



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Research Commons

<http://researchcommons.waikato.ac.nz/>

Research Commons at the University of Waikato

Copyright Statement:

The digital copy of this thesis is protected by the Copyright Act 1994 (New Zealand).

The thesis may be consulted by you, provided you comply with the provisions of the Act and the following conditions of use:

- Any use you make of these documents or images must be for research or private study purposes only, and you may not make them available to any other person.
- Authors control the copyright of their thesis. You will recognise the author's right to be identified as the author of the thesis, and due acknowledgement will be made to the author where appropriate.
- You will obtain the author's permission before publishing any material from the thesis.

**Street-level bureaucracy and occupational therapy practices in
Aotearoa New Zealand.
A genealogical critique**

A thesis
submitted in partial fulfilment
of the requirements for the degree
of
Doctorate of Philosophy
at
The University of Waikato
by
E. Mary Silcock



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2018

Abstract

As a human science that is also part of administering and supporting bureaucracy, occupational therapy functions in multi-layered networks of power that support many different social structures. Occupational therapists' work often involves operationalising health, education and social services at the street-level, positioning them between the aspirations of both policy and social activism and material life outcomes. Through a genealogical critique, this thesis problematises the practice of occupational therapy through a Foucauldian lens that views everything as dangerous. By viewing occupational therapy practice as dangerous, the power relations at the street-level of the mundane and taken-for-granted have been problematized as part of much larger social structures of power and discourse.

Several Foucauldian tools were deployed in order to ensure that a focus on occupational therapy practices was maintained; three distinct research methods were utilised to access a range of heterogeneous genealogical information. Firstly, an historical archival analysis of the four iterations of the Competencies for Registration for occupational therapists document (1990 to the current day) produced by the regulatory authority, the Occupational Therapy Board of New Zealand, was carried out. Secondly, practice observations of occupational therapists working in different practice settings were analysed as three individual case studies. Concurrently with these two methods, a critical action method using a research blog was developed to create a medium for public discussion of practice through an open engagement with the profession. The combination of these three methods enabled access to a range of elements for analysis. Many of these elements inter-linked, overlapped and connected to historically contingent networks of dominant power that have formed through the processes of colonisation, the establishment of the health system and normalised medical practices, and economic forms of governance. The nuances of how occupational therapy is practised at the street-level offered opportunities to contest the dominance of these networks. In all three case studies there was an unspoken understanding and a normalisation of materiality as an accepted

and significant element of how the profession practised. The material regimes of knowledge and material practices in these unspoken norms were highly productive and able to contest other lines of power. Along with this alternate network of power, the most recent version of the Competencies for Registration offers a further opportunity for occupational therapists to contest dominant power relations in a way that could capitalise on the secure position the profession has developed through its material network of power. Opportunities for alternate pathways of practice which privilege Te Ao Māori and Te Tiriti o Waitangi are a possibility in the legally sanctioned Competencies. The close connection of occupational therapy practices to real life material outcomes for other people, position the street-level doing of occupational therapists at a juncture where action and decision making can re-configure power relations. Re-thinking practice in terms of what the doing of occupational therapy does in relation to networks of power, is an opportunity for practitioners to enact policy at the street-level in ways that use their ability to influence power from the bottom up whilst being alert to the dangers presented by doing so.

Keywords: power, Foucault, materiality, practitioners, post-colonial

Acknowledgements

Before I commence the long list of people I could not have completed this thesis without, I need to acknowledge the University of Waikato who granted me a Doctoral scholarship for three of the four years taken to complete this thesis. As well as the financial support that enabled me to study fulltime, the scholarship gave me time as a parent to my young children as well as to be a student.

Without the scholarship I would not have been in a position to carry out this doctorate and for the opportunity it has given me I am extremely grateful.

I am also indebted to my diverse supervision team, Dr Maxine Campbell, Professor Clare Hocking and Associate Professor Craig Hight. As chief supervisor, thank you Maxine for being a constant positive support, always being available and allowing me to find my own way. I have also really appreciated the ongoing input from Craig who generously agreed to continue supervising after moving to Australia mid-way through. Without your methodological guidance and critique this thesis would be on an entirely different level and I have highly valued your input throughout. Finally, Clare who has been a life-long part of my tertiary level study journey, having taught me as an undergraduate, supervised my Masters of Philosophy and now seen me through a doctorate. Thank you so much Clare, over these 25 years, you have taught me how to participate in the academic world, to write, edit, format, reference and publish. Without your support I doubt I would have reached the stage of completing a PhD.

As well as my academic supervisors, Associate Professor Linda Te Aho in the Faculty of Law generously agreed to review the chapter on sovereign power and legal practices for me and Rita Robinson kindly offered to read the final draft of the thesis, thank you both for your time. I also want to thank the occupational therapists who agreed to participate in the research and all the therapists who contributed to the blog. Without your willingness to be involved and ongoing interest, the research process would have been extremely daunting. As well as these individuals the Occupational Therapy Board of New Zealand and Whakaora Ngangahau-Occupational Therapy New Zealand have also been active supporters of the research and me as a researcher. Without this professional support I

would have not got as far with the project as I have, both in the academic content and on a personal level.

Lastly, I need to acknowledge and thank my three sisters, my parents and several wonderful friends. Without their support, encouragement and practical help to look after my children I would not have been able to complete this thesis. And as my main cheerleaders, Ariel, Trelise, and Greer, thank you for your advice (“just add another sentence and hand it back – that’s what I do”) and ability to celebrate the little milestones with me, it made a big difference.

Table of Contents

Abstract.....	iii
Acknowledgements.....	v
List of Figures	xii
List of Tables.....	xiii
List of Maps	xiv
Chapter 1: Introduction.....	1
Street-level bureaucracy and occupational therapy.....	5
What exactly is occupational therapy?	7
Methodological Influence	12
Analysing power.....	14
Materiality and occupational therapy.	18
Feminist Critique and Critical Reflexivity	21
Structure of the Thesis	23
Chapter 2: Philosophical Base of Research Design	29
Genealogy as Critique	30
Productive intent of genealogical critique.....	30
Archival Research.....	33
Remaining on the surface.	33
Power and Discourse.....	35
Sovereign power.	37
Sovereign power, colonisation and material outcomes.	39
Economic-governmental power.....	41
Materiality.....	44
Critical Self-reflexivity	46

Chapter 3: Research Methods	51
Connections between the Methods	51
Insider position and ethical axis.	52
Research Blog	54
Archival Analysis	57
Practice observations	60
Recruitment strategy.....	62
Workplace descriptions.....	64
Informed consent process.....	65
Procedure for observations.....	66
Compiling the workplace genealogies.....	66
Ethical comments on observation as a method.....	68
Critical Reflection on Choice of Methods.....	70
Summary.....	73
Chapter 4: Contextual Background	75
Colonisation of Aotearoa New Zealand.....	75
Waikato context.	77
Health Service Provision in Aotearoa New Zealand	83
Summary.....	87
Chapter 5: Sovereign Power and Legal Practices	89
Genealogy of Legal Practices	92
The competencies as a legal document.	95
Health regulation as a legal structure.	97
Legal monitoring of occupational therapists.....	99
Contesting colonially interpreted law.	101
Sovereign Power and Rights Based Legislation.	103

Sovereign power at the street-level.	104
Post-colonial Implications	107
Summary	109
Chapter 6: Economic-Governmental Power and Governmentality.....	111
Enterprising up the Health Sector.....	113
Enterprising practices at the service level.	115
Enterprising up the market.	120
Commodification of healthcare.	123
Enterprising up Regulation.....	130
OTBNZ and governmental structures.	131
OTBNZ and globalisation.....	135
Enterprising up at the Street-level.....	137
Responding to enterprise.....	138
Enterprising up practice.	139
Summary	147
Chapter 7: Unsaid Practice.....	149
Tokanui Hospital.....	150
Institutional history.....	152
Institutional custodial care and colonial practices.	154
Occupational Therapy at Tokanui Hospital	156
Current unsaid practices.	160
Archival Silencing	165
The grey archives.	170
Generic Silencing.....	171
Summary	178
Chapter 8: Materiality and Power.....	181

Everyday Materiality.....	184
Materiality and the Discursive.....	187
Materiality at the micro-level.....	188
Materiality and discourse.	196
Summary.....	204
Chapter 9: Critically Engaging with the Profession	207
The Research Blog	208
Creating a Critical Discursive Space.....	210
The Blog as a Positive Endeavour	212
Unpredicted Outcomes of the Blog.....	214
The Blog as a Discursive Practice.....	216
Chapter 10: Discussion	219
Danger at the Hard Edge of Material Outcomes.....	220
The hard edge of sovereign power.....	220
The hard edge of capitalism.	227
Opportunities at the Hard Edge of Material Outcomes	232
Bypassing dominant knowledge regimes.....	232
Alternate Pathways of Practice	238
Material regimes of knowledge at the micro-level.....	239
Material regime of knowledge as a site of resistance.....	241
Limitations of the Research.....	244
Future Research Directions	246
Concluding Statement	247
References.....	248
Appendix 1: Blog Front Pages.....	282
Appendix 2: Poster Presentation Asia Pacific Occupational Therapy Congress..	283

Appendix 3: Examples of the Competencies for Registration Documents	284
Appendix 4: Sample of Observational Notes from each Case Study	288

List of Figures

Figure 1: Competencies for Registration documents 1990-2017	57
Figure 2: Show your Ability, Hamilton, Aotearoa New Zealand, 2016.....	126
Figure 3: Tokanui Hospital, 2014	151
Figure 4: Occupational therapy staff at the Creative Workshop, Tokanui Hospital, 1995	158
Figure 5: Hydrotherapy pool with occupational therapy staff and me, 1995.....	159
Figure 6: Seating and wheelchair staff and me, 1995	159
Figure 7: Mental health ward, Waikato Hospital, 2016	161
Figure 8: Special school, 2016	162
Figure 9: Wheelchair Service, 2017	164
Figure 10: Doniella, in a wheelchair fabricated at Tokanui Hospital.	168
Figure 11: Education Pathway	172
Figure 12: Forensic Client Pathway	174
Figure 13: The Prioritisation Tool	177
Figure 14: Wheelchair service workshop, 2016	185
Figure 15: Core board communication aids	192
Figure 16: Kitchen at forensic ward, 2015.....	194

List of Tables

Table 1: Service Locations by Decade	114
Table 2: Connecting with the Profession	209
Table 3: Blog Posts and Comments.....	211

List of Maps

Map 1: Waikato-Tainui Rohe & Waikato Region.....	79
Map 2: Waikato-Tainui Raupatu area	81
Map 3: Tokanui Hospital and Waikeria Prison	152

Chapter 1: Introduction

As a regulated and mainstream health profession, occupational therapy in Aotearoa New Zealand is utilised in the provision of many health, education and social services. These services use occupational therapy to operationalise policy and meet service contract expectations that require the profession's legitimised expertise. Occupational therapists' work is expanding to fulfil a variety of street-level bureaucratic roles in an increasing range of sectors. By having an operationalising role, occupational therapy has a position in these networks of bureaucracy that can influence the health, education and social conditions for people who live in Aotearoa New Zealand. When the initial plans for this thesis were forming in 2012, publically funded bureaucracy in Aotearoa New Zealand was at the beginning of a new period of reformation, to provide 'Better Public Services' in order to "retain the strengths of our State services while addressing weaknesses such as fragmentation, government agencies working in silos, and inefficiencies" (The Treasury, 2014, p. 1). Two years later, a review was launched by the Productivity Commission to "look at ways to improve how government agencies commission and purchase social services" (The Treasury, 2017, p. 1). Both these moves at the level of policy heralded another re-structuring of the way health, education and social services were to be managed and controlled by central government.

During the subsequent five years, many new processes and systemic changes occurred in public and contracted services that have served to align the objectives of these policies. These have included roll outs of centralised data collection and information sharing systems such as the dedicated eHealth programme (Ministry of Health, 2017b); the complete re-creation of government departments such as the Child, Youth and Family Service, now named Oranga Tamariki, the Ministry for Children (Oranga Tamariki, 2017); and the introduction of a Community Investment Strategy which highly prioritises evidence based outcomes, data analysis and building the capability of the community sector to operate accordingly (Ministry of Social Development, 2016, p. 7). Meanwhile, outside this governmental policy sphere, there has been a parallel increase in

public alarm about a plethora of societal issues, which have continued throughout 2017.

Headlines in the media such as “NZ’s homelessness the worst in OECD - by far” (Satherley, 21 July 2017); “UNICEF releases damning child welfare report - New Zealand has topped the global teen suicide rankings, again (Walters, 15 June 2017); “NZ’s highest rate of family violence in the developed world - Amy Adams has ‘had enough’ “ (Adams, 21 March 2017); “Moko inquest: 94 kids killed since Nia Glassie’s horrific murder [10 years ago]” (Savage, 3 October 2017); “NZ’s bulging prison population ‘unprecedented’” (Edens, 25 May 2017); “United Nations report slams New Zealand’s use of solitary confinement” (Johnstone, 27 April 2017) and “Special education wait times ‘appalling’” (Gerritson, 2017) cover a gamut of social sectors and indicate serious widespread problems in the social body.

As an occupational therapist I have been, and continue to be, employed in services that work with many of the people who are, or at risk of being, one of the statistics above. Workers like me practise in people’s homes, communities and institutions to provide health, education and social services with people who are often living in conditions that are far from actualising the high-level aims that government policies espouse. Michael Lipsky coined the term ‘street-level bureaucrat’ and contends that these workers, who have been delegated various levels of power “effectively *become* the public policies they carry out” (original italics) (Lipsky, 1980, p. xii). Becoming the policy does not necessarily mean the intended outcomes of the policy are realised. The actions of street-level bureaucrats can have a variety of influences on how policy is negotiated and enacted. In her examination of health, education and welfare practitioners, Gofen (2014) suggested there are a variety of divergent actions which can influence policy decision-making from the street-level in productive, passive or negative ways. These actions are highly nuanced and are closely connected to micro-level norms of practice related to individual disciplines. The importance of these micro-level decisions was also emphasised by O’Sullivan (2015) in his work involving health outcomes for the indigenous Australian Aboriginal people. He

placed street-level bureaucrats as central participants in the politics of indigenous health due to their ability to prioritise and make decisions that have direct outcomes on the care received. Viewing occupational therapy's role and position within the bureaucracy of delivering services as part of enacting policy supports the perspective of Michel Foucault that everything is dangerous (Foucault, 1983), raising questions about what the doing of occupational therapy does. By building on this perspective, this thesis has problematized certain occupational therapy practices as a form of street-level bureaucracy. The gap between the aspirations of both policy and social movements and the reality of practice as a street-level bureaucrat (Lipsky, 1980) is where this thesis is situated.

The primary motivation for the project was to contribute to a greater understanding about how social outcomes remain the same (or worsen) despite the enormous volume of energy and attention spent trying to make them better by policy analysts, researchers, managers, street-level workers and activists alike. As a practitioner, I, like thousands of other street-level bureaucrats in Aotearoa New Zealand, have been motivated for much of my career, enthusiastically taking up many types of external training and post-graduate study, as well as supporting various service re-structures and funding changes in order to provide a better service with better outcomes. Despite this however, services do not appear to be better and society does not appear to be more just. Life outcomes for many people have not changed despite my (and the thousands of well-intentioned others) attempts to do practice differently. The lack of outcomes of policy and social activism suggests that at the level of practitioner there are other apparatus of power operating. The regime of practices formed through practitioners' work, sits outside the apparatus of policy and social activism and has formed a social structure in itself. As Millar and Rose (2008) have consistently argued, so called experts of the human condition have become an increasingly important structure underpinning the way advanced democracies function. As one of these nominated experts, occupational therapy is part of this structure. The thesis explores how practices are connected to macro-level governance and control of the population, while at the same time are able to

negotiate and contest this level of power through every day and often unspoken practices. At the same time the research was designed to actively unsettle the stability of these practices by questioning what the doing of normalised practice does.

