satisfaction rating of 7.4 vs 6.0). It is possible that non-OT models (such as Te Whare Tapa Wha) provide structure and guidance (Foster, 2002) whilst also promoting holistic and client-centred practice, at the core of occupational therapy. However, it is also possible that the settings themselves promote the use of models, and thus, satisfaction comes from the setting and as a by-product- the model. There is good reason to investigate the links between the use of Occupational therapy models and satisfaction, such as that remain answered based on this study include, is it the model and what it means for the therapist (e.g., culturally relevant) used that promotes higher job satisfaction, or other factors such as their familiarity with the model/s or is support in their work context. Given the data collected this

study is not able to make any suggestions with regards to links betweenthis study is not able to make any suggestions with regards to the links between models of practice and satisfaction and therefore may be appropriate to research further.

Colleagues

When asked to identify satisfaction relating to their support from colleagues 46% of the participants (19/32) feel very satisfied with the support received from colleagues, 36% (15 respondents) feel satisfied with support from other health professionals, 41% (17 respondents) feel satisfied with feeling valued by colleagues and patients. However, 17% (7 respondents) were somewhat dissatisfied that colleagues have a clear understanding of their role. There appears to be a connection between relationships with colleagues and role satisfaction. This is unsurprising as humans are social beings, and the opportunity to share a place of employment promotes bonding, connection and strength through shared experiences. These findings are supported by Moore, Cruickshank and Haas, (2006) who found that relationships with occupational therapy peers and other health professional colleagues were a key source of job satisfaction for occupational therapists. These positive aspects likely play a role in reducing burnout and increasing satisfaction as therapists feel less pressure on themselves individually, knowing they can connect with colleagues to talk through issues or cases. Research by McCombie and Antanavage, (2017), and Scanlan and Still, (2013) reflected the research findings in that professional relationships, social support and feedback result in positively effects for therapists' job satisfaction. Relationships with colleagues are often not without their challenges, with team dynamics, conflicts and hierarchy being evident at times. However, if these aspects are mitigated promptly and healthy professional relationships develop then therapists are more likely to feel satisfied with the collegial relationship aspects of their working life (Devery, Scanlan & Ross, 2018). When working in isolation, such as in rural practice, relationships with colleagues can be fostered through regular breaks spent with colleagues (e.g., allotted breaks like mealtimes), social bonding outside of work, networking by attending professional development (PD) opportunities in other areas, being members of special interest groups and connecting utilising technology (Ryan & Deci, 2000; Van den Broeck, Feris, Chang, & Rosen, 2016). Collegial relationships and employment opportunities (e.g., PD) is an area particularly pertinent to rural practitioners who often find themselves working in relative isolation.

Professional Development

When asked to identify satisfaction relating to access to professional development 33% of survey participants reported being satisfied with travel times to access workshops and training. This is positive, yet surprising, given that many rurally-based therapists/participants are likely to live some distance from the location of many professional development (PD) opportunities (i.e., often based in large cities) Unlike previous studies which found that New Zealand rural practitioners had significant difficulty accessing professional development opportunities due to geographical location (OTBNZ, 2018). Devine, (2006), and Solowiej, Upton and Upton, (2010) found that rural occupational therapists considered ongoing PD important in upskilling, particularly when rural therapists are considered to be generalists. Generalists being OTs who work throughout the life spans of clients with a variety of health conditions, providing different types of interventions (Donnelly, Donnelly, Brenchley, Crawford, & Letts, 2014), as opposed to a specialist (i.e., working with a specific impairment group) (Cook & Cook, 2003). Therefore, it is essential that therapists are engaging in PD to ensure they are keeping up to date with the latest relevant evidence/research-based for their practice, that they are confident in the specific practice skills as a rural therapist, and this will help to ensure best practice and outcomes for their clients (Craik & Austin, 2000; Hayes et al., 2008; Lloyd et al., 2002). The reported satisfaction with PD in this survey is not reflective of overseas research, which found travel times and large caseloads to be barriers in participating in PD (Devine, 2006). There are many potential reasons for these differences, concepts such as the access to online training, the relatively small size of New Zealand, with less travel distances between places than in Australia and other larger countries. It is also possible that the culture of Occupational Therapy supports the engagement in PD, therefore barriers are reduced, and opportunities are encouraged by managers. All of which highlights the access to PD as an area of strength for the NZ Occupational Therapy climate.

Supervision

When asked to rate satisfaction relating to supervision 38% (15 respondents) felt satisfied with their access to an appropriate supervisor. Ease of access to supervision and supervision training in NZ is interesting given overseas literature identifies challenges in engaging in supervision, particularly for rural therapists (Kuipers et al., 2015). There are many reasons that supervision access is satisfactory for NZ Occupational Therapists. For example, the OTBNZ mandated requirement for supervision as part of the professional obligation to maintain registration and competence, a culture of supervision in NZ, that

supervision provides an opportunity for networking and support, or promoting a platform for reflection, best practice, and a tool for change and burnout reduction.