To carry out this type of analysis the methodology of genealogical critique has been used to design the research and a post-colonial stance has been taken in the way the critique has been applied. As Aotearoa New Zealand is a colonised country, the power relations of street-level bureaucrats remain historically connected to the colonial imposition of Euro-normative worldviews, beliefs and practices. Michel Foucault's work provided broad methodological guidance, one that was able to encompass a post-colonial lens at the same time as a focus on the micro-level of practice. The focus on practice has, in turn, enabled the complexities of working on the ground, at the hard edge of people's life outcomes, whilst always negotiating the macro-level social forces that drive health and social services, to be incorporated in the analysis. As well as having this methodological breadth, Foucault's work had political and activist intent in the way it conceptualised power, and his concepts of the productivity of discourse and power have been applied in an active way through the process of conducting the research. As such, the research was designed with an active intent to become part of the discourse and practices of the profession as much as an intellectual endeavour. From my experience it is micro-level detail that is required in order for occupational therapy practitioners to actualize academic critique or to re-imagine "practices, systems and structures that create conditions of occupational oppression, inequity and injustice" (Laliberte Rudman, 2014, p. 380). Accordingly, the thesis focusses on how micro-level practices act as capillaries of power at the ground level. I contend that this is where the multiple power games that support social structures and discourse are played out and negotiating these games with productive intent requires informed thought.

Street-level bureaucracy and occupational therapy.

Within the occupational therapy profession the position of power and political implications of being a street-level bureaucrat is not something that has been well acknowledged. Although there is a body of work emerging that provides a critical perspective about occupational therapy practice, it tends to remain at the theoretical level rather than examining the micro-level exercise of power in everyday practices. In 1995 disability activist Paul Abberley challenged occupational therapy by suggesting its micro-level practices had coercive power that supported social structures of disablement due to normative beliefs the profession held and the tendency to blame the system or the service user for any poor outcomes (Abberley, 1995). Abberley's analysis did not extend to observing what occupational therapists did, rather it was an analysis of interview transcripts of therapists describing why they practised the way they did.

It has taken some time for the profession to respond in any way to critique such as Abberley's and the idea that occupational therapy is part of the production of structural power relations, but a body of work from a critical perspective is forming. From the mid 2000's Canadian occupational therapist and academic Karen Whalley Hammell has critiqued a variety of aspects of practice, including the poor attendance by the profession to addressing power imbalances flagged by disability scholars (Whalley Hammell, 2007); occupational therapy practice in relation to theoretical assumptions of wellbeing, occupation and belonging (Whalley Hammell, 2009, 2014; Whalley Hammell & Iwama, 2012); client-centred practice (Whalley Hammell, 2013a), culturally safe practice (Whalley Hammell, 2013b); and the relationship between practice and human rights (Whalley Hammell, 2015a, 2015b). Fellow Canadian Daniel Molke has added to this critique, coming to a similar conclusion to Abberley, and suggesting occupational therapy has more potential to be coercive than therapeutic due to the normative assumptions held by the profession. He concluded "it is clear that occupational therapists must have an awareness of the dangers inherent in practice governed by normative consideration" (Molke, 2011, p. 172), reiterating a similar warning that Hocking (2009) had also given to occupational therapists in

relation to the way they understood theories and conceptualisation of occupation.

Elsewhere critical perspectives on practice have appeared as part of a movement to politicize occupational therapy. In the introduction to *Occupational Therapy without borders: Learning from the spirit of survivors* (Kronenberg & Pollard, 2005), the editors state “in the development of health and social services there has been a distinct border between those who deliver the service and those *upon* whom – not *with* whom – a service is delivered” (italics in original, p.2) that clearly identifies the presence of structural boundaries between practitioners and the social body. Added to this political response is an increasing commentary on the origins of, and practices inherent, in the profession. The way that occupational therapy has assumed its underlying beliefs and approaches are appropriate and useful for non-Euro-normative contexts has been described as Euro-centric (Iwama, 2006; Iwama, 2007; Whalley Hammell, 2009) and the Euro-normative individualistic understandings of the profession have been presented as a problem in cultures that have worldviews founded on collectivism (Galhegio, 2010; Gilsenan, Hopkirk, & Emery-Whittington, 2012; Guajardo, Kronenberg, & Ramugondo, 2015; Ramugondo & Kronenberg, 2015).

These critical perspectives have informed this project and are an umbrella under which the research sits. What is missing in this body of work is however, the material detail of what happens at the street-level. The micro-level of practice is a common ground where the power relations flagged in these academic critiques are played out. Problematizing what happens at the street-level is a way of understanding more about the contribution of practitioners in both maintaining underlying dominant power relations and in the way practitioners on the street form an important societal structure in their own right. Completing this thesis provides another perspective of what the doing of occupational therapy does in terms of power relations, adding to the body of knowledge for the profession but also to that of policy, post-colonial and health practitioner related literature. Before proceeding with more detail about how

the thesis was designed to achieve this, a description of occupational therapy as a profession and the role practitioners' play as street-level bureaucrats is provided to clarify the type of nominated experts occupational therapists are and what exactly they do.

What exactly is occupational therapy?

Occupational therapy is generally considered to be a health profession. The profession has a global definition produced by the World Federation of Occupational Therapists:

Occupational therapy is a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement (World Federation of Occupational Therapy, 2012).

The Aotearoa New Zealand professional association of occupational therapists, Occupational Therapy New Zealand-Whakaora Ngangahau Aotearoa (OTNZ-WNA) supports this definition. The association has also added:

Occupation is all the things you do: self-care, looking after others, leisure, work. Occupation and health are linked. An occupational therapist is a registered health provider who uses the theory of occupation to improve well-being and quality of life (Occupational Therapy New Zealand-Whakaora Ngangahau Aotearoa, 2017).

In many countries (including Aotearoa New Zealand) occupational therapy is a licensed profession and subject to legal regulation. The regulatory authority, the Occupational Therapy Board of New Zealand (OTBNZ), further describes the scope of practice of an occupational therapist:

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 (Occupational Therapy Board of New Zealand, 2004c).

In practice, occupational therapists generally work with people when their health or wellbeing has been compromised and they are requiring specialist assistance and rehabilitation. Occupational therapy is practised in a diverse range of settings that have evolved in response to the variety of ways health services are provided. These settings include traditional hospital and community based health related services such as physical and acute medical health, mental health, child development, vocational and employment support, and older persons care. Occupational therapists are also beginning to work in many other less traditional areas such as public health, health promotion, health and safety, kaupapa Māori health services¹, education, disaster management, penal systems, refugee resettlement and assistance in war affected countries. These services are provided at a range of places, including health clinics, institutions, people's homes, workplaces, schools, and even online.

Professional history.

Occupational therapy became a distinct profession in the early 1900's in America, Canada and the United Kingdom. The name of the profession is generally accredited to psychiatrist and humanist Adolph Meyer (1866-1950) who published a paper titled 'The philosophy of Occupational Therapy' in 1922. Meyer was heavily influenced by the pragmatist John Dewey, who remains a prominent influence in occupational therapy theory (Cutchin & Dickie, 2012). With increasing support and endorsement by the medical profession, occupational therapy grew and was provided in tuberculosis sanatoria, mental

¹Kaupapa Māori means 'provided by Māori for Māori'.

asylums and institutions for the physically disabled. After World War I the profession became more widespread due to the need for rehabilitation for injured and returned soldiers. Between the two World Wars formal training programmes were established (Molke, 2011). From this time the profession rapidly expanded throughout the world. In 1952 the World Federation of Occupational Therapists (WFOT) was formally inaugurated by representatives from the USA, United Kingdom (England and Scotland), Canada, South Africa, Sweden, New Zealand, Australia, Israel, India and Denmark (World Federation of Occupational Therapists, n.d-a). WFOT became officially linked to the World Health Organization in 1959 and the United Nations in 1963. From this largely Euro-American foundation, occupational therapy has spread to having ninety-two WFOT member countries in 2018 that span the globe, including Asia, South America, Africa and the Middle East regions (World Federation of Occupational Therapists, n.d-b).

Occupational therapy in Aotearoa New Zealand.

Occupational therapy was introduced to Aotearoa New Zealand after a Medical Superintendent of the Auckland Mental Hospital, Dr H.M. Buchanan, visited England in 1938. He was impressed with the occupational therapy he observed there and recruited Margaret Inman a trained nurse, midwife and occupational therapist to establish an occupational therapy department at the Auckland Mental Hospital. Margaret arrived in Aotearoa New Zealand in 1940 and in the same year established a training course where four students were trained as occupational therapists. The students were sponsored by the Department of Health, two South Island based hospitals and the charities the NZ Crippled Children's Society (CCS) and the Red Cross (Skilton, 1981). The diversity of these governmental, local and philanthropic organisations suggests there was an awareness of, and interest in, the profession by a variety of sectors involved with the provision of health and disability related services from the time it was established in the country. The rapid establishment of the profession continued with the enactment of the Occupational Therapy Act in 1949 which was a continuation of the political moves towards a regulated workforce in many

aspects of health service provision, as described in this historical overview of the health system:

The [Health] Department's involvement with professional registration began with general nurses and midwives at the turn of the century and was later extended to other groups including plumbers and gasfitters (1912), masseurs (1920), opticians (1928), dentists (1936), psychiatric nurses (1945), occupational therapists and drain-layers (1948), physiotherapists (1949), and dietitians (1950) (Department of Health, 1974, p. 71).

The Act enabled the formal regulation of the profession through a regulatory authority, the then named New Zealand Occupational Therapy Board. Over time the Occupational Therapy Act (1949) was amended and eventually superseded by the legislation that occupational therapists are currently regulated under, the Health Practitioners Competence Assurance Act (2003). There are sixteen health professions currently regulated under this Act (Ministry of Health, 2015c). In 2017 occupational therapy was the fourth largest allied health profession with 2435 practitioners (Occupational Therapy Board of New Zealand, 2017), roughly comparable in size to clinical psychologists (2500). Pharmacists (3500) and physiotherapists (4500) are the two professions which are larger in size. In comparison to nursing (approx. 52,700) and medical practitioners (14,600), the allied health professional groups make up a significant minority of the overall regulated health workforce (Ministry of Health, 2016a).

Along with the New Zealand Occupational Therapy Board providing a legally sanctioned institutional structure for the profession, the voluntary New Zealand Association of Occupational Therapists was established at a similar time, in the 1940s. As indicated in the brief history above, the New Zealand Association of Occupational Therapists was one of the founding members of the WFOT in 1952 and has remained strongly connected to this organisation. The now named Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa (OTNZ-WNA), along with the Occupational Therapy Board of New Zealand (OTBNZ), are the two formal profession-specific structures of the

profession. The two organisations are not equivalent however, in that the voluntary OTNZ-WNA continues to struggle to attain a membership of more than 50% of the occupational therapists who are registered, making its representation and reach to the profession significantly less than the Board's (Anderson, 2015).

As well as these two professional structures, other elements have also contributed to the historical trajectory of the profession, one of which is the way occupational therapy is a highly feminised profession. Men were not permitted to train to be an occupational therapist until the 1960s (Gordon, Riordan, Scaletti, & Creighton, 2009) and since then there have been few who have. In the twelve years between 1975 and 1987 only nineteen men qualified as occupational therapists (Wilson, 2003). In 2017 there were 204 men who have annual practising certificates, equating to 8.3% of practising therapists (Occupational Therapy Board of New Zealand, 2017). The percentage of men in the profession is equally low in countries such as Australia at 8.5%, (Occupational Therapy Board of Australia, 2016), Canada 5.9% (Government of Canada, 2015) and United Kingdom and America each have 10% (World Federation of Occupational Therapists, 2016). As well as these similarities in gender ratios, the number of practising therapists per head of population is approximately equivalent. There are five practising therapists for every 10,000 Aotearoa New Zealand citizens, which is akin to the ratios in the above countries, suggesting that the profession, in terms of people and prevalence, has followed a comparable trajectory to other historically similar countries (World Federation of Occupational Therapists, 2016)². In summary, as a profession, occupational therapy emerged from Euro-normative roots, alongside many other health professions. In Aotearoa New Zealand it has followed a trajectory shared by other countries which has included legal regulation, feminisation and a minority status within health professions. These conditions of existence are a part of the way occupational therapy has been shaped in Aotearoa New Zealand. Much of Michel Foucault's work focussed on what he calls the human sciences and the

² The Scandinavian countries have by far the most occupational therapists per 10,000 with Denmark having fifteen, Norway and Faroe Islands twelve and eight respectively, Sweden eleven, and Belgium and Iceland nine (World Federation of Occupational Therapists, 2016).

formation of historically contingent conditions of existence that have enabled the human science disciplines to survive so successfully (see Introduction Dreyfus & Rabinow, 1982). Occupational therapy in Aotearoa New Zealand shares some common conditions of existence with occupational therapy worldwide but in order to examine the subtlety of localised street-level practices the design of the research needed to capture much more minute histories and detail than this.

Methodological Influence

The initial influence for the research design was from the work of physiotherapist David Nicholls. Nicholls' doctorate analysed practices of the physiotherapy profession using Foucauldian informed discourse analysis (Nicholls, 2008). When listening to Nicholls speak about his work, the usefulness of a Foucauldian approach for examining practice and power relations at the street-level was apparent, and became the inspiration for me to design a project to produce a similar critique for occupational therapy. Nicholl's subsequent publications (Nicholls, 2012; Nicholls, Walton, & Price, 2009), particularly his commentary on methodology with Joanna Fadyl (Fadyl & Nicholls, 2013; Fadyl, Nicholls, & McPherson, 2013) also assisted some of the methodological design. After this initial influence, the design of the project has developed into its own unique combination, reflecting the different positioning of the research, the micro-level nuances of the profession of occupational therapy and the intention to be an active critique. Although three methods were separately deployed they have been analysed as one to form an overall genealogical critique. The individual methods were an historical archival analysis, practice observation (which became three separate case studies or mini-genealogies), and an experimental action method using a critical and self-reflexive weblog (blog). Examining power relations made accessible by these methods required a very deliberate analytical plan and strategic focus due to the myriad of possible lines of enquiry that could be followed. The constant risk of ontological slippage due to the diversity of the methods also required close attention throughout the research process.

There were several readings of how power impacted on occupational therapy that played important roles in making the necessary strategic decisions

and to keep an ontological congruence throughout. The first was a Canadian institutional ethnography of occupational therapy in mental health services by Elizabeth Townsend, titled *Good intentions over-ruled* (1998). Townsend's study focused on the effects of institutionally based power relations. By following occupational therapists around, she observed the constant tension and contradiction between everyday practice and the objectives of the structures and organizations they worked in. Townsend suggested that the therapists had little awareness of the structures that their work was perpetuating, stating "no wonder occupational therapists feel tension, as they think they are enabling participation but are really perpetuating the organization of healthcare" (p.46). The second was the doctoral thesis of Linda Finlay who examined the practice of mental health occupational therapists through a phenomenological lens, interrogating the problematic subjectivities facing practitioners. She described therapists being "challenged by caring-power relationships as they struggle to negotiate degrees of involvement and are damaged by pressures, abusive people and lack of professional recognition" (Finlay, 1998, p. ii). The stark descriptions in Finlay's work provided insight into personal subjectivities of occupational therapists that have been rarely articulated elsewhere. The examples in Finlay's and Townsend's research indicated a range of power relations that were acting in unspoken ways in everyday practice. The existence of these silent practices opened up a whole new line of enquiry in the thesis.

The way power operates through silent discourses was a third reading of power that was an invaluable methodological influence. In their critique of policy related to disability and chronic illness, Sunderland, Catalano, and Kendall (2009) link the strength of silent discourses to a collective and unconscious turning away from situations that people find personally difficult to see or comprehend. They contend that the collective way this occurs renders sectors of society invisible, forming a gap of silence where they become forgotten. They argue that this is how the lives of people such as those with disabilities or chronic illness become invisible to us, even though they are living right in plain sight. The differing perspectives and threads of analysis within these three studies demonstrated the

myriad of possibilities for an analysis of power as well as the highly nuanced ways power relations are played out at the micro-level. They all indicated at the micro-level unspoken practices are intersecting with power relations occurring at the macro-level of institutions, social structures and policy forming subject positions that have influenced collective actions. As a methodological tool to aide an analysis faced with complexities such as these, Foucault suggested a strategy to help choose where to focus an analysis of power on.

Analysing power.

Foucault suggested using visible sites of resistance as a productive place to start an analysis of power:

I would like to suggest another way to go further toward a new economy of power relations. A way which is more empirical, more directly related to our present situation, and which implies more relations between theory and practice. It consists of taking the forms of resistance against different forms of power as a starting point (Foucault, 1982, p. 780).

Foucault's advice has been taken in this analysis and by identifying particular sites of resistance in the local context of Aotearoa New Zealand the power relations this resistance was part of became a place in which to start to the genealogy. There were particular actions and unspoken practices that marked out sites of resistance to power by occupational therapists. Several such sites became apparent as the thesis evolved and they all provided useful lines of inquiry that has either informed the background context of the problematisation or have become central to the arguments presented. One of the sites of resistance was the collective avoidance by occupational therapist to professionalising activities.

Collective resistance.

There has been a collective form of resistance within the profession in the way occupational therapists have avoided participating in a range of professionalising strategies. From the early days of the profession, professionalising attempts by the voluntary Association have been resisted by poor membership uptake. There

has been a similar persistent resistance to the mandatory governing and disciplinary practices of the OTBNZ in later years (Penman, 2013) and little inclination to pursue ongoing post graduate education and scholarship (Graham, 2017; Wilson, 2003)³. Occupational therapists have also resisted taking up evidence based practice with any rigour in Aotearoa New Zealand (Graham, Robertson, & Anderson, 2013; Tse, Lloyd, Penman, King, & Bassett, 2004) which reflects a similar trend elsewhere in the world (Kristensen, Ytterberg, Jones, & Lund, 2016; Marr, 2016; Upton, Stephens, Williams, & Scurlock-Evans, 2014). These collective resistances appear to have become unspoken norms in the profession. There has also been very little response from practitioners to successive attempts by leaders to shape occupational therapy towards a more politically and publically involved profession.

In the inaugural bi-annual Frances Rutherford Lecture⁴ Mary-Anne Boyd expressed clear concern about the outcomes for the profession of remaining disengaged and resistant to higher levels of education “I firmly believe that occupational therapists, by allowing this country to ignore occupational therapy advanced education, deny themselves the chance to assure quality occupational therapy to the public of New Zealand” (Boyd, 1984, p.10). The concern with the quality of occupational therapy articulated by Boyd came at the same time the Chair of the Occupational Therapy Board was also expressing concern about the standing of occupational therapy amongst other health professionals (New Zealand Occupational Therapy Board, 1985). Over thirty years later, after massive changes in the profession, instigated primarily as a result of these concerns, little had changed in the behaviour of practitioners. Gail Whiteford, a past Head of School of Occupational Therapy at AUT University, was still echoing very similar frustration. In her keynote presentation at the professional association conference she stated “personally, I have been frustrated for years

³ In 2017 there were twenty-four occupational therapists enrolled in PhD and eleven in Masters level post-graduate programmes (Graham, 2017).

⁴ The Frances Rutherford Lecture is presented at the national association conference which is held bi-annually and is awarded to occupational therapists as an acknowledgement of their contribution to the profession.

by a staggering lack of motivation to not just respond to, but to shape the terrain in which we practice” (Whiteford, 2007, p. 13). More recently, in her 2012 professorial address Clare Hocking implored in a somewhat gentler but nonetheless continued appeal to the profession to alter the collective lack of politically motivated action:

Stepping up to the challenge requires the courage born of recognising health injustices and knowing that an occupational perspective is an important part of the answer. It will be an exciting journey that honours the profession’s commitment to biculturalism and its early history of social activism. I invite you to join me (Hocking, 2013, p. 37).

The success and longevity of resistance by occupational therapists to the range of professionalising and disciplinary strategies described above indicated collective power relations operating that were productive and stable. Examining this site of resistance led to another body of work that provided another site of resistance to trace. The way that occupational therapy remains a legitimate but relatively unknown profession, where its practices are not clear to others, indicated another site of resistance to power.

Liminal positioning and underground practice.

Despite emerging alongside other health professions whose roles have become relatively well recognized and familiar, such as social workers, physiotherapists, psychologists and speech-language therapists, occupational therapy’s trajectory did not follow a similar route. Although it has an equivalent therapeutic role to these professions, it is internationally perceived as blending into the background (Fortune, 2000), as invisible, misunderstood or stereotyped (Kinn & Aas, 2009) or as a large well-kept secret (Wilding & Whiteford, 2007) where even those managing health services are unsure exactly what occupational therapists do (Hunter, 2013). These international studies indicate there is a perception of occupational therapy that appears to be widespread, suggesting power relations occurring in a much larger context than the local Aotearoa New Zealand setting. An ethnographic study of occupational therapy in the early 1990s sought to examine this liminal positioning or ‘underground practice’ of the profession.

The term underground practice was coined by Cheryl Mattingly and Maureen Fleming in their five year long ethnographic study of occupational therapists at an acute care North American hospital (Mattingly, 1991, 1994; Mattingly & Fleming, 1994). The authors observed how occupational therapists responded to conflicting regimes of knowledge by practising in underground or clandestine ways such as not documenting or recording their work; combining competing therapeutic approaches within the same intervention; and assisting other staff to provide care to people on the ward in order to provide real-life therapeutic input as opposed to formal treatment modalities. These practices had developed in order to negotiate the often competing expectations of the workplace to conform to positivistic rehabilitation approaches with what the therapists perceived as their occupational therapy role, to work on the everyday priorities of the person receiving the service (Mattingly & Fleming, 1994). Being underground enabled the occupational therapists to manage the competing demands of the workplace by making micro-level decisions that were not spoken about.

If considered in terms of being a street-level bureaucrat, the decision to practise underground is one way occupational therapy becomes the policy it is enacting. The combination of the critical perspectives discussed earlier, which highlighted the variety of dominant structures of power that occupational therapy has not attended to; Townsend's insights into the lack of awareness of occupational therapists of the macro-level structures they were part of; Finlay's depiction of a range of silent practices that involve the personal subjectivities of therapeutic relationships; and Sunderland et al.'s (2009) theorisation of collective silencing practices of whole situations or peoples, the power relations of practising underground became a focal point of resistance due to the dangers that this situation presents.

The awareness of the productivity of collective unspoken resistance to professionalising activities and the strength of underground practice as a professional norm, culminated in another marker of power relations being identified. From my own experience as an occupational therapist I was aware

that underground practice often occurred through the materiality of doing occupational therapy. The materiality of practice is noticeably absent in the literature about power relations and the profession. Along with the resistances described above, the absence of such an important part of the occupational therapy role in theoretical critique provided another landmark that guided the direction of the analysis.

Materiality and occupational therapy.

Despite the liminal position of occupational therapy, it is a stable and surprisingly resilient profession. The resilience of the profession in a highly competitive and hierarchical healthcare environment dominated by positivistic medical knowledge, flagged another site in which resistance to power was occurring. The material world (generally referred to as the environment) is a primary actant in the doing of occupation based practice and is a significant element in the way occupation has been reconceptualised in current occupational therapy theory. In the early 1990s there was a 'renaissance of occupation'⁵ in the profession that returned theoretical attention to its historical roots and the connection it has with material things and use of the natural everyday environment as essential components of practice.

Despite the importance of the material world in occupational therapy, the 'material turn' and new materialism that has begun to flow into health-

⁵ The 'renaissance of occupation' was led by Californian Elizabeth Yerxa in the late 1980's and 90's (Yerxa, 1993; 1998). Occupational therapists were called to return back to practice that centered on the use of human occupation, with an explicit focus on use of occupation based knowledge as a source of power for the profession.

The curriculum for a new millennium needs to revitalize the centrality of the idea of occupation. Such a complex, potentially fruitful idea promises to be a new source of power for an integrated, autonomous profession that defines its own scope of knowledge and practice (Yerxa, 1998, p.370).

From this renaissance, the separate but conjunct discipline of Occupational Science emerged and the first Doctoral programme to study occupation from a scholarly rather than applied perspective was developed at the University of Southern California (Yerxa, 2000). Since then Occupational Science has been incorporated into WFOT mandated documents as essential knowledge for occupational therapists (World Federation of Occupational Therapists, 2011), and is a core part of the two occupational therapy education programmes provided in Aotearoa New Zealand (Auckland University of Technology, 2017; Otago Polytechnic, 2017).

related sociological work has not yet been taken up in occupational therapy scholarship. The work from social studies of science theorists such as Bruno Latour (1987), Andrew Pickering (1995) and Karen Barad (2003), who privilege the material world and materiality over language and representation in their theoretical contributions, has however started to trickle into other health practice literature.

French researcher Myriam Winance has provided a detailed analysis of how the materiality of wheelchairs transform the user, due to a collective process occurring between the wheelchair user's body and the wheelchair, along with the people involved in the 'empirical tinkering' necessary to provide a wheelchair (Winance, 2010). Another example is Setchell, Nicholls, and Gibson (2017) who recently theorised how the body of people who have their hips replaced is a subversive element in the doing of physiotherapy practice. The focus on the materiality of the body as an actant, by Winance (2010) and Stechell et al. (2017) is a useful site of analysis due to the way the body of others is often a primary material concern of health professionals' practice. In this research, materiality is not focussed on in this way. Other forms of materiality in everyday practice that occur outside the direct interactions with a person receiving a service have instead been the target. There is emerging literature that has also taken this approach.

Social work academic Helen Scholar has recently published a tentative exploration into what she describes as the "paraphernalia of social work practice and identity" (Scholar, 2016, p. 4) and targets other forms of materiality, that of objects and artefacts, as a site of interest⁶. Scholar has drawn on David Nicholl's

⁶ Interestingly in this paper, three (a third of those that met the criteria for inclusion) published works of Clare Hocking (Hocking, 2008a, 2008b, 2008c), produced from her doctorate titled *The relationship between objects and identity in occupational therapy: A dynamic balance between rationalism and romanticism* (Hocking, 2004) have been used as source material for the discussion about how objects and artefacts are referred to in relation to practice and/or identity in social or health professions. However the role of object and artefacts in occupational therapy practice is never mentioned again in the paper. It is physiotherapy and medical practice that are used as examples. The strong relation and interdependence of the material world and occupational therapy appeared overlooked in this work, despite occupational therapy being the only health or social profession cited in the list of disciplines interested in material aspects of practice "The significance of the material aspects of practice has been attracting increasing

work, particularly his examination of the role of the treatment bed as an actant of everyday power relations in physiotherapy practice (Nicholls, 2012).

Materiality has been considered in a similar way in this thesis and has involved the extra-discursive elements of architecture and geography, as well as everyday objects and material practices (such as use of digital technologies, fixing or making things and creative occupations such as cooking).

Through the course of the thesis the materiality of day to day occupational therapy practice has been problematized as an unspoken form of power that is both a danger and an opportunity for the profession. It is presented as an alternate line of power available to the profession, one that bypasses the power games of language, traditional regimes of knowledge and hierarchical structures within the health professions. A central reason for adopting this perspective is to provide an alternate way of viewing practice in order to not support the underlying regimes of truth that are contributing to the structures and power relations that the thesis is intended to critique. A common way this occurs in the profession is attempting to contest existing power relations by marking out occupational therapy as an expertise with specialised knowledge in order to gain status as a health professional. By doing this the profession is inadvertently supporting underlying truths related to knowledge and power based on Enlightenment thinking and Euro-normative views of the world. By providing a practice based critique with a strong emphasis on materiality, the design of the research attempts to bypass this problematic positioning. In the same way Deborah Laliberte Rudman advocated for occupational scientists to “push beyond a concern with disciplinary survival or status to focus on the ‘use’ of occupational science” (Laliberte Rudman, 2014, p. 4), the intent of the thesis is to prioritise what occupational therapy does rather than the role it has in power games related to hierarchies of knowledge and

interest, particularly in the last 10–15 years, in various professional disciplines including organisation studies (Borgerson & Rehn, 2003), science and technology (Latour, 2000), geography (Evarts, Lahr-Kurten and Watson (2011), marketing and consumer behaviour (Miller, 2012), occupational therapy (Hocking, 2000) and professional learning (Fenwick, 2012)” (p. 2). Hocking’s work clearly positions materiality and occupational therapy in plain view, but it still has been relegated to silent discourse.

status. Responding to the responsibilities of being a practitioner and street-level bureaucrat while also sharpening our critical edge, “to inform more nuanced, contextualized, and socially responsive forms of occupational therapy” (Gerlach, 2015, p. 245) requires a detailed understanding of micro-level practices in relation to power. The thesis is intended to be of use to practitioners to do this as well as providing an analysis of what occurs in the gap between policy and policy implementation. Before the way the thesis does this is explained, there is one major limitation of the research that became more pronounced and relevant as the project developed which needs articulation. As the analysis developed and my own abilities and knowledge grew, the way occupational therapy is practised predominantly in patriarchal domains of medicine, law, business and the trade and construction industries, without any significant feminist critique became an increasingly troubling position.

Feminist Critique and Critical Reflexivity

Occupational therapy remains a highly gendered profession that still is associated with traditional roles of women and women’s work. An example of this is the way that although most occupational therapists have not carried out remedial art and craft activities as a therapeutic occupation for the last 20 years, a lingering connection between occupational therapy and feminised craft remains. Occupational therapist Susan Denshire (2011) wryly refers to herself as a “sock knitter” in her auto-ethnographic essay that reflects on her experiences of gendered healthcare provision. Labels such as the ‘kitchen lady’, ‘basket weavers’ or ‘knitting lady’ still linger and are used by the general public⁷ and colleagues alike to refer to occupational therapists (Fortune, 2000; Kinn & Aas, 2009). Perceptions such as these support occupational therapists having to “resist the ridicule” encountered from other staff when practicing occupational therapy (Fortune, 2000, p. 229) and the way other healthcare staff perceive occupational therapy as being easy and not considering it real work (Wilding &

⁷ For a more recent example a headline in the United Kingdom based Guardian newspaper reads: “Occupational therapy and mental health: ‘It’s not about basket weaving’” (28 January, 2015) <https://www.theguardian.com/social-care-network/2015/jan/28/occupational-therapy-mental-health-support>

Whiteford, 2007). The fact of the profession being feminised and therefore subordinated because of the type of work it does is generally not articulated within the profession. There has not been any attention to the incongruence between this perception and the reality of practice. Occupational therapists are heavily involved in practical work such as building design and modification, repairs and maintenance of equipment, technical modification and adaptation of products and vehicle modifications as well as medico-legal domains such as working in secure facilities such as prisons and forensic units, occupational safety and health and medical assessments such as driving capacity and mental state examinations, which all could be argued are considered more traditionally masculine (or at least not feminised) work.