Understanding the exact factors that are resulting in high satisfaction rates relating to supervision is important, given that when OTs have access to appropriate supervision their satisfaction and retention rates are higher (Lloyd et al., 2014). With the geographical diversity of NZ, there was the possibility that access to supervision would have been challenging for rural therapists, as evidenced in the literature on the topic. For example, Martin, Kumar, Lizarondo and VanErp, (2015) who found geographical location as a barrier to accessing supervision for rural practitioners.

Bi-cultural Implementation

Satisfaction relating to the implementation of bi-cultural practice was an important area of required growth identified by participants in this survey. Many survey participants identified difficulty with bi-cultural implementation in their practice context, which may be due to a limited understanding of what bi-cultural practice is, and what it looks like, in relation to day-to-day practice, a consideration also supported by Crawford, (2016). When asked "Are you satisfied with the implementation of bi-cultural practice within occupational therapy in New Zealand? Please explain "7 New Zealand European/Pakeha stated, 'yes' and 8 stated 'no'. Compared to no individuals identifying as either New Zealand Māori and Pasifika reporting they were satisfied with the implementation of bi-cultural practice. The results highlight that New Zealand European, NZ Māori and Pacifika occupational therapists in this survey, all thought more work is required regarding the implementation of bi-cultural practice. In 2019, 152 therapists identified as Māori (OTBNZ 2019). Given that the majority of NZ Occupational Therapists are European, there is potential that most of the narrative on experiences is from the perspective of Pakeha therapists. When considering the importance of maintaining role satisfaction for Māori OTs, as echoed by the obligations of the treaty, it is important to engage with Māori therapists to establish 'what would bicultural practice implementation look like for you?' The term and concept of bi-cultural practice may be still relatively new for therapists (first coming to the forefront of Occupational Therapy language in the 2016 E-portfolios). What is known is that the concept of bi-cultural practice, what it means and how this can be implemented is still being learnt and understood. Which is supported by the OTBNZ, (2016) audit findings where it was identified that 19% of occupational therapists e-Portfolios referenced multicultural practice as opposed to bi-cultural practice (competency two of OTBNZ competencies). Thus, echoing the consideration that

therapists were still attempting to understand the bi-cultural practice concept, and how this could be incorporated into practice.

The OTBNZ has been working to assist therapists in understanding and implementing bi-cultural practices. As evidenced by Te Tiriti o Waitangi being included as an overarching context for the board competencies, and one of the five competencies being specifically dedicated to bicultural practice as of 2016. The survey findings reflect the 2016 OTBNZ audit findings, with many therapists participating in this research reporting that they were still learning what bi-cultural practice is, and thus it is yet to be implemented in their practice. Several made comments to the amount of work required prior to implementing bicultural practice into roles/ settings. Overall, therapists in this survey (European, Māori and Pacifika) reported the profession was in the learning stage of implementing bi-cultural practice (what it is, what it looks like) and yet to realise this fully in current practice. Others felt that their setting did not set the precedent, by not appearing to prioritise bi-cultural practice (e.g., no powhiri to welcome new staff). The research is reflective of the OTBNZ audit findings where it was noted that there were varying levels of knowledge and understanding around bi-cultural practice.

Income

Of the 32 people who responded to the gross annual salary range question, the majority (9 or 28%) earn between $60,000 – $69,000 a year, 5 respondents (16%) identified as earning $50,000 – $59,000, followed by 4 (13%) earning $70,000 – $79,000. Followed by 3 respondents (9%) for both income bands of $40,000-$49,000 and $80,000-$89,000. Role satisfaction and higher salary also appeared to be linked, findings which mirror previous research by Bailey, 1990; Zontek, DuVernois & Ogle, 2009; and Sehlen, et al., 2009) who identified lack of pay progression among reasons therapists leave positions (leaving a position used as a proxy for job dissatisfaction). As evidenced by individuals in the higher income bracket identifying themselves as more satisfied overall, when compared to colleagues in lower-income brackets.

The connection between salary and satisfaction is important to consider for future planning by employers and key stakeholders in the industry (i.e., occupational therapy and related employers). Opportunities for pay progression and career development (therefore further salary progression) without significant salary capping is essential if employees wish to keep their staff satisfied, and therefore retain them. The concept of salary progression, career development and reduced salary capping is also important to consider for governing

bodies when considering the funding of health professionals. Namely, that the pay progression of staff needs to be prioritised, and therefore allocated appropriately. These findings about salary and satisfaction highlight the key role appropriate and adequate salaries, and opportunities for progression play in the satisfaction of occupational therapists, which is an important consideration in the recruitment and retention of therapists from a wider national level.

Limitations

In total, 32 participants were included in this survey. A sample size of 32 provides a snapshot of the overall occupational therapy population, and its views on a topic, but as a result, is likely a small percentage of the rural population. However, the survey captured therapists' views in an area that has not been previously explored and leaves space for future research specifically relating to factors identified in this study. The researcher acknowledges the limitation of a small sample size, and thus the difficulty in generalising the findings.