The complexity of how occupational therapy practices are shaped by gender has not had any rigorous feminist critique in the academic literature, with gender generally referred to in passing or as part of commentary about the workforce. The power relations associated with gender appear to be a silent discourse in the profession and I suggest that keeping these power relations silenced is a dangerous practice. The complexities of the type of work occupational therapists do and how it impacts on the power relations and subjectivities of the people involved, appear to have many connections to gender. As I became more attentive to the disconnection between the pervasive nature of these unspoken discursive rules and the lack of acknowledgement of it by the profession the way gender is bracketed out of occupational therapy became more apparent.

These implications and how they are intrinsically part of the power dynamics and genealogy of the profession have not been incorporated in this project. After approximately three years of research I came to the realisation that I was an embodiment of how occupational therapy ignores gender relations in our practice. I was bracketing and minimising gender relations in my theorisation as if it was a separate and inconsequential issue. The omission of gender as a central shaping force of the profession is a major limitation of this study. Gender relations are a prevailing line of power that intersects and

overlaps with the other lines of force identified in this research. At times gender has been touched on as part of these lines but it has not been theorised in any way. The interconnections between gender and power require a dedicated critique in order to give this significant element of occupational therapy the intellectual attention it deserves.

What this research does do is provide a problematisation that offers a strong contribution of the intersecting forces to those of gender. Presented in the thesis are four separate lines of force that were identified through the genealogical analysis. These lines were connected to current day street-level occupational therapy practice that was operationalising policies intended to deliver Better Public Services or were enabling the Community Investment Strategy to be implemented. The connections and networks identified through these connections are of course only one reading of how this particular ordering of things could be viewed.

Structure of the Thesis

The structure of the thesis follows a pathway where the methodological considerations, methods and background context are presented first, followed by five chapters of analysis and a concluding discussion. A traditional separate literature review has not been adhered to, instead, the relevant literature is discussed and integrated throughout the thesis. The following section outlines the structure of thesis by providing a brief summation of the contents of each chapter.

Chapter two - Philosophical base of research design

In chapter two, the methodology of genealogical critique is explained as well as the post-structural underpinnings of the project. The discussion includes the critical reflexivity required to conduct this form of research. Michel Foucault's concepts of materiality, discursive practices and the use of problematisation as a means of critical and political action have been explained and the way these have been applied is described. As well as Foucault, the work of sociologist Mitchell Dean is presented as a strong conceptual guide, particularly his later

work on sovereign and economic-governmental power. These two bodies of work have underpinned the analysis, which in turn has been viewed through a post-colonial lens. Post-colonial and indigenous scholarship is discussed and the way this lens has shaped the analysis described.

Chapter three – Research methods

Presented in chapter three are the three methods that were used to carry out the research. These methods were an historical archival analysis, practice observation and a critical action method using a blog. The historical archive that provided the central source of data collection was that of the four iterations of the Competencies for Registration produced by the Occupational Therapy Board of New Zealand. The practice observations took place at three different workplaces of occupational therapists and the blog was a two year bi-monthly project that operated alongside the other two methods. The way these methods were deployed and how the data collected was combined in the analysis then described. Part of this description is a critical reflection of the outcomes of these methods and the way they formed an ethical axis to the research.

Chapter four – Contextual background

Supplementing the two chapters of methodological introduction, chapter four provides additional historical information necessary to contextualise the content of the analysis. The short chapter briefly describes the colonial context of Aotearoa New Zealand and how colonising practices were locally applied to the Waikato region, where the research was carried out. The way the health system has evolved since colonisation to the current era has then been summarised to provide additional political and economic historical context.

Chapter five – Sovereign power and legal practices

This is the first of five chapters that present the central analysis of the research. The first element analysed is the way sovereign power and the law have created a legal assemblage through connections between legal structures and practice. The way this assemblage connects to colonising practices is problematized through presentation of the archival analysis of the Competencies and examples

of practice from the case studies. The way sovereign power and sovereignty is exercised at both the governing and the street-level of practice is discussed and the connections with material outcomes outlined. The possibilities offered by the alternate legal subjectivity within the current Competency document and Code of Ethics is touched on as a way to contest colonising practices. The chapter concludes by introducing the inseparable nature of the dialectic of sovereign and economic-governmental power when considering material outcomes and how this supports ongoing practices of colonisation.

Chapter six – Economic-governmental power and governmentality

In this chapter the analysis extends the problematisation of sovereign power and sovereignty to incorporate economic strategies and practices of governmentality. The constant interplay between sovereign and economic-governmental power is presented through a close study of the changes in the OTBNZ governing documents and style of governance that introduced enterprising and globalised economic strategies into occupational therapy. These power relations are then contextualised to the level of practice through a tracing of the way the case studies in the research evolved as publically funded services since the introduction of corporate and business practices into the sector. The emphasis on the individual and self-responsibility that has occurred through these historically contingent events is cast against the simultaneous expectation for occupational therapists to work in ways that support understandings within Te Tiriti o Waitangi that are not congruent with practices of individualism and market driven models of service delivery.

Chapter seven – Unsaid practice

The next two chapters focus on more specific and unique elements that relate to how occupational therapy is practiced. Foucault's concepts of subjugated knowledge and discursive practices have been drawn on heavily in these chapters. To provide a focal point in history in which to do this, a problematisation of the unspoken practices connected to a large former mental health facility, Tokanui Hospital is carried out. The hospital had a strong institutional presence in the Waikato region from the time Hamilton City was a

colonial outpost. Closed since 1998, the practices and services that Tokanui Hospital once provided are traced backwards from the present day case studies. Part of the problematisation focusses on the way the unspoken practices of occupational therapy are part of collaborations that produce silent discourses. The silencing that occurs around the care and services people with complex illness and disability receive is interrogated by examining the archival and generic silencing practices that could be seen occurring in the wider genealogical analysis.

Chapter eight – Materiality and power

In chapter eight the power-knowledge dyad is examined further in relation to the role of material regimes of knowledge in occupational therapy practice. Materiality and material practices as forms of power are analysed as extra-discursive elements of practice. The way materiality is both an instrument and outcome of discourse is discussed in relation to the occupational therapists' work in the case studies and in the way this connects with the dangers of having delegated sovereign power.

Chapter nine - Critically engaging with the profession

In this final chapter of the analysis section the way the research blog functioned as a method is discussed as well as the use of social media as a form of critical action. A summary of the way the blog was engaged with is presented and numerical information related to individual posts provided. The use of the blog as an active component of genealogical critique is described, including the offline and unexpected outcomes of using this form of research method. The way the blog formed an unpredicted ethical axis to the research is described and the chapter concludes with a discussion of how the blog is itself a material practice that was confronting other strongly held discursive practices of occupational therapy.

Chapter ten - Discussion

After the five chapters of analysis, the final chapter presents occupational therapy as a problematisation in the form of dangers and opportunities for the

profession. The dangers are connected to what the doing of occupational therapy does in terms of dominant and silent discourse. The doing of occupational therapy is then viewed in terms of opportunities available to the profession. The possibilities for occupational therapy to bypass dominant power relations due to the stable position it has developed in health and public services are then suggested. After these arguments, future research directions the thesis opens up are discussed along with an outline of the limitations of the research. A concluding statement follows that encapsulates the thesis of the thesis.

Chapter 2: Philosophical Base of Research Design

As described in the introduction, this project sought to answer questions about the positioning of occupational therapy in the health and social service landscape of Aotearoa New Zealand. The initial questions that informed the research design were:

- What are the dominant discourses creating the current context of occupational therapy in Aotearoa New Zealand?
- What are the power relations and positions of subjectivity the profession assumes from the identified discourses?
- How can the profession advantageously use the power relations evident in the discourses for the future development of occupational therapy in Aotearoa New Zealand?

From this broad starting point the project developed away from using discourse analysis as a primary methodology to become a genealogical critique. The methodological shift occurred as the research methods were deployed and the way they combined to form a platform of critical action crystallised. Carrying out a genealogical critique offered the possibility of producing an academic project that drew on the methodological tools of discourse analysis while at the same time enabling a form of critical activism. Genealogical critique is a methodology described by Colin Koopman (2013) and is grounded in the conceptual understandings found in Michel Foucault's work, particularly those of problematisation and the use of this intellectual activity as a productive endeavour. As such, an understanding that the historical trajectory of occupational therapy in Aotearoa New Zealand was only one possible path the profession could have taken is a guiding presumption of the project. Although occupational therapy is one of many human sciences, it has its own unique historical pathway that has supported the opportunities and possibilities that exist now and which lead to an array of future directions.

Genealogy as Critique

The pathway and trajectory of occupational therapy as a profession has been problematised using an approach of genealogical critique. Genealogical critique is concerned with problems that are submerged and difficult to articulate “those problems found below the surfaces of our lives — the problems whose itches feel impenetrable, whose remedies are ever just beyond our grasp, and whose very articulations require a severe work of thought” (Koopman, 2013, p. 1). As an occupational therapist the problems I had faced when practicing were difficult to articulate. They involved the profession as a whole, myself as an individual and the way the people I worked with were treated by health and social services. Although difficult to grasp, these problems were right there just below the surface of day to day practice. Untangling how these problems have been historically constituted is the purpose of a genealogy and by doing so become a form of critique. The act of critiquing itself then becomes a political act and part of the history of what is being critiqued. The way this active dynamic is achieved is through the adoption of a problematising approach to the history of ideas being analysed.

Productive intent of genealogical critique.

Problematisation is used in a dual way by Foucault, as both a verb, where it is an act of inquiry, (to problematise) or as a noun, where it becomes the object of inquiry (a problematisation) (Koopman, 2013). For this project problematising how occupational therapy has been historically constituted in Aotearoa New Zealand positions the profession as the problematisation or the problem. Being a problem does not necessarily imply that occupational therapy is wrong or bad, rather it seeks to be alert to the potentialities of the profession. As articulated by Foucault in one of his lectures at Berkeley University, this way of considering problems is not intended to be a judgement but rather a strategy of activism:

I would like to do genealogy of problems, of problematiques. My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have

something to do. So my position leads not to apathy but to a hyper- and pessimistic activism (Foucault, 1983, pp. 231-232).

Genealogy as critique is using this problematising method as a form of critical action. As Koopman (2013) described, “the critical inquirer observes practical problematisations that are already extant and seeks to fashion a methodological apparatus that would enable us to draw up, organize, and engage these problematisations”(p. 99). The idea of engaging with the problematisation (the profession of occupational therapy) has been an important aspect of the research design. The ongoing engagement I have had with the profession throughout the research implementation has made the act of problematising part of the current landscape of the profession, becoming a form of activism. This is how Folkers (2016) explains a genealogical critique becomes a “positive endeavour” (p. 19), as it contains the objective to alter what it is critiquing through its critique. However, balancing this objective with an approach that is also attempting to bypass normative evaluations of right and wrong was a constant tension. Foucault alludes to this tension that the role of the intellectual has in relation to activism in an interview shortly before his death,

The role of an intellectual is not to tell others what they have to do. By what right would he do so?... The work of an intellectual is not to shape others' political will; it is, through the analyses that he carries out in his own field, to question over and over again what is postulated as self-evident, to disturb people's mental habits, the way they do and think things, to dissipate what is familiar and accepted, to re-examine rules and institutions and on the basis of this re-problematisation (in which he carries out his specific task as an intellectual) to participate in the formation of a political will (in which he has his role as citizen to play) (Foucault, 1984/1988, p. 265).

By examining and problematising my own profession I have been able to combine the role of a researcher with the citizen role of being an occupational therapist. I did this in several ways. By presenting the research regularly to local groups of occupational therapists I remained connected to everyday working

occupational therapists and was able to get their feedback and response to my analysis as I was writing it. This helped keep my work grounded in the practices of the profession rather than my intellectual critique as a researcher. The collaborative way the case studies were written up into a formal report also kept the research focussed on day to day practice. These reports became a usable document for the services, supporting my civil role as an occupational therapist contributing to the way the profession practised. As well as maintaining this practitioner contact, contributing to the work of the OTBNZ and OTNZ-WNA throughout the project kept it part of the workings on the ground at the institutional level of the profession. In various ways I was involved with some of the day to day operations of both of these organisations, simultaneously making my project part of these professional institutions and reinforcing my civil involvement with the profession.

A considerable danger of taking a critical activist approach to problematising is the connection of discursive practices to discourse and power. There is a real danger of inadvertently supporting the structures of power that are being problematised through the way research is conducted, the language used and how the problem is conceived (Bacchi, 2012, 2016). As emphasised by Annemarie Mol “[M]ethods are not a way of opening a window on the world, but a way of interfering with it. They act, they mediate between an object and its representations” (Mol, 2002, p. 155). Hook also elaborates on this point in detail, particularly in relation to attempts to “liberate repressed discourse” by giving it a voice which can end up reproducing the discourse under critique in another way (Hook, 2001, p. 535). The awareness of this potentiality is an ethical consideration of the research and is discussed later in the chapter as part of the critical self-reflexivity required. Before these ethical considerations are discussed however, a clarification of which of Foucault’s methodological tools were used to guide the genealogy is required. The way his concepts of power, knowledge and subjectivities have been utilized in the problematisation are discussed in relation to the three methods of the research; the historical archival analysis, participant observation (which became three separate case studies or

mini-genealogies), and the experimental form of critical action using a weblog (blog).

Archival Research

Like archaeology, genealogy requires patience and a gathering of details from a large polymorphic range of source material. The careful study of archival documents from a broad range of sources is a way to access where, how and when regimes of truth and certain bodies of knowledge emerge. Foucault called this compiling a history of ideas, and important to developing a history of ideas is the understanding that these histories are non-determinative, where contingency, accidents and unintended events make outcomes unpredictable (Hansen, 2016). Foucault described the process of genealogy as “gray, meticulous, and patiently documentary. It operates on a field of entangled and confused parchments, on documents that have been scratched over and recopied many times” (Foucault, 1977/1984, p. 76). Archival documents are a central source of material and the choice of which records were studied was carefully considered.

Remaining on the surface.

Remaining on the surface, rather than delving into what things represent or what deep meanings they may hold for the subject was a key method Foucault used and is part of maintaining a flattened ontological methodological position in this research. To remain on the surface Foucault connected power, knowledge and discourse through identifiable practices rather than through representation or language. There is an underlying assumption that knowledge that renders an object knowable (knowing occupational therapy as a ‘thing’) is as supported through what is done as much as through theories or authoritative opinion (Bacchi, 2012). To keep practices as the target of analysis, Foucault privileged archival documents which recorded mundane activities, prescriptive guidelines and direct sanctioned practices over authoritative texts or visible cultural monuments as his primary sources of material. Foucault described these sources as being documents created

...for the purpose of offering rules, opinions, and advice on how to behave as one should: "practical" texts, which are themselves objects of a "practice" in that they were designed to be read, learned, reflected upon, and tested out, and they were intended to constitute the eventual framework of everyday conduct. These texts thus served as functional devices that would enable individuals to question their own conduct, to watch over and give shape to it, and to shape themselves as ethical subjects (Foucault, 1984/1985, pp. 12-13).

As well as the direction toward what type of archival documents to prioritise to remain on the surface, Foucault elaborated on the role of practices in his discussion on method in relation to his genealogical problematisation of the penal system in *Discipline and Punish*:

The hypothesis being that these types of practice are not just governed by institutions, prescribed by ideologies, guided by pragmatic circumstances -whatever role these elements may actually play- but possess up to a point their own specific regularities, logic, strategy, self-evidence and 'reason'. It is a question of analysing a 'regime of practices' - practices being understood here as places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect (Foucault, 1980/1991, p. 75).

Drawing on this methodological stance, written texts that were operational and practice oriented, as well as observing the actual doing of occupational therapy, were primary sources of information used to identify regimes of practice for the genealogy. The experimental research blog was also viewed as a practice rather than as a source of language or text to analyse.

A privileging of surface happenings occurred by focussing on these forms of practice as they were not reliant on the understandings of Enlightenment humanism where deep meaning, rational explanation or scientific truth is sought to understand and progress the human condition (Lather & St. Pierre, 2013). Instead, remaining on the surface, at the level of practice, is how Elizabeth St. Pierre (2013) explains post-structural work is able to flatten ontology: "ontology

in the “posts” flattens what was assumed to be hierarchical. Here, there is no Real – nothing foundational or transcendental – nothing beneath or above, outside – being to secure it. Language and reality exist together on the surface” (p. 649). The way that language and reality have been flattened in this research has been to focus on practices, with a mindfulness of the constant interplay between “the discursive effects of the material and the material effects of the discursive” (Hook, 2001, p. 538). By combining the array of practice based information provided by the three methods of data collection, the heterogeneous nature of power and discourse was made more visible.

Power and Discourse

Foucault’s approach to analyzing power has been one of his major contributions to post-modern thinking (O’Farrell, 2005). His belief that power relations are “rooted deep in the social nexus, not a supplementary structure over and above society” (Foucault, 1982, p. 791) differs from more traditional theories of power such as those described by Marx, Gramsci or Althusser which view it as an oppressive top-down concept (Rose, O’Malley, & Valverde, 2006). Foucault’s understanding of power focusses on material and micro-level practices which support certain relations of power that otherwise may remain unnoticed and continue to operate with unquestioned autonomy (Dreyfus & Rabinow, 1982). A principal way in which this occurs is through the triad relationship between power, knowledge and truth, and the subject. The way the triad forms heterogeneous assemblages in which subjectivities are produced is a central tenet to the act of problematisation.

Foucault conceptualised heterogeneous assemblages in what he called a *dispositif* or a grid of intelligibility. He described a *dispositif* as “discourses, institutions, architectural arrangements, regulations, laws, administrative measures, scientific statements, philosophical, moral, philanthropic propositions – in short, the said as much as the unsaid ” (Foucault, 1977/1980, p. 194). The way that a *dispositif* can be viewed as a composition of theoretical lines (Deleuze, 1991) or heterogeneous elements (Foucault, 1977/1980) has been used to understand how shaping forces have been formed in occupational

therapy. The wide variety of elements that influence the everyday practice of occupational therapy form forces that produce subjectivities, becoming a field of experience in which the individual therapist and the profession itself is subjected (Frost, 2015). Subjectivities are constantly negotiated as the lines intersect, mingle, re-group, split, break or fracture (Deleuze, 1991, p. 162), as these create different arrangements of force. Different arrangements can also occur when new elements enter the field of experience. These can be the result of chance occurrence (Hardy, 2015), the re-configuration of already existing elements or active resistance to shaping forces. Resistance to power relations actively changes the strategic positions of subjects, and subsequently the trajectory of the *dispositif* becomes a political act (Frost, 2015).

The historical archival analysis of the Competencies for Registration for occupational therapists documents was carried out using these ideas. There were many heterogeneous elements visible in each of the four iterations of the document. The way these elements connected to each other formed shaping regimes of practices as they were producing a field of experience for occupational therapists and occupational therapy. An example of where experiences produce regimes of practice is the mandatory engagement therapists have with the content of the Competencies through the annual recertification process, connections between this content and workplace performance appraisals, and the ongoing monitoring of competence based on the Competencies through an online ePortfolio. These surface level practices were sites where subject positions were required and resistance and strategic subjectivities possible. Recognising lines of force and elements within the Competencies required a much broader knowledge of macro-level power relations such as the law and economic models of healthcare delivery. The micro-level, practice based Competencies provided interconnections between sovereign and economic-governmental forms of power and occupational therapy. As well as these, there is an over-arching context of colonisation. The moving dialectic of sovereign and economic-governmental power in Aotearoa

New Zealand is contingent on the colonial history of the country and lines of this dialectic could be also be traced to the micro-level of practice.

Sovereign power.

Although Aotearoa New Zealand no longer has an actively reigning British sovereign⁸ due to its Commonwealth status, a power of sovereignty remains in the legal assemblages and practices that are exercised through the parliamentary structure, the law and judicial systems. These wide ranging legal assemblages have a foundational place in how the country is organised and governed and the law is generally positioned as an indisputable authority. The practices that support this authority are how the power a reigning monarch once held are replicated in contemporary forms of government. Mitchell Dean (2013) describes three defining practices of sovereign power: the ability to over-ride the law in exceptional circumstances such as war or financial crisis; the ability to delegate and vest power to others, and the existence of situations where the power of the sovereign can be annulled or cancelled such as during an international sporting match or in international airspace (Dean, 2013, p. 222). Sovereignty remains active and highly involved in contemporary power relations at global and local levels, and since the 9/11 aeroplane strikes in New York in 2001, sovereignty has become highly visible in international contexts. For example, the increasing exercise of sovereign power in decisions involving free trade agreements, the so named war on terror, and the global management of dislocated refugees and migrants are all made through authority delegated to parliamentary processes to make decisions on behalf of sovereign nations (Neal, 2004).

Although Foucault sought to “cut off the king’s head” in order to study power “outside the model of Leviathan, outside the field delineated by juridical sovereignty and the institution of the State” (Foucault, 1997/2003, p. 34), Dean suggests that Foucault, along with other major philosophers of contemporary sovereign power, Carl Schmitt and Giorgio Agamben, have been unable to escape the presence of sovereignty in their studies of power (see chapter 8, Dean,

⁸ There is however an actively reigning Māori sovereign, King Tuheitia Paki but his sovereignty is not recognised by British law.

2013). Elsewhere, Foucault has also been criticised for not adequately critiquing the law in relation to societal power relations, most prominently by Alan Hunt and Gary Wickham (Hunt, 1992; Hunt & Wickham, 1994) who described Foucault as expelling the law from an analysis of modernity. In his explanation of Foucault's position Gordon (2013) concedes that the law was not a central concern for Foucault, but explains that this was because he considered it as just one of many forces in wider networks of power. Since his earlier criticism Hunt (2013) appears to support this explanation and has revised his critique, suggesting instead that Foucault's approach to power is useful to understand how the growing assemblages of the law and associated judiciary in contemporary democracies combine with other knowledge to form new practices and power relations.

In Aotearoa New Zealand sovereign power, sovereignty and the historical relationships these concepts have with colonial practices such as the delivery of public services are an example of such an assemblage. The historical event when Te Tiriti o Waitangi and the Treaty of Waitangi were signed in 1840 introduced the concept of a ruling monarch into the way the colony was governed and controlled, legitimising British understandings of sovereign power as a regime of practice⁹. The traditional ways that Māori controlled and organised their society was rendered invisible in this assemblage. The tikanga¹⁰ and cultural practices that were shared by the tribes throughout the country were not reconcilable with the imposed understandings of sovereignty and British law. The condition of existence this situation created has produced colonising practices unique to Aotearoa New Zealand which continue in the current era. Post-colonial scholars such as Pavlich (2013) argue that the way the law and sovereign power continue

⁹ As discussed in chapter four, the two versions of the Treaty differed in how the concept of sovereignty was understood. Māori have maintained since the signing of the Treaty of Waitangi that they never ceded sovereignty to British rule, rather they agreed to a partnership where they retained the right to self-determine their own way of living, as implied in use of the words *kāwāngatanga* and *tino rangatiratanga* in Te Tiriti o Waitangi.

¹⁰ Tikanga means the "correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention, protocol - the customary system of values and practices that have developed over time and are deeply embedded in the social context". Retrieved from <https://maoridictionary.co.nz/>

to be strongly tied is through arrays of local level legal structures which continually form; arrays that are based on the original imposition of colonial rule.

For occupational therapy, the Occupational Therapy Act (1949) and the myriad of other legislative obligations that come with being a regulated health profession have created such a structure. To analyse how the surface level doing of occupational therapy was part of local level legal structures, sovereign power and colonisation, the material outcomes of sovereign power has been used as a focal point. Material outcomes are strongly connected to occupational therapy practice and more importantly for the context of this research, material outcomes are a primary concern of indigenous scholars and much post-colonial work due to the dehumanising effect sustained material deprivation creates (Bargh, 2007c; Jackson, 2007; Joseph, 2014; Smith, 2012). By focussing on the material, a de-centering of the law as a foundational truth was enabled, the flattened ontological position of attending to both language and reality suggested by St. Pierre (2013) was maintained, and a prioritisation of the material effects of discourse as advocated by Hook (2001) was possible.

Sovereign power, colonisation and material outcomes.

The high involvement of occupational therapy with material outcomes such as where someone may live, what equipment they receive, where they can go and what activities they can do, places the profession at a site where colonising practices are played out and negotiated. What an occupational therapist considers acceptable, and how this is provided, is a judgement of what sort of life is considered human for the person involved. Indigenous rights scholar Linda Tuhiwai Smith directly connects material outcomes with the dehumanising effect of colonialism due to the difficulty of imagining reality being otherwise.

..the cycle of colonialism is just that, a cycle with no end point, no emancipation. The material locates us within a world of dehumanizing tendencies, one that is constantly reflected back on us. To imagine a different world is to imagine us as different people in the world. To imagine is to believe in different possibilities, ones that we can create (Smith, 2012, pp. 203-204).

Viewing practice through a post-colonial lens, positions occupational therapy as dangerous. What makes it dangerous is the contingent way it emerged with certain regimes of truth that have supported sovereignty. There is a tight connection between Euro-normative understandings of science and Enlightenment humanism, with colonial practices enabled by sovereign power. These connections are an underlying context to practising healthcare in Aotearoa New Zealand as the health system is administered and governed through policy and law, supporting “the almost God-like perfection” (Jackson, 2007, p. 179) given to the impartiality of English common law. At the local level of policy Helen Wihongi (2010) asserts that the medico-legal assemblages formed between the Crown, Crown agents and health experts are how policies

...only address the policy issues that affect themselves [Euro-normative cultures], finding solutions that solve their issues, and developing evaluation criteria that measure the impact of the policies from their value base. Such policy processes continue to alienate Māori and tino rangatiratanga¹¹ (p. 153).

These health policies are privileging dominant regimes of truth which are how, as Jackson (2007) also explains, the connection between positivistic Euro-normative science and the law (along with the economic understandings of market forces) have subordinated indigenous beliefs. The constant possibility that occupational therapists have for choosing one path of action over another at the level of the material creates a space where resistance, re-configuration or support of these regimes of truth can occur. Due to the high levels of materiality in occupational therapy, it is a significant discursive and non-discursive element in the practice of occupational therapists. In turn, the material outcomes as a result of these practices are how power relations at the micro-level have effect.

The overlap between these post-colonial concerns and the materiality of discourse is an important intersection in this research. As part of local level legal health structures occupational therapists embody the law and sovereignty as

¹¹ Tino rangatiratanga means “self-determination, sovereignty, autonomy, self-government, domination, rule, control, power”. Retrieved from <http://maoridictionary.co.nz>

street-level bureaucrats. Street-level material outcomes are where Smith (2012) explicitly links structures that form an “underlying code of imperialism” where power relations reproduce “material realities and legitimating inequalities and marginality” (Smith, 2012, p. 201). The profound way material reality continues to impede the rights to self-determination for Māori despite the increasing success and representation of Māori in economic, political and legal sectors is stressed by Robert Joseph (2014). By privileging the material in this research, the highly nuanced interactions between sovereign power, colonisation and occupational therapy have been problematized in a way that is right at the surface of practice. The other major force that has profound material outcomes for others is that of economic-governmental power. Capitalism and globalisation are other structures heavily implicated in material outcomes and the enactment of sovereign power. These macro-level structures are also primary issues for indigenous peoples due to the subsequent commercialisation of their cultures, land and knowledge (Bargh, 2007b; Bargh & Otter, 2009), which as well as supporting economic disparities also serve to entrench the dominant understandings of sovereignty and the legal practices of the law.

Economic-governmental power.

In advanced democracies such as Aotearoa New Zealand, sovereign power cannot be incorporated in an analysis without also including economic-governmental forms of power. These two axes of power have become co-existent in democratic forms of governing and the relatively recent introduction of neoliberal economic strategies of governing in the 1980-90’s are an example of the way this co-existence plays out. These new economic models were only able to be enacted by passing legislation such as the State Sector Act (1988) which maintains a degree of sovereign control on how economic strategies were operationalized despite the intent of de-regulating public service provision in the Act. At the same time however, economic imperatives have also forced sovereign power to over-ride these laws, using the practice of exception, as it did in the global financial recession in 2007-8. In Aotearoa New Zealand the economic crisis of the recession forced the government to exercise its sovereign

power to make legal exceptions and bail out corporate banks and financial institutions to ensure they did not collapse (Hickey, 2014).

The genealogy of the research has focused on the time period of 1990-present which coincided with these major neoliberal political reforms¹². The concept of governmentality has been applied to trace the line of economic-governmental power in the occupational therapy practice examined for this research. The way this line connects with sovereign power has then been problematised.

Through the neoliberal reforms, methods of legally governing health practitioners altered in ways that created new subjectivities and relations of power. These were visible in the genealogical analysis of the Competencies of Registration documents where an overt economic based rationality was inserted into occupational therapy practice during the time of the reforms. Drawing on Peter Millar and Nikolas Rose's (2008) work on governmentality, the Competencies can be viewed as a means by which occupational therapy became positioned as one of the expert professions who function as "powerful translation devices" (p. 43) spreading an economic rationality through the social body. Anthropologist Marilyn Strathern (2000) has clearly articulated how this rationality was introduced to practitioners, such as occupational therapists, coining this as the 'enterprising up' of the public sector through changes in practice expectations. Specifically, the mass introduction of practices originating from the finance and accounting sector (such as audit, quality assurance and contracted services) into the public service sector disciplined practitioners' work to appear in ways that are enterprising, efficient and accountable. Because of the personal and micro-level nature of the work occupational therapists do, this economic rationality then has the ability to trickle down to the people occupational therapists work with.

A principal factor in enabling the spread of an economic rationality is the idea of population based governance rather than the previous strategies that involved local solutions to problems. By collecting specific statistical knowledge

¹² In chapter four these reforms are described in more detail.

about populations (such as those with disabilities, ethnic groups, single parents, or wealth of households), processes and decisions could be made to manage the overall wealth, security and health of the country (Rose et al., 2006). For population based governing strategies to be administered, reliable experts are required to provide the knowledge and information necessary to make decisions. Because of this need for information and expertise, professions like occupational therapy and the other human sciences have become an essential part of publically funded health, social and education services. Occupational therapists are involved with an increasing range of services within the social body¹³, assisting the spread of the dominant regimes of truth that underlie this form of governing along with supporting the regimes of knowledge and practice that give nominated experts their status and authority.