With uncertainty and discrepancies in the definition of 'rural', it is challenging to identify the exact number of rural occupational therapists in Aotearoa New Zealand, and thus the potential participant numbers for future studies. It is also difficult to identify who are eligible participants given that rural is challenging to define, and many therapists are not sure as to if they identify as rural or not. Therefore, it is important that the definition and concept of rurality be explored further. The therapists highlight the concept of rurality may not be tied to the geographical location of the therapist, as typically considered. However, it may be more appropriate to identify rurality based on the clients' experiences, and thus the strengths and concerns they bring based on their geographical location. The low level of male participants' limits gender related conclusions. Although gender disparities are expected, given the population ratios of 246 males and 2,732 females, practicing as occupational therapists in New Zealand, 1 does not allow for accurate and reliable gender conclusions. Therefore, the researcher was unable to make correlations between overall satisfaction, and specific factors, with gender.

Chapter Six: Conclusion

Length of time in a position, access to professional development opportunities and salary were all identified as significant factors in influencing the satisfaction of rural occupational therapists in NZ. It is important to recognise the factors that increase an occupational therapist's role satisfaction; however, it is equally important to acknowledge the interaction between the identified factors and individual preferences of occupational therapists. Where one therapist may enjoy the rural travel component, another may find this is the least satisfying aspect of their role. These factors likely change over time with experiences, service dynamics, and the progression of the profession. Further implementation and education of bi-cultural practice need to be implemented to ensure therapists feel culturally safe and satisfied with the implementation of bi-cultural practice and the implications this has for recruitment and retention of therapists in the profession (e.g., Māori & Pacific especially) and safe practice for our clients. The completed research is a starting point about a topic where more understanding is required. The identified gaps, such as understanding the experiences of new graduates, and the relationship between hours worked and satisfaction should be explored further to ensure therapists remain satisfied in their roles, in order to continue to retain individuals in such an important profession.

This project explored the factors influencing the satisfaction of physical health occupational therapists working in rural Aotearoa New Zealand. Whereas previous studies have predominantly been based overseas and focused on the satisfaction of mental health occupational therapists. This project aimed to provide an overview of the satisfaction of physical health occupational therapists working in rural New Zealand. Using a survey that utilised both qualitative and quantitative aspects created a snapshot of the factors influencing satisfaction.

Although the focus was on job satisfaction there were some aspects identified where further research is required, that are not specific to satisfaction itself. Of significant interest was the general difficulty participants had in identifying if their work was a rural practice for occupational therapists, thus there may be challenges with personal identity or ensuring that the correct individuals are supported or included in future research. Rural appeared to be a challenging term for therapists to identify with, with several participants stating they were unsure as to if they were rural therapists. Therapists who were unsure as to if they were rural therapists often reported that they worked with rural patients, in an urban setting, such as in a hospital acute ward. The concept of rurality being tied to the therapist's own experiences are

interesting to consider, as are the factors regarding geographical isolation and the effect this has on both the therapist and the client. As a result, it is possible that although rurality is relayed to the experiences of clients, and the therapists who identify as working with rural clients, the self-identification of being a rural therapist could differ greatly depending on the experiences of the therapist.

From the completed survey the researcher has several recommendations.

Firstly, it is recommended that research specifically seeks to understand the climate of new graduate occupational therapists in Aotearoa New Zealand. In particular, how as a profession we can support the next generation of therapists. Understanding the new graduate experience is critical as new graduates bring fresh ideas, knowledge and skill to the workforce. In a profession where the average age of therapists is 41 (OTBNZ, 2017) it is essential we support the primarily younger new graduates in their role satisfaction, which will flow on to influence retention, and have positive outcomes for the therapist, their colleagues, clients and the wider profession. To better understand the current professional climate for new graduates the researcher recommends qualitative surveys or interviews to explore this in more detail. Understanding new graduate experiences is an important body of work to meet the needs of novice practitioners to ensure new graduates stay in the profession and continue to develop their skills and add to the workforce.

Further exploration is also required regarding the potential relationship between working hours and the impact this may have on role satisfaction. In this study where those who worked the longest hours were also the most satisfied, those who worked fewer hours were less satisfied. Potentially, it is related to increased responsibility, for example, therapists who are taking on more managerial aspects within their role, or those working with high caseloads and hours not reflective of the caseload expectations. Another possibility is that therapists who are working full time or more are doing so because they have passion and enjoyment in their role. Therefore, they are satisfied and as a result, work longer hours. However, further research is required to understand this in an Aotearoa New Zealand context.

The research also highlighted the importance of further education and training about the implementation of bi-cultural practice. It was identified that more training and support is required to facilitate increased confidence and implementation of bi-cultural practice. The researcher is aware that a new initiative for removal of scope is that all therapists moving through the scope removal process must complete ‘Te Rito’ online modules, educating participants on the Treaty of Waitangi, cultural safety, and cultural considerations. Also that

the OTBNZ is in the process of re-drafting the competencies to strengthen the requirements of therapists to actively implement bi-cultural practice or Te Tiriti o Waitangi obligations into their practice. This is a step forward in raising the awareness, understanding on the topic nad acknowledging and enacting Māori mataranga, or ways of being and knowing.