Occupational therapists have historically been a translation device between people with illness and disability and many other forms of authority such as the family, the State, the medical profession and the law. As seen in the case studies of this research, because of the material nature of this 'translating' and the real outcomes for the people therapists work with, the way it is carried out supports certain types of personhood and ways of living in order to receive public services. Due to the introduction of enterprising business practices into public service provision, individualising disciplinary strategies such as risk and accountability measures (such as the mandatory ePortfolio which monitors individual occupational therapists) the conduct of occupational therapists is also managed in similar ways to the way this translating position functions. Their conduct is also linked to sovereign and economic-governmental power through the discursive, particularly through material practices of employment and regulation. The subjectivities created by these positions where occupational therapists are a conduit of policy into material outcomes whilst at the same time are required to negotiate a similar exercise of power that is conducting their

¹³ Traditionally occupational therapists have always been employed by hospitals and institutions, and therapists are also increasingly working in less traditional settings such as schools, justice services, child protection, insurance providers, addictions services and environmental planning.

conduct, is a site of ongoing power relations for the occupational therapy profession. While power relations within the profession and its position in the hierarchies of human sciences and society have been a target of study by the profession for some years¹⁴ these have generally not focused on the minute details of practice. The mundane, routine and everyday workings that sustain discursive practices have not been attended to despite this micro-level being where the exercise of power in contemporary forms can be identified, as Rose et al conclude in their paper “Governmentality”:

Instead, we need to investigate the role of the gray sciences, the minor professions, the accountants and insurers, the managers and psychologists, in the mundane business of governing everyday economic and social life, in the shaping of governable domains and governable persons, in the new forms of power, authority, and subjectivity being formed within these mundane practices. Every practice for the conduct of conduct involves authorities, aspirations, programmatic thinking, the invention or redeployment of techniques and technologies (Rose et al., 2006, p. 101).

The focus of this research on the mundane practices of occupational therapy provides a way for the axis of economic-governmental power to be made visible. The micro-level, heterogeneous and mundane discursive practices of occupational therapists are problematised with the understanding that these support certain regimes of truth. These discursive practices in turn produce subjectivities and experiences that are dynamic and constantly negotiated. An important aspect of the heterogeneity of these practices is the relation between the discursive and material or extra-discursive factors. The way these factors are interconnected is another key Foucauldian insight that has informed the analysis.

Materiality

The emphasis on materiality and how the material is incorporated in post-structural work varies. While Bacchi (2012) clearly privileges material practices

¹⁴ A brief summation of some of these is provided in the introduction chapter, pages 5- 6.

in the way she has problematised public policy, this is primarily through analysing written operational text. In comparison, critical psychologist Derek Hook (2001) and others carrying out health practitioner related research (Fadyl et al., 2013; Nicholls, 2012; Winance, 2010) emphasise the importance of incorporating actual material objects, equipment and environments in the way they problematise practice. In his critique of linguistic based discourse analysis Hook contends that an effective Foucauldian genealogy analyses the discursive through the extra-discursive rather than purely through representation and language. Hook also suggests in a similar vein to St Pierre's (2013) argument of how a flat post-structural ontology is achieved, that by providing substantial extra-discursive references to corroborate an analysis a "double epistemology" (Hook, 2001, p. 539) is provided, where the knowledge of language is supplemented with a knowledge of the reality of material things.

The extra-discursive element of materiality contributes to occupational therapy practices in many forms - geography, buildings, workspaces, therapeutic equipment, administrative tools, vehicles and office arrangements. In addition to these common influences, the central theoretical component of the profession, that of occupation as a primary contributor to health and wellbeing, predominantly involves utilising and interacting with the material world. From its inception the profession has involved craft, art and everyday activities as therapy along with the adaptation of the environment to support recovery, rehabilitation and independence in ordinary life settings. These extra-discursive elements are all integral parts of doing occupational therapy. As observed in the case studies of this research, materiality was a historically contingent force that had shaped the formation of the occupational therapists discursive practices. Due to the interdependence occupational therapy has with materiality it offered another highly useful site in which to problematise practice in relation to power, knowledge and subjectivities while at the same time maintaining a post-colonial lens that targeted material outcomes.

Although having a primary focus on materiality is a distinctive Foucauldian analytical tool, the distinction between the discursive and extra-

discursive was not a major concern for Foucault. Rather, he was interested in how they combined together to form practices in the formation of a dispositif of power (Foucault, 1977/1980). Hook (2001) described this as a blurring between the discursive and extra-discursive. Hook goes on to caution the analyst to be aware that this blurring can aid and abet “the contemporary effacement and denial of the potency of discourse’s material effects” (p. 538). Being mindful of this danger is another methodological tool useful to prevent an underestimation of the discursive effects of materiality and the material effects of the discursive (Hook, 2001, p. 538). For occupational therapists some of these material-discursive interplays are seen in how material conditions (geographic placement of a dwelling, number of people living in a house, availability of public transport) can influence who is allowed what, who can live where, and what level of participation in community life is deemed acceptable. In the context of Aotearoa New Zealand these material effects need to be considered in relation to the colonial history of the country. Material deprivation was part of how colonial order was enforced, particularly the deprivation of land. The material outcomes of this historical deprivation continue to impact on the lives of many Māori people, and only a fraction of the land taken through processes of colonisation has been returned, continuing the effects of this colonial practice.

Critical Self-reflexivity

Having a constant critical self-reflexivity throughout the research was essential to maintaining the integrity of my subject position as a researcher. It has been an intensely personal experience where the position of being an insider-researcher has provided high levels of ethical substance from which my own ethics of the self and ethico-political standpoint has been continually shaped. Having a continually critical self-reflexivity involved not only the methodological congruence with what I was writing and doing with the post-structural understandings I was basing the research on, but also how I as a white female occupational therapist was judging the information I was engaging with. How was I to conduct a research project without it being founded on the Enlightenment humanism that I was supposedly trying to bypass? The very fact

of focussing on my own profession as a PhD topic was embodying the rational accumulation of knowledge as a way to develop understanding of the human condition. Genealogy as a critique was positioning me as a knowing subject, assuming an ability to know what it is to be human as well as making the profession an object of knowledge in order to progress it toward a more enlightened state. The ontological conundrum this position presents is difficult to manage and is a focus of critique of Foucauldian methods, one that Foucault was well aware of (Dean, 2013; Dreyfus & Rabinow, 1982; Koopman, 2013) and is a primary reason for focussing on the surface and practices, rather than the metaphysical depths (Foucault, 1966/1970).

There were several strategies I deployed in order to remain on the surface and counteract the taken-for-granted knowledge based on Enlightenment humanism that I held as a health professional. The object of knowledge, occupational therapy, has been analysed in terms of how it has “come to be formed, understood, and spoken about in certain ways, not the validity of the experiences of specific subjects” (Hayes, 2003, p. 93). Foucault sought to privilege the text over the author (the “author is dead”), evaluating the text for its critical purpose rather than the engagement the producer had with it (Dalgliesh, 2013). To keep this critical perspective in both the textual documents and the practice based observations an intentional writing out of the subject was maintained. Individual therapists were not interviewed and audio/video recordings were not made of their practice. Person specific details such as gender, age, ethnicity, or work histories were also not part of the analysis. The decision to keep the practice observation as a “fly on the wall” only was made intuitively as an occupational therapy insider. I felt that overt recording of the occupational therapists’ practice would impede willingness to participate in the research and had the risk of discouraging natural practices. I also knew that much of what I would be observing in the offices of occupational therapists would not be visible or audible for a recording device due to the work being carried out on a computer or writing in notes. As I had changed my methodological focus to a genealogical critique of practice rather than a

discourse analysis it also was not as important to catch what the occupational therapists said verbatim. I did not need to capture what they said they did rather I was interested in the observable actions of this doing. Hence when the therapists are referred to they are positioned as a part of the occupational therapy practice observed and only in terms of what they were doing rather than saying, thinking or feeling. These strategies helped keep the subject out of the analysis, keeping the focus firmly on material and discursive practices.

Another strategy to maintain the emphasis on the critical purpose of occupational therapy has been to deliberately avoid incorporating clinical work, occupational therapy theory or research in the analysis. These profession specific paradigms were not the target problematisation, and by maintaining a focus on the how, what and where, the research was kept away from the inclination to seek deeper meanings of why the profession operated as it did; which naturally lead to paths of Enlightenment based reasoning and rationality. Another of these paths leading towards Enlightenment humanism was the temptation towards suggesting what was acceptable or right in my writing. Genealogy is not concerned with universal values or defending these (Chapter six, Dean, 1994a; Koopman, 2013), though the ability of an analyst to bracket out normative judgement is another of the major critiques of Foucauldian informed genealogies. The presence of unconscious value-laden normative bias by the analyst was one of Jurgen Habermas's principle concerns with Foucauldian methods, which include what data will be collected and, accordingly, what is discovered in those data (Habermas, 1985/1987). These concerns are also closely aligned to Nancy Fraser's critique that despite its claim to the contrary, genealogy cannot avoid suggesting right and wrong or good and bad in the way power is considered as a problem – to define something as a problem is to make a normative judgement about it (Fraser, 1981). Koopman (2013) concedes that although genealogy is normatively bound, like all social science, this can be addressed to some extent through the high adherence of self-reflexive critique by the analyst. He also suggests that although Foucault sought to escape normative frameworks in his analysis and does not suggest solutions to

problems, this does not need to be the case for genealogists. A Foucauldian informed problematisation lends itself to developing solutions and in this way he suggests a genealogical critique can be attached to normative projects.

The epistemological conflicts described above reflect the difficulties in conducting post-structural work. The dominant forms of knowledge that I had always drawn on as a white female occupational therapist were in danger of clouding the research, changing it from a questioning of ontological foundations to another form of Enlightenment humanism attempting to know more about other realities and subjectivities in order to get closer to the truth. As an occupational therapist working with people who are often invisible to mainstream society, in a profession that is often invisible and which has strong values of advocacy and person-centred practice, it is a strongly normative position for me to assume that the knowledge of these experiences is important to know to expose the 'truth'. Elizabeth St Pierre attributes this epistemological slippage as part of an urgency "to disrupt disciplinary, exclusionary canons by including the knowledge of the dispossessed. To that end, twentieth-century knowledge projects of Enlightenment humanism continued unabated (and still do)" (St. Pierre, 2013, p. 649). Maintaining the level of self-reflexivity required to avoid slipping into normative value laden judgements was a difficult task. It took the majority of my four years of research to understand that this slippage was occurring and it was the way I slipped into certain ways of writing about power that became important reflexive flags.

Many times the micro-level details of how power was travelling through the profession exposed not only my own subjectivities in relation to power and truth games, but also the normative judgements I was making. One of the consistent flags was my tendency to describe power as coming from the top down, controlling docile occupational therapists and over-determining how occupational therapy developed. The continual positioning of occupational therapy in my writing as being oppressed and powerless flagged to me underlying subjectivities I held in relation to authority, gender and hierarchies of knowledge. Another similar flag was the way I continually wrote about the State,

capitalism and medical science with negative connotations. The negative response reflected my own subjectivities in power relations that involved money and wealth, bureaucracy and the actions of medical professionals that I have personally experienced and professionally witnessed. One further flag that indicated a normative judgement was the way I tended to imbue indigenous worldviews and postcolonial perspectives with positive connotations. All of these reflexive flags prompted me to bring my problematising back to the what, where and how of the surface, rather than the perspective of the therapist participants, theories of the profession, or a hermeneutic interpretation of what the analysis meant.

In conclusion, the overall research project is a genealogy of a particular set of practices which also has a critical intent. The critical intent lends the content of the thesis towards solutions to the problems that this particular research presents and the concluding discussion lays out dangers and opportunities of certain practice directions or pathways. The normative assumptions of what is a danger and what is an opportunity have been mitigated as much as possible through the application of Foucault's methodological tools, applying a constant critical self-reflexivity and presenting the research as only one version of events.

Chapter 3: Research Methods

The methods used in the research were specifically chosen because they generated a polymorphic range of material to analyse and at the same time supported the intent of the project to be a form of critical action. They all target practices and allowed the incorporation of the extra-discursive into the analysis as much as language and the discursive. The three different research methods used were an historical archival analysis, practice observation (which became three separate case studies or mini-genealogies), and an action method using a critical and self-reflexive weblog (blog) to engage other occupational therapists in the research. These methods enabled a form of triangulation by which real life practice observations could be contrasted with text based documents which in turn could be actively presented for thought and discussion on the blog. Implementing these methods occurred concurrently, though the document based analysis was prioritised for completion first in order to inform the practice observations and blog content. Ethical approval for the above methods was obtained from the Faculty of Arts and Social Science Human Research Ethics Committee, University of Waikato. Each of the three methods is now described in detail, along with an explanation of why they were chosen, what they entailed and the ethical considerations they involved. A discussion on how the three methods connected and the way having an insider position created an ethical axis to the research is then presented. A critical reflection on the outcome of choosing these methods and researcher positioning is then provided.

Connections between the Methods

The three methods described above were carried out in an overlapping fashion. The blog was initiated first in August 2014 and was the last to finish in August 2016. The archival analysis was started not long after the blog and a year before the first workplace analysis. The timing of the archival analysis was deliberate in order to have some historical foundation on which to ground the workplace observations. Through the combination of these overlapping methods an in-depth cartography of the profession at the particular time and place of the

research was developed. All of the methods of the research were connected to my insider positions in the profession in some way and these positions were a significant component of the project being a genealogical critique.

Insider position and ethical axis.

My insider positions invaluablely assisted the way the project was able to become praxis and are imbued with the privileges of being a white woman who has English as a first language. As occupational therapy is a highly feminised profession, being female provides an insider position as does speaking English due to the Anglo-European roots of the profession and dominance of English language in academia. Along with these factors I also was an inside practitioner as I have never been an academic, manager or held any forms of professional leadership. In this respect the power relations that I experienced had primarily involved being an employee, a health practitioner, a white female and latterly as a single mother. A primary intent of the research design was to problematise the profession and its participation in the delivery of health and social services in a way that practitioners could relate to and apply in their daily work. Remaining deliberately and visibly inside the profession has been an additional element that was not originally planned or structured, but has been an important contributing factor in how the project developed over the four years. There were several ways I remained visible to the profession. I applied for and was appointed as a Board member of the Occupational Therapy Board of New Zealand at the same time as I commenced my PhD studies. This made me visible to those occupational therapists who take note of these appointments, but more so to the governing institutions of the profession. Being appointed to the Board provided me with vital inside knowledge of the material practices of the Board, the legal assemblage occupational therapists practice under and the broader political environment of healthcare governance in a way that was not deliberately orchestrated. As well as this Board appointment I made a point of contributing to online occupational therapy fora about topical issues,

participated in writing submissions about government policy¹⁵, provided input for publication in the monthly OTNZ-WNA magazine¹⁶, and co-published two manuscripts in the New Zealand Journal of Occupational Therapy (Silcock, Campbell, & Hocking, 2016; Silcock, Campbell, Hocking, & Hight, 2017). Added to these formal activities I co-convene the Local Area Network of occupational therapists in my local region. Organising monthly meetings for interested occupational therapists was a way of connecting personally with a broad range of therapists who work in the region and along with the connections made with my case study participants was an important way in which the project became an active critique. My visible local profile resulted in me being asked to present my research four times to different occupational therapy services in the region as well as to the Local Area Network. These presentations became one of the biggest sources of attracting followers to the blog. These other unplanned occurrences contributed to the overall project in equivalent ways to the formal methods and provided a valuable and critical ethical axis to the research.