This project provided the researcher with the opportunity to add to the small but growing body of research relating to occupational therapy practice in Aotearoa New Zealand, with a particular focus on rurality. The researcher hopes that the project findings assist in providing context to the current climate of occupational therapy practice in Aotearoa New Zealand, and will assist therapists and employers in understanding the significant relationship job satisfaction has on retention and recruitment.

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Appendix A: Sample of research articles included in literature review

Article	Source	Design	Numbers of participants	Factors included	Limitations of research
Broski & Cook (1994)	Ohio	Survey	24 people	How allied health staff felt about their jobs	Not occupational therapy specific Completed ~26 years ago Small number of participants
Eklund & Hallberg (2000)	Sweden	Questionnaire	334 people	Perception of job satisfaction of staff	Distributed to all members of the association
Panchasharam & Jahrami (2010)	Bahrain	Cross sectional survey	13 people	Job satisfaction of staff	No setting diversity (hospital based) Geographically specific
Turgeon & Hay (1994)	Ontario	Survey	55 people	Work-related issues	Limited to Males
Meade, Brown & Trevan-Hawke (2005)	Queensland	Demographic questionnaire	113	Comparison of job satisfaction between male and female occupational therapists	Specific geographical location (difficulty generalising

Appendix B: Master list of survey questions

Please note that this survey was entered into 'Qualtrics' online survey system not in paper form.

This appendix has been included to showcase the survey questions, coding and display/ flow logic.

Please see Appendix D for snapshots of the survey as seen by participants on Qualtrics.

First page:
Participant Information Form

Project title: Occupational satisfaction: Are physical health occupational therapists working in rural New Zealand satisfied within their roles?

Name of Researcher: Lucy Noble (Otago Polytechnic Master's of Occupational Therapy).

Introduction
Ensuring the wellbeing of health professionals is crucial. Health professionals who are burnt out are at an increased risk for making errors and compromising outcomes for the individuals they are working with (Delgadillo, Saxon & Barkham, 2018; Salyers et al., 2015). Health professionals are more likely to resign when dissatisfied with their jobs, which has a flow on effect in relation to loss of institutional knowledge, increased training costs for the organisation, and reduced continuity of care for clients/patients (Jones, 2004; Ray, Wong, White & Heaslip, 2013; Woltmann et al., 2008).
Therefore, the researcher has identified a gap in the literature, specifically related to job satisfaction of physical health occupational therapists. To alleviate this gap, and add to New Zealand specific data, a survey is being sent to all New Zealand registered occupational therapists who express interest in research. Themes from this survey will then be pulled and grouped, in order to highlight the current climate of the profession.

What is the aim of the project? (What is the study about?)
The purpose of this research is to assist in recognising the factors identified by physical health occupational therapists that influence their job satisfaction, specifically, therapists working in rural New Zealand. From the data gathered during this research it is hoped that the climate of the occupational therapy profession, specifically physical health, will be captured.

What will my participation involve?
Should you agree to take part in this project, you will be asked to complete a survey that will include both open and closed questions related to your practice, practice environment, and satisfaction in a number of areas. Once the survey is submitted your identifying information will be removed.
You can decline to participate without any disadvantage to yourself of any kind. If you choose to participate, you may withdraw from the survey at any time, without giving reasons for your withdrawal. Simply exit the survey prior to submission.
Once the survey has been submitted you will not be able to withdraw your participation, as the information supplied by you will be unable to be traced back to you. You can refuse to answer any particular questions if you do not wish to provide answers.

What if I have any questions?
If you have any questions about the project, either now or in the future, please feel free to contact either: Lucy Noble (researcher) or Sian Griffiths (Master's Supervisor).

Lucy Noble – nobll1@student.op.ac.nz
Sian Griffiths - Sian.Griffiths@op.ac.nz

NEXT PAGE

Consent

We will ensure your confidentiality through not collecting any identifying information, and the use of an anonymous link for survey participation. All data is stored in a password protected electronic format. To help protect your confidentiality, the survey will not contain information that will personally identify you.

Electronic consent: Please select your choice below.

Clicking ‘agree’ indicates that:
You have read the information on the previous pages and you voluntarily agree to participate.

Clicking 'disagree' indicates that:
You do not wish to participate in the research study by completing this survey.

□ Agree

□ Disagree

Zone out if not eligible

Are you currently working in physical health in New Zealand?

□Yes

□ No

Zone out if not eligable

Are you registered with the Occupational Therapy Board New Zealand (OTBNZ)?

□ Yes

□ No

Zone out if not eligable

Rural is generally defined as a "population between 300-999 people".
Do you identify as a rural practitioner? (work in a rural setting, or actively cover rural settings regardless of your base)

□ Yes

□ Not sure (why) _____

□ No (why)_____

Zone out if not eligable

Q1 .Do you work for a:

□ District Health Board (DHB)

□ Non-Government Organisation (NGO)

□ Private practice

□ Primary Health Organisation

□ Non-Government Organisation (NGO)

□ Other (please specify) _____

□ Prefer not to say

Q2. In which geographical location are you based?

□ Northland □ Taranaki

□ Auckland □ Waikato

□ Bay of Plenty □ East Coast of North Island

□ Hawke's Bay □ Manawatu-Wanganui

□ Wellington □ Nelson-Marlborough

□ West Coast of South Island □ Canterbury

□ Otago □ Southland

Q3. On a scale of 1-9 (with 9 being very satisfied and 1 being very dissatisfied) rate your general level of satisfaction in your current role

1 2 3 4 5 6 7 8 9

_____

Very dissatisfied Satisfied Very satisfied

Q4. What other benefits/perks do you have as part of your employment? Please select as many as applicable

□ Medical insurance

□ OTNZ-WNA membership paid

□ Other professional membership paid _____

□ Uniform provided

□ Clothing allowance

□ Continuing professional development

□ Discounts for local businesses/ services

□ Bonus payment

□ On call allowance

□ Vehicle you can take home/use for personal use

□ Vehicle allowance for use of private vehicle

□ Accommodation

□ Laptop/tablet (for personal use)

□ Phone (for personal use)

□ Other not included above, please state _____

□ None of the above

□ Prefer not to say

Q5. What are the most challenging aspects of your job?

□ Role conflicts

□Excessive paperwork

□Bureaucracy

□ Minimal career advancement

□Burnout/Stress/ Overload

□ Caseload size

□Not using Occupational Therapy skills

□Inflexible hours

□Insufficient time for position expectation

□ Distance from home

□ Childcare issues

□ Lack of supervision

□Peer relationships

□Management/ Management style

□ Other: please specify_____

□ Prefer not to say

Q6. Please rate your level of satisfaction relating to the following professional development factors

	Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Dissatisfied	Very dissatisfied	N/A	Prefer not to say
Ability to access professional development opportunities	☐	☐	☐	☐	☐	☐	☐	☐
Access to feedback and performance appraisals	☐	☐	☐	☐	☐	☐	☐	☐

Q7. Please rate your level of satisfaction relating to the following resource factors

	Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Dissatisfied	Very dissatisfied	N/A	Prefer not to say
Access to resources required to complete role	☐	☐	☐	☐	☐	☐	☐	☐

(cars, computers, phones etc)								
Access to resources required to impliment intervention (adequate rooms, availability of rooms, equipment etc)	☐	☐	☐	☐	☐	☐	☐	☐
Access to required IT systems (Enable, AccessAble, etc)	☐	☐	☐	☐	☐	☐	☐	☐

Q8. Please rate your level of satisfaction relating to the following management factors

	Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Dissatisfied	Very dissatisfied	N/A	Prefer not to say
Availability of your manager	☐	☐	☐	☐	☐	☐	☐	☐
Management style	☐	☐	☐	☐	☐	☐	☐	☐
Feeling valued by your manager(s)	☐	☐	☐	☐	☐	☐	☐	☐
Concerns are addressed by your manager	☐	☐	☐	☐	☐	☐	☐	☐

Q9. Please rate your level of satisfaction relating to the following role factors

	Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Dissatisfied	Very dissatisfied	N/A	Prefer not to say
Caseload management	☐	☐	☐	☐	☐	☐	☐	☐
Pay progression opportunities	☐	☐	☐	☐	☐	☐	☐	☐
Diversity of work	☐	☐	☐	☐	☐	☐	☐	☐
Flexibility of working hours	☐	☐	☐	☐	☐	☐	☐	☐

Work life balance	☐	☐	☐	☐	☐	☐	☐	☐
Client contact to paperwork ratio	☐	☐	☐	☐	☐	☐	☐	☐
Job security	☐	☐	☐	☐	☐	☐	☐	☐
Appropriate levels of staffing	☐	☐	☐	☐	☐	☐	☐	☐
Autonomy	☐	☐	☐	☐	☐	☐	☐	☐
Access to annual leave	☐	☐	☐	☐	☐	☐	☐	☐
Access to staff discounts (retail stores and services	☐	☐	☐	☐	☐	☐	☐	☐

Q10. Please rate your level of satisfaction relating to the following colleague factors

	Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Dissatisfied	Very dissatisfied	N/A	Prefer not to say
Support from your occupational therapy colleagues	☐	☐	☐	☐	☐	☐	☐	☐
Support from other health professionals	☐	☐	☐	☐	☐	☐	☐	☐
Colleagues having a clear understanding of your role	☐	☐	☐	☐	☐	☐	☐	☐
Feeling valued by your colleagues and patients	☐	☐	☐	☐	☐	☐	☐	☐

Q11. Please rate your level of satisfaction relating to the following travel factors

	Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Dissatisfied	Very dissatisfied	N/A	Prefer not to say

Travel times (to get to your place of employment)	☐	☐	☐	☐	☐	☐	☐	☐
Travel times (to see your patients)	☐	☐	☐	☐	☐	☐	☐	☐
Travel times (to access workshops/ training etc)	☐	☐	☐	☐	☐	☐	☐	☐

Q12. Please rate your level of satisfaction relating to the following supervision factors

	Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Dissatisfied	Very dissatisfied	N/A	Prefer not to say
Access to an appropriate supervisor	☐	☐	☐	☐	☐	☐	☐	☐
Access to supervision training	☐	☐	☐	☐	☐	☐	☐	☐
Ability to participate in supervision	☐	☐	☐	☐	☐	☐	☐	☐

Q13. Please rate the following factors that are the most rewarding/ positive aspects of your current position in the order you feel reflects this. You can change the rating of each factor by dragging it to the position you wish.