At times I was publicly discussing aspects of my research that raised ethical conflicts between my roles as researcher, occupational therapist, OTBNZ member and OTNZ-WNA member. One of the main ethical considerations was in relation to my position on the OTBNZ while undertaking the research. There was an ongoing need to balance my ethical conduct in relation to the Board as I did not want to undermine the OTBNZ as a regulator but at the same time wanted to continue a critique about the current situation for occupational therapy. This ethical conflict became more pronounced when I reached a point in the analysis where I was critiquing the current documents of the Board. I published blog posts “Our new competencies” ([14/1/2016](#)); “New alliances of knowledge” ([22/2/2016](#)); and “Individualisation versus collectivity” ([9/3/2016](#)) that discussed

¹⁵ These submissions were to Health Workforce New Zealand about future planning for the health workforce, to the Ministry of Education about the use of seclusion in schools to manage student’s behaviour and to the Ministry of Business, Innovation and Enterprise about measuring the outcomes of publically funded scientific research.

¹⁶ I contributed an article about my approach to bicultural practice in 2014, wrote a letter to the editor about occupational therapists as change agents in 2016, and provided a research column about post-structural research in 2017 (yet to be published).

some of the implications within the new Competencies for Registration document (enacted in 2015). At the same time the co-published paper titled *How Western structures shape our practice: An analysis of the Competencies for Registration for occupational therapists in Aotearoa New Zealand 1990-2014* was accepted by the New Zealand Journal of Occupational Therapy (Silcock et al., 2016). Due to the ethical discomfort I was feeling about the two positions I was balancing, I sought support from the OTBNZ to remain on the Board. This support was given on the proviso that they were informed prior to any further conflicts that may arise (Occupational Therapy Board of New Zealand, 2016c). Despite obtaining the support of the Board I felt I did need to resign before my thesis was complete and published. Being a Board member was presenting an unacceptable level of ethical tension as I felt limited in what I could say in a public manner about my research.

Research Blog

The construction and operation of the blog [Whakaora Ngangahau/Occupational Therapy in Aotearoa New Zealand – What is shaping us in 2014 \(2015, 2016, 2017\)?](#) was the first form of data collection to be initiated in the project and was also the most experimental aspect of it. The blog was originally intended to capture another form of text to analyse to provide information about current day practice. The possibility that it may create an opportunity for a critical discursive space to develop in the profession was a secondary motivation for choosing it as a method. As the blog evolved and time passed it became apparent that using the blog comments as a form of data for analysis was not congruent with the rest of the project with its focus on materiality and the practice of occupational therapy. Using the comments from followers was providing data on what occupational therapists said about their doing as opposed to what this doing actually looked like. Because of this methodological incongruence, using the blog comments as a form of textual data was not included in the overall analysis. Instead the blog became an avenue for critical action as a practice itself. Posting on the blog was an experience that was challenging for both me and the followers who commented in response to the posts. The act of participating in

the blog was a practice and form of data collection in itself. It became an active connection between the academic analysis, practitioners and the profession and an important positive endeavour of the research.

The free blog hosting site wordpress.com was used to design and create the blog. The first post of the blog was on 6 August 2014 and the last was on the 11th August 2016¹⁷. I published a post twice a month, which resulted in 43 posts during this two year period. An ethical statement was posted as the front page of the blog (Appendix 1) that carefully detailed what the blog was for, what posting on it would mean and how to contact me and my supervisors¹⁸. An 'About Me' page was created to supplement this information and provide some personal background to the project. After several posts I received a few offline and personal email correspondences about people being afraid to say things publically so I also added instructions on the front page about how to be anonymous on the blog.

Establishing an awareness and interest in the blog was a crucial aspect for its success. I carried out several strategies to publicise it and attract followers. I used the two main professional structures, the Occupational Therapy Board of New Zealand (OTBNZ) and the Occupational Therapy New Zealand-Whakaora Ngangahau Aotearoa (OTNZ-WNA) magazine, OT Insight, to contact and disseminate information about the blog throughout the first year. Both these organisations sent mass emails publicising the research, and OTNZ-WNA published information about it in the OT Insight, both digitally and in hard copy. I also directly invited occupational therapists who I had personal connections with to follow the blog asking if they would share it again with their own contacts. As well as this, when I presented my research to local occupational therapists at various times through the duration of the research, I made sure I emphasised it and provided a sheet for therapists to provide their email address

¹⁷ This was the end date for the research, I have continued the blog as a personal project.

¹⁸ This page was removed as the front page when the blog ceased to be part of the research project and has been replaced with a "blog status update" sidebar which explains that the blog was a research project but now is a personal site only.

so I could personally invite them to follow the blog¹⁹. I also submitted a poster presentation titled “Creating a critical space: Blogging as a reflective tool for collective agency” at the Asia-Pacific Occupational Therapy Congress in 2015 to publicise it (Appendix 2). By the end of the two year research period, the blog had attracted roughly 80 followers who were occupational therapists (just over 3% of practising therapists) from around the country.

The blog postings were practice oriented, discussing outcomes for the people occupational therapists work with, the tasks expected of occupational therapists, skills they are required to utilise and how these fit into wider sociological understandings. The posts coincided with the stage of the project I was conducting at the time. For the first eighteen months I discussed the Competency documents at length, and then during the last six months I commented on insights I was having through the process of writing up the main chapters in the thesis. I connected these postings to my own experience as an occupational therapist. When posting on the blog I took care to avoid referring to the workplace observations of the case studies to preserve the therapist’s anonymity. I generally ended the posts with a question to the reader to try to evoke a response, such as “I’d love to hear your thoughts and reactions when reading those quotes” ([28/10/2014](#)), “Does the CCFR process have any effect on your day to day practising?” ([27/8/2015](#)), and “Have you worked in situations that made you uncomfortable?” ([27/6/2016](#)).

The way the blog evolved and the type of participation on the blog provided useful insights about using social media as a medium for critical action. It also functioned as a platform for critique and provided an open way of maintaining an ethical axis of the research. The blog has been analysed in detail and included as a separate chapter (chapter nine) at the end of the analysis section of the thesis.

¹⁹ This was by far the best personal strategy for recruiting blog followers as it only required one click to accept the invite and become a follower as opposed to sending a link to the blog which required more user effort to find how to sign up to receive the blog posts (especially via email rather than as a member of wordpress.com).

Archival Analysis

In order to ground the genealogy in historical practices, a practice based archive was necessary to source that could provide historical documents that could be examined over a time period. Several options were considered, including past curricula of the occupational therapy education providers, the content of the *Occupational Therapy Journal of New Zealand*, and the monthly *OT Insight* magazine of the professional association. However as the focus of the research was on practices these archival resources did not seem close enough to day to day occupational therapy. What is close to practice are the Competencies for Registration documents produced by the Occupational Therapy Board of New Zealand (OTBNZ). Although they did not have as long a history as the other archival records, the Competencies are the main guiding document on what is expected in everyday occupational therapy practice. The inception of the Competencies also marked an historical change in how occupational therapists were governed by the OTBNZ and through wider political forms of governance of the public sector. For these reasons the four iterations of the Competencies were chosen as the primary texts on which to ground the genealogy.



Figure 1: Competencies for Registration documents 1990-2017

The Competencies first emerged in the profession at a clear historical point, 1990. Prior to this the profession had no legally framed documents that prescribed the practice expectations of occupational therapists. The reasons for the implementation of a competency framework were important macro-level and historical markers for the profession and enabled an analysis that was cartographical in nature, spanning the broader health and public service

landscape. In addition to this historical significance, a new version of the Competencies was planned to be released (in early 2015) during the course of the research, making these documents an ideal mechanism for tracing lines of power as a history of the present.

There are four versions of the Competencies for Registration documents²⁰. After the inaugural version in 1990, there have been iterations published in 1995, 2000 and 2015. They are publically available documents, held in government and public libraries. The documents are all structured as competence frameworks. The practice expectations of occupational therapists are divided into several separate roles. These roles have diminished in number over the years, with the first two versions starting out with ten roles, the third version reduced to seven and the fourth, current version, having only five. Each role then has a list of performance criteria that occupational therapists must demonstrate in order to be considered competent. These criteria vary in number depending on the role, ranging from two or three to thirty. The first two versions had over three hundred performance criteria within the document, with this number decreasing along with the number of roles (Appendix 3). Graduates of occupational therapy education programmes are measured against the performance criteria in the Competencies, as are all practising occupational therapists through the annual re-certification process.

The analysis of the Competency documents was carried out over the first eighteen months of the research. A detailed reading of each version of the Competency documents was made and a separate analysis written about each one. Alongside the text of the Competencies documents, the meeting minutes of the Occupational Therapy Board of New Zealand were also reviewed. Although

²⁰ In addition to these quasi-legal Competencies there was another voluntary ongoing monitoring of competence programme, the Cornerstone programme. This was produced by the professional association in the 1990's but was not included in the genealogical analysis. This was because the Cornerstone programme was not well taken up by the profession and it was not part of the legally mandated processes of the Occupational Therapy Board. It is important to acknowledge as it was the first emergence of an ongoing monitoring of competence in the profession and although a detailed analysis of the content of the programme has not been undertaken, it was markedly different from the system that was mandated in 2004.

not published, these minutes are public records accessible through the Official Information Act (1982). Permission was sought from the Chief Executive of the Board to read the minutes. The minutes were reviewed over the time period in which the Competencies were written, from the 1980's-2016 and were read in the hard copy form, until 2004, after which they became electronic records. Notes were made about details in the minutes that pertained to political changes, expectations from the Ministry of Health, interactions the Board had with the profession as a whole, the processes of producing each of the Competency documents and any other contextual information that appeared significant. The meeting minutes provided invaluable insight into decision making which impacted on how the Competency documents were produced. They also provided many traces relevant to other paths of inquiry such as the formation of ethical codes in health practice, the corporatisation of the health service, and the legal assemblages formed between the Ministry of Health, health care users and health practitioners. As Graham (2011) explained the identification and following up of discursive traces is part of a Foucauldian informed method as it assists in revealing additional elements in particular formations. These additional traces can lead to a deeper understanding of how objects of knowledge (in this case the Competencies) have been produced. The other important element that offered many fruitful discursive traces was the annual recertification process, a primary function of the OTBNZ since its inception in 1949.

The annual recertification process is a material practice where therapists are issued an annual practising certificate, or license to practise, and is legally necessary in order to use the title occupational therapist. Prior to 1990 this was an annual formality where therapists were only required to pay a small fee (around \$25) in order to receive their annual practising certificate. After the introduction of the Competencies for Registration, this loose arrangement changed and the ensuing processes were one of the ways the Competencies have become connected to day to day practice. The OTBNZ progressively developed a complex and detailed system for monitoring the ongoing competence of practitioners, and an online public register which included the

processes that managed the annual recertification of occupational therapists. These new systems involved digitalisation, guidelines, handbooks and mandatory processes which all provided additional textual material for analysis. The Competencies for Registration were connected to all of these processes as they provided the practice framework on which these systems were reliant. The development of these interconnections was traced through the OTBNZ meeting minutes and with the combination of the formal Competencies and the mandatory practice based processes a rich source of information for genealogical analysis was amassed. To collate the information from these sources in an intelligible and usable way, each Competency document was analysed individually in conjunction with the processes used by the OTBNZ at that time. Initially significant further reading on the political context, history of health reforms and bicultural healthcare practice was required in order to understand the historical contexts in which each version of the Competencies was embedded. The first three analyses built on each other and by the fourth analysis a more nuanced commentary on the re-configurations, disappearances and emergence of elements occurring through the various iterations of the documents was able to be formed. These raw analyses provided an evidential trail of historical occurrences which has led to the current expectations of practice. The lengthy process of carrying out this detailed archival research also contributed to the overall project by providing content for discussion on the research blog. All occupational therapists need to engage with the Competencies and during 2014-2015 they were highly topical due to the most recent version being released in 2015. As an OTBNZ Board member at the time, my insider-researcher position was a constant ethical consideration for both my Board role and my research. Managing the ethical tensions of the situation assisted in developing an ethical axis to the research and is discussed later in this chapter.

Practice observations

The idea of carrying out practice observation as a method developed after some exploration of methodological congruency in Foucauldian informed research.

Initially I had planned to interview key occupational therapists and leaders of the profession and conduct a discourse analysis of these interviews to identify dominant discourses shaping the profession. However after some reading and consideration, particularly of David Nicholls and Joanne Fadyl's (2013) concern about the congruency of using interviews as method in Foucauldian informed research, this method was abandoned. The predominant concerns that Nicholl and Fadyl articulated were that interviews are unable to capture the materiality of practice and how this is an essential component of a Foucauldian analysis. As well as this, echoing Hook's (2001) concern that dealing solely with textual sources supports an understanding of discourse as an effect of power rather than as an instrument of power (p. 539), they also ask whether in carrying out interviews "we are generating texts that reproduce precisely those discourses that captured our interest in the subject to begin with?" (Fadyl & Nicholls, 2013, p. 27).

In order to capture the doing of occupational therapy in a way that privileged the materiality of practice while remaining aligned to an approach of a genealogical critique, a method that allowed an observation rather than discussion of practice was designed. This method consisted of me observing occupational therapists working for an entire working week, 8am-4.30pm (the standard work hours). These observations were not intended to be an ethnographic study, but rather a gathering of examples of practice at the surface level of occupational therapy. The observations took place in the office base where the therapists carried out their everyday mundane duties. To remain on the surface without positioning therapists as subjects, these observations focussed on what was involved in doing occupational therapy at each workplace, not on the performance of the individual therapists. For example, processes of documentation, centralised funding applications, and service specific procedures were examined, telephone calls, liaison with other staff and staff meetings were noted and environmental factors such as noise, security procedures, office layouts and what resources were used were recorded. As well as this direct observation of practice, the histories of the service the therapists worked in and

a review of significant service policies, standards and employment related documents was carried out. In essence this became a mini-genealogy of each worksite. These mini-genealogies then were used as part of the larger genealogy of the entire project. To keep this method manageable the number of workplaces was limited to three and the three weeks of observation were spread over a six month period between November 2015 and April 2016.

Recruitment strategy.

The recruitment strategy used was designed to attract participants as well as maintaining interest in the overall project. Participating in the case studies was positioned as part of a larger project, one that was questioning the way occupational therapists practised as a collective. The strategy involved repeatedly publicising the research over 2014 and 2015 outlining to the profession at large what I was trying to achieve through multiple communication channels. I used the blog, sent mass emails to all registered practitioners through the OTBNZ register and published an article in the monthly professional association magazine (Silcock, 2015) asking occupational therapists if they would like to participate in the research by allowing me to observe their workplace. I also publicised the research early on at a Local Area Network meeting of occupational therapists in the Waikato region (that I co-convene) and sent a mass email to those on this emailing list (approximately 200 therapists). Sustaining these activities over a long period of time resulted in a relatively easy recruitment of three suitable workplaces.