Direct client contact

Nature of caseload

Programme development

Staff supervision

Clinical research

Management responsibilities

Participation in service activities

Childcare availability

Holiday time/ annual leave

Professional development opportunities

Salary/ pay

Team/ colleague opinion of occupational therapy

Management/ Management style

Flexibility of hours

Career development/ promotion

Work/life balance

Relationship with team or peers

Other_____

Q14. Are you satisfied with the implementation of bi-cultural practice within occupational therapy in New Zealand? Please explain.

Q.15. Is your cultural satisfaction important to you in the satisfaction you have within your role? Please explain.

Q16. Do you feel satisfied with the cultural safety of your role? Please explain

Q17 I am content in my position and have no desire to leave my current position. If no, why?

□ Yes

□ No _____

□ Prefer not to say

If yes, skip to question 17 (How long have you been in your current job?)

Q18 I often think about quitting my job. If yes, why?

□ Yes _____

□ No

□ Prefer not to say

If no, skip to question 17 (How long have you been in your current position?)

Q19. As soon as I find another job I will quit. If yes, why?

□ Yes _____

□ No

□ Prefer not to say

Q20. How long have you been in your current job?
□ 0-1 year

□1-5 years

□5-10 years

□ 10-15 years

□ 15-39 years

□ 30+ years

□ Prefer not to say

Q21 Did you work in a physical health setting prior to your current position?

□ Yes

□ No

□ Prefer not to say

If no is selected skip to question 20

Q22 What was your reason for leaving your previous role?

Demographic Block

The next block of the survey includes questions to find out more about the individuals taking this survey.
Please note: All responses are anonymous and you will not be identifiable.
Any potentially identifying information will be removed at submission.

Q23. What ethnicities do you most strongly identify with? Select all that apply

□ New Zealand European/Pakeha

□ New Zealand Maori

□ Pacifika

□ New Zealander (Other)

□ Other please specify _____

□ Prefer not to say

Q24. Which age group are you in? (drop down box)

□ 20-25

□ 26-30

□ 31-35

□ 36-40

□ 41-45

□ 46-50

□ 51-55

□ 56-60

□ 60-64

□ 65+

□ Prefer not to say

Q25. What gender(s) do you identify with?

□ Male

□ Female

□ Non-binary / third gender

□ Prefer not to say

□ Other

Q26 When did you qualify as an occupational therapist?

2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010
2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998
1997	1996	1995	1994	1993	1992	1991	1990	1989	1988	1987	1986
1987	1986	1985	1984	1983	1982	1981	1980	1979	1978	1977	1976
1975	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965	1964
1963	1962	1961	1960	1959	1958	1957	1956	1955	1954	1953	1952
1951	1950	1949	1948	prefer not to say							

Q27. How long have you been working as an occupational therapist?

□ 0-1 years

□ 1-5 years

□ 5-10 years

□ 10-15years

□ 15 -30 years

□ 30+ years

□ Prefer not to say

Q28. What client age group do you currently work with? Select all that apply

□ Under 18

□ 18-24

□ 25-34

□ 35-44

□ 45-54

□ 55-64

□ 65 – 74

□ 75-84

□ 85 or older

□ Prefer not to say

Q29. What is the amount of time in which you work in a particular setting? (Please give an estimated percentage of your total work time. The total should add up to 100).

_____ Inpatient acute

_____ Inpatient rehabilitation

_____ Community acute/ community assessment team

_____ Community rehabilitation

_____ Needs Assessment

_____ Vocational services

_____ Other (please specify)

Q30. How long have you worked with this client group?

□ Less than 1 year

□ 1-5 years

□ 5-10 years

□ 10-20 years

□ 20-30 years

□ 30-40 years

□ 40+ years

□ Prefer not to say

Q31. In terms of paid working hours, how many hours a week do you generally work?

□ Less than 8

□ 8-16

□ 24-32

□ 32-40

□ Over 40

□ Prefer not to say

Q32. What is your gross annual salary range?

□ Less than 10,000 □ 10,000-19,999 □20,000-29,999 □30,000 -39,999

□ 40,000 – 49,999 □ 50,000- 59,999 □60,000 – 69,999 □70,000-79,999

□80,000- 89,999 □ 90,000-99,999 □100,000- 149,999 □ More than 150,000

□ Prefer not to say

Q33. What is your highest qualification as an occupational therapist?

□ Bachelor in occupational therapy

□ Post graduate certificate in occupational therapy

□ Post graduate diploma in occupational therapy

□ Master's in occupational therapy

□ Other:_____

□ Prefer not to say

Q34. Do you consciously use an occupational therapy frame of reference, conceptual model or framework?

□Yes

□ No

□ Prefer not to say

If no is selected, skip to Question 33

Q35. If yes, what occupational therapy frames or reference, frameworks or conceptual models guide your practice, select all that apply

□ Model of Human Occupation (MOHO)

□ Person Environment Occupation (PEO)

□ Canadian Model of Performance and Engagement (CMOP-E)

□ Kawa Model

□Other, please specify _____

□ Prefer not to say

Q36. Do you use non-occupational therapy models to guide your current practice? if so, please specify

□ Yes _____

□ No

□ Prefer not to say

Q37. Are there any comments, related to your satisfaction as an occupational therapist that you would like to make that has not been addressed elsewhere? Please make them

here_____
_____
_____

If this survey has highlighted any concerns for you please liaise with the appropriate services, whether this is your manager, your GP, or a counselling service.

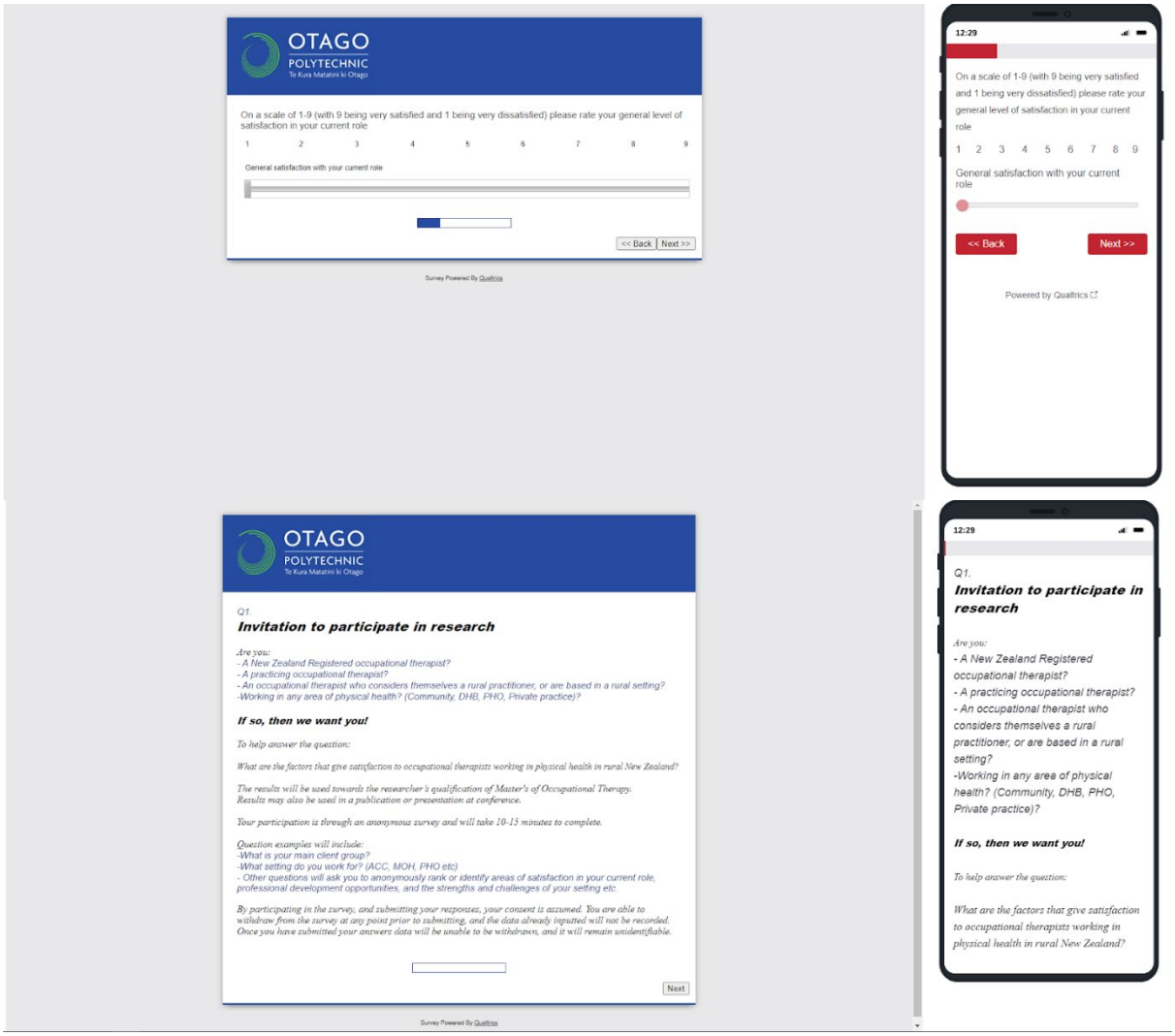
You have now reached the end of the survey. By pressing 'submit' you will finalise your participation and submit your information.

Once the survey has been submitted it is unable to be withdrawn, as it is anonymous it is unable to be linked to you.

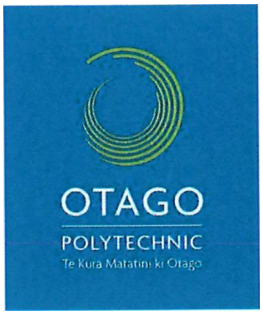
Thank-you for your time. Your participation in this survey will go towards the researchers Master's qualification and assist in informing the current professional climate.

Appendix C: Snapshot of Qualtrics layout

Desktop (right) and cell phone (left)



Appendix D: Ethical Approval



12 February 2021

Lucy Noble

Dear Lucy

Ethics approval for project

Reference Number: 877
Application Title: Occupational satisfaction: Are physical health occupational therapists working in rural New Zealand satisfied within their roles?

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

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

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

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

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

Regards

Dr. Liz Ditzel

Chair, Otago Polytechnic Research Ethics Committee

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www.op.ac.nz

Appendix E: Ethical approval from the Kaitohutohu Māori Research Consultation

Whāia te pae tawhiti kia tata. Whāia to pae kiā maua.
Persue the distant horizons so that they may become your reality.

Office of the Kaitohutohu Māori Research Consultation Feedback
Date: 24 September 2020
Researcher name: Lucy Noble
Department: Master of Occupational Therapy
Project title: Occupational satisfaction: Are physical health occupational therapists working in rural New Zealand satisfied in their roles? What are the factors that give satisfaction to rural occupational therapists working in physical health in New Zealand?

TAIAO: Achieving environmental sustainability through Iwi & Hapū relationships with the whenua & moana	
Mātauraka Māori: Exploring Indigenous knowledge	
Hauora: Improving health & wellbeing	As the applicant has pointed out, whakapapa underpins everything for Māori, so therefore it may be useful to consider asking if the anonymous survey participants have Māori whakapapa. Māori are under-represented in the field of OT, despite Māori being a fast growing, young population. If this survey was able to identify Māori feedback, it could provide some useful feedback on the satisfaction levels for Māori OT and their ideas on how recruit more Māori to this profession and to increase and transform participation in occupation. This profession offers the opportunity to enhance peoples tino rakatirataka (self-determination), to ensure equity and enable social justice. The applicant is able to drawn on Māori concepts and use these to align her research methodology. These concepts could also be used as survey questions, to explore the sociocultural realities of OT practitioners and their satisfaction levels in this profession. We wish you all the best with your research Lucy.
To Live as Māori: Kaitiakitaka to ensure Māori culture and language flourish	

Unlocking the innovation potential of Māori knowledge, resources and people.

Name: Kelli Te Maihāroa
Position: Tumuaki: Rakahau Māori | Director: Māori Research, Otago Polytechnic

Appendix F

Participant information sheet

Invitation to participate in research

Are you:

- A New Zealand Registered occupational therapist?
- A practicing occupational therapist?
- An occupational therapist who considers themselves a rural practitioner, or are based in a rural setting?
- Working in any area of physical health? (Community, DHB, PHO, Private practice)?

If so, then we want you!

To help answer the question:

What are the factors that give satisfaction to occupational therapists working in physical health in rural New Zealand?

The results will be used towards the researcher's qualification of Master's of Occupational Therapy. Results may also be used in a publication or presentation at conference.
Your participation is through an anonymous survey and will take 15-20 minutes to complete.

Question examples will include:

- What is your main client group?
- What setting do you work for? (ACC, MOH, PHO etc)
- Other questions will ask you to anonymously rank or identify areas of satisfaction in your current role, professional development opportunities, and the strengths and challenges of your setting etc.

By participating in the survey, and submitting your responses, your consent is assumed. You are able to withdraw from the survey at any point prior to submitting, and the data already inputted will not be recorded. Once you have submitted your answers data will be unable to be withdrawn, and it will remain unidentifiable.

Click the below link to be taken to the survey

https://otagopolytechnic.au1.qualtrics.com/jfe/form/SV_29TcsfW65mC2YpU

Appendix G

Email invitation to OTBNZ requesting distribution of survey

Tenā koutou,

I am a whakaora kakahau (occupational therapist) from Southland, currently enrolled as a student at Te Kura Matatini ki Ōtāgo (Otago Polytechnic) with the School of Occupational Therapy, completing my Master's Degree.

In partial fulfilment of my Master's project, I am currently undertaking research on factors influencing role satisfaction of occupational therapists working rurally in physical health settings in Aotearoa/ New Zealand.

I understand that you are able to circulate electronic invitations to occupational therapists who are willing to participate in research.

In this regard, I would like to request that you please distribute my 'invitation to participate in research' containing the link for participation in my survey via a bulk email. If you could provide me with the email recipient numbers, and opening rate that would be most useful. If the invitation could be circulated to occupational therapists as soon as is possible please.

I have attached information on my study including my ethics approval for your information.

Once my studies are complete I hope to publish about my research and research findings in the Aotearoa/ New Zealand occupational therapy professional literature.

Thank you for the consideration of my request, and hopefully the circulation of my invitation to the occupational therapists. Should you need further clarification, please do not hesitate to contact me at xxx or my primary supervisor Sian Griffiths at xxx

Kā mihi

Lucy Noble