Inclusion criteria

There were two main criteria for inclusion in the research as a suitable workplace. Firstly there needed to be at least three occupational therapists employed at the work site and they all needed to share one office. Three therapists were necessary to provide a substantial quantity of observations without a need to follow people around. From my experience as an occupational therapist I knew that many of the material practices that I was interested in would be observable in the main work area of each workplace. The routine and everyday work of occupational therapists involves a lot of organising, telephone

conversations, emailing and online/computer work. The other reason for having more than one therapist to observe was that often occupational therapists disappear from their offices for extended periods to do their clinical work, meaning there would be little to observe if there was only one therapist involved. Along with these considerations, I was very conscious of my position as a researcher and wanting the project to be seen as beneficial for the profession and of use to the therapists themselves. I did not want to follow the therapists around as this would individualise and subjectify them in ways that were not the intent of the research. I was interested in the discursive practices of the profession not the individual therapists as a subject. Remaining based in the office for the week of the observations was intended to reinforce this. Whilst my presence was still a subjectifying one as I was constantly taking notes about what the therapists were doing, it was hopefully experienced more as a subjectification of the group rather than of the individual therapists. My insider knowledge of the profession also enabled me to understand the surface level of what I was observing without the need for highly subjective scrutiny of the therapists (e.g. constant questions about what they were doing or wanting to read/view what they were doing to understand the processes). This also assisted me to maintain a focus on general practices rather than on the individual.

The second main criterion for the inclusion of a workplace was for it to be located in the Waikato region. This enabled me to engage with the therapists in the case studies in a much more regular and involved way. I was able to meet with them in person to explain what the research was about before they committed to participating. I was also able to spend as much time as they required to explain and check the draft analysis once the observations were complete and I returned to the workplaces several times to present and discuss the written work I was producing. The ability I had to do this became a strong element in the project becoming a genealogical critique as the therapists developed a personal connection and interest in the research and many of them followed the blog after being participants. Maintaining this local focus also assisted me in recruitment as I was known in the region, bringing an element of

trust into the researcher/researched relationship (I was one of them) that may have been more difficult to establish elsewhere.

Workplace descriptions.

The first case study was a high security acute forensic ward at the large regional hospital. This worksite was suggested by a colleague who had worked there previously and he essentially brokered contact between me and the occupational therapy team leader. There were four occupational therapists and one occupational therapy assistant who worked out of a building allocated for occupational therapy in the ward complex. The second case study was a private for profit wheelchair service. The owner of the company contacted me directly expressing interest in being part of the research after reading of it in the recruitment emails. The company employed several occupational therapists sited in the same building. Three of these therapists volunteered to be the primary participants and for the week of observation all worked from one shared office. After these two case studies had been completed and no other services had come forward I recruited the third workplace directly. I contacted one of main special education providers based in the Waikato to ask if the occupational therapists would be interested in participating. I wanted to include the education sector in the research as it provided diversity from both the health and adult oriented services of the other two case studies. A particular school was approached as I knew it employed three occupational therapists on site (from its website) which matched my criteria. After sending the team leader information and meeting with the occupational therapy team, they also agreed to participate. The school based therapists presented a different worksite in that they were based in the education sector but also because they were physically housed in an open plan office as part of a large multi-disciplinary team (physiotherapists, speech language therapists, music therapists, psychologists and therapy assistants). The multi-disciplinary environment broadened the practices that I observed to include negotiations and collaborative work with other professions that I did not see at the other workplaces.

Informed consent process.

Before any of the workplaces agreed to participate I met with the appropriate team leaders and managers to discuss the research and provided organisation participant information sheets that described what I planned to do and the types of service documentation I would like to review. I also provided a copy of the consent form at this time. Once the team leader/service manager had agreed, I then obtained consent from the individual therapists themselves. This occurred differently for each of the workplaces, depending on the way the service operated. I met the therapists at staff meetings at the forensic ward and at the special school to explain what was involved and what participation would mean. I also provided copies of the participant information and consent forms for individual participants. For the wheelchair service, I met with the three senior managers of the service initially, and they then discussed with their team whether or not to participate. After a time of deliberation all the workplaces and the therapists who would be observed agreed and gave consent for me to observe them working.

Although I was observing only occupational therapists, all the services were much larger than just occupational therapy providers. There was a core of people who regularly came into the offices who were not occupational therapists (such as other health professionals, occupational therapy assistants and wheelchair technicians), and the special school therapists shared an office with eleven other people. Because these other staff members were unable to be excluded from the observations, informed consent was also obtained from all of these additional people. The consent form specified that if any one person did not wish to participate, the observation would not go ahead. A process for contacting me to indicate a withdrawal of consent was outlined so this could be carried out directly with me rather than via the team leader/manager. These ethical safeguards were put in place to ensure that if the staff at the worksite were feeling coerced to participate or were uncomfortable refusing consent they could opt out with a degree of anonymity.

Procedure for observations.

The observations involved me sitting in a corner of the office of the occupational therapists and observing their administrative and other office based tasks over the course of a week. These observations took the form of a time-based record. As the therapists carried out a task I would note down what they were doing, how long it took and any environmental components to it. The content of the work or who was doing it was not of interest, it was the task itself and the purpose of it that I attended to. At times I would ask questions to understand in more detail a process, such as an online system or service requirement and these would be added as explanatory notes to the timeline. These observations also guided me towards service documents that were useful to analyse. Appendix 4 provides a sample of my observation notes, one for each of the three case studies.

As well as detailed notes for a full working week, I collected texts and documents such as policies and procedures, job descriptions, service level contracts, operational manuals and auditing and reporting guidelines. I also took photos of the office environments and some of the primary workspaces the therapists worked in (without people) at both the wheelchair service and forensic ward. At the special school I felt less comfortable taking photos as it seemed to be crossing into a different sort of observation due to the workspace being a completely shared one. The workspace was not indicative of occupational therapy in particular and the photos would have been recording inter-professional practices which were not the focus of my research. However, when I engaged with the therapists to go over my draft analysis I did ask if I could use a photo of a particular communication aide to illustrate a certain practice, which they willingly provided.

Compiling the workplace genealogies.

At the end of the week long observation period I negotiated a date with the therapists to return within six weeks to share my written analysis. The analysis was carried out using my observational notes, the documents from the workplace and further genealogical research about the histories, legislation,

policies and operational guidelines the therapist were required to comply with. The analysis was structured with an historical summary of how the service had developed to its present operation followed by a commentary on knowledge, power and subjectivities and how these elements combined within the workplace. The mini-genealogy that was created with the analysis was then formatted as a formal document (approximately 10,000 words) for each workplace.

The genealogies were then shared with the participants in order for them to check accuracy and to request anything to be deleted, modified or added. It was sent to them a week before a pre-arranged meeting so they had time to read it. Because it was such a large document I also wrote a two page summary that covered the main points to provide a much less daunting and accessible version. The documents were initially only provided to the therapists involved to ensure I had written nothing they were uncomfortable with before it was seen by their team leader or manager. I met with the therapists as a group to go over the genealogy to ensure they had every opportunity to contribute and provide feedback about the analysis. They also all had my email address so that they could add additional comments at a later stage if they wished. This consultation resulted in some minor alteration of the content of the analysis for all of the documents. For example, in the forensic service my description of a performance appraisal and pay process was incorrect, wording was changed to better reflect the multi-cultural nature of the staff on the ward, staffing ratios, and how certain mandatory practices such as supervision were met were clarified. After this review by the therapists, the analysis was then provided to the team leaders and managers for their review and feedback. Two of service managers both did this with some further minor clarifications and factual corrections. These involved service level contract details, caseload information, statistical reporting requirements and some historical corrections. After a final draft of the analysis was agreed upon it was given to the workplaces as a formal document to use as they wished. Two of these services shared it with higher level organisational

management, and all of the therapists appeared to find the information interesting, new and relevant.

The way in which the observations took place and the extensive consultation with the therapists involved through the writing process of the analysis, were deliberately designed in order to incorporate a critical practice element to the research. By developing a collegial relationship with the participants as well as a research one, it enabled the critique to have the potential to change what I was critiquing (each workplace) whilst carrying out the critique. Providing the analysis as a formal document which the workplaces could use was also a way that the workplace analyses did not get lost in the larger project and gave the therapists something concrete to consult and think about.

Ethical comments on observation as a method.

There were several ethical issues in using case studies and observation as a method that required thoughtful management. A primary issue was preserving the anonymity of the therapists and the workplaces. As Aotearoa New Zealand is such a small country and there are so few occupational therapists, it was a significant possibility that the workplaces and the participants could be identified in the research. To mitigate this occurring as much as possible the workplace genealogies have not been included in this published doctorate. When the workplaces are referred to they have been described in as general terms as possible – a forensic ward (there are several at the worksite where this was), a special education provider and a wheelchair service. The case studies and the content of the genealogies were also never discussed on the blog. The exceptions to this public non-disclosure were the times I presented to local occupational therapists. These therapists knew I had been conducting research in our local region and that was why I was invited to discuss my research with them. Some of the participating therapists and their team leaders were in the audience for these presentations. To protect their privacy and maintain trust and engagement with the research I ensured the content was very general and focussed on the macro-level of policies, historical elements and occupational

therapy practice. The location or names of the workplaces were never mentioned and I was careful not to single out the therapists in the audience or indicate they were participants. There was a significant ethical balancing occurring during these presentations. I was very motivated to do them as part of my genealogical critique as they were an excellent way to remain connected to the profession throughout the project and make the research an active resource for practitioners. However critiquing your own profession in public is a confronting experience and one that I did find challenging.

The one area of practice that I found most challenging to critique in a direct way was that of bicultural practice. Colonisation and the way occupational therapy is connected to colonial practices is not a concept that is discussed in the profession and I was very aware of treading carefully when critiquing and writing about it. I wanted to maintain an open conversation that was productive in order to support the fragile emergence of biculturalism that is currently occurring in the profession. The lack of direct critique of colonising practices in relation to the how the occupational therapists practised in the case studies is a silence in the thesis and was a deliberate choice due to the likelihood of me remaining in a public position in the profession after my doctorate was published. Examining how occupational therapy is part of the project of colonisation requires in-depth scholarly attention which could not be given within the scope of this thesis.

The other main ethical issue in carrying out the case studies was that I was on the Occupational Therapy Board at the time. I made this clear to all the therapists involved before they agreed to be part of the research and it was written on the information sheets for participants. What made it an ethical issue is that my observations provided very useful information for the Board about issues occupational therapists face in practice. I was very aware of this however, and if there was an observation that was useful to convey, I was very careful to speak in extremely general terms about 'my research' so individual workplaces and therapists could not be identified. An example of such an occurrence was an ongoing discussion the Board was having about the

supervision requirements of new graduates. There were new graduate therapists in all the case studies, so I had observed how they were working in a diverse range of settings. I was able to discuss these observations in a very general way to contribute to the Board's level of understanding of what was happening out in the workplace. The Board has stringent ethical conduct/conflict of interest processes. Although it did not occur, if the workplaces or therapists I had observed had come to the Board's attention I would have been required to declare a conflict of interest and leave the room. Although this would have compromised the anonymity of the research participants, the Board members code of conduct prevented this being known beyond the Board. Being on the Board was another way the research was able to be a genealogical critique as it provided another opportunity for critical thought to enter the profession but this time at the level of governance and local institutional structures.

Critical Reflection on Choice of Methods

Compiling a practice based genealogy using three such diverse methods was a challenge due to the large amount of heterogeneous material and information each of them generated. Although this has added immensely to the richness of the analysis there are aspects that I would modify in the future. Choosing the Competencies for Registration documents as a main textual base for the genealogy provided a clear trajectory through time to follow. However, these documents were very large (particularly the first two versions which had ten competence roles and over three hundred performance indicators) and provided a plethora of possible lines of inquiry. To manage this mass of text it may have been more efficient to use the smallest current version as a starting point. The three prior versions then could have been utilised to trace the history of the current document. Organising the analysis in this way would have limited the breadth of the text being analysed into a more manageable volume whilst still

being completely connected to a current problematisation of occupational therapy²¹.

The workplace observations were perhaps the most successful method of the research as they provided extremely useful data due to the highly visible practices that occupational therapists engage in, even in an office. They also provided concrete historical events to trace which formed visible lines of inquiry. Having a solid historical trajectory attached to one locality also became an important way in which a post-colonial lens could be applied in a way that was recognisable and associated with known material practices particular to the region. As already discussed, the workplace observations became an important part of the positive endeavour of the research. The human connection involved with being in the same room for a sustained period, as well as the recruitment and follow up meetings I had with the therapists, were very effective for developing trust and interest in the research. I attribute this success to my insider status, as an occupational therapist as well as being from, and living in, the region where the workplaces were located. However if I used this type of method again I would approach the analysis as a collaborative co-designed project, guided by what the therapists or the service wanted from the research. The experience of conducting the case studies in the manner I did suggested to me that a more collective approach could possibly open up the potential of a genealogical critique in much greater ways. The possibility of understanding highly nuanced taken-for-granted practices of the workplaces and of utilising power relations at this level in productive ways would have been greatly

²¹ Working back from the current situation through time is actually how Foucault approached genealogical analysis or what he called "histories of the present" as explained by Dreyfus and Rabinow (1982) in *Michel Foucault: Beyond structuralism and hermeneutic*: "Writing the history of the present is another matter. This approach explicitly and self-reflectively begins with a diagnosis of the current situation. There is an unequivocal and unabashed contemporary orientation. The historian locates the acute manifestations of a particular "meticulous ritual of power" or "political technology of the body" to see where it arose, took shape, gained importance, and so on "(p.119). This is the approach taken with the workplace genealogies in the way I worked back from the current therapists roles to how occupational therapy was originally situated at the large colonial institution, Tokanui Hospital. It is not how the Competencies were analysed and in hindsight working back from the current version to the 1st version from 1990 may have been a more congruent approach.

enhanced if the project had been generated from the participants rather than me.

Lastly, although the research blog became a very positive and productive method it was also the most challenging. The ongoing commitment to post on the blog (twice monthly for two years) and the pressure of writing in an interesting and engaging way was demanding to sustain. Using the blog as a research method required more dedicated time and commitment to the art of blogging in order to capitalise on the possibilities of the method. On reflection, the way I used the blog was more of an online forum or special interest group because of my own limited prior engagement with blogging and using social media. It also possibly reflected my own underground and subordinated occupational therapy subjectivity as I instinctively wanted to keep the blog a specialised occupational therapy resource rather than intending it to be a social network with other like-minded people. I deliberately avoided networking with international occupational therapists through social media (by not pursuing twitter, Facebook or LinkedIn connections with the blog) as I wanted to keep it about Aotearoa New Zealand occupational therapy. However, this will have seriously compromised the potential for a social network to form with other bloggers and attracting any outside followers or sharing of posts (there was only one follower from outside Aotearoa New Zealand). By keeping the blog so contained, it limited the horizon of the research to the familiar and known rather than opening it up to much more unpredictable possibilities of public social networks. As a form of critical action using a blog had an unknown effect on the readers and commenters and as discussed in chapter nine, it was also directly confronting the strongly held subjectivity of underground practice that many occupational therapists (including me) hold close. The strength of this subjectivity was not anticipated and is an important consideration in how the blog functioned as a visible form of critical action. Although it was a political act it was a contained act and remained within power relations that were more predictable and secure. From the experience of using blogging as a research method, the way it could be utilised for political action due to its public nature

and connectedness are numerous. Blogging also served as an important way to facilitate a negotiation of my own subject position as a researcher. It facilitated opportunities to develop a position and stance within my profession due to the need to exercise my own voice and develop a position from which to stand.

Summary

Carrying out the research for this project was an evolving process with all the methods informing and contributing to how the methodology of a genealogical critique was conducted. All of the methods were designed and carried out to produce information about historically contingent interplays of macro and micro level power relations at the level of practice. The research provides examples of how the profession has negotiated and responded to these power relations at particular places and at particular times. By focussing on discursive practices, the surface level of occupational therapy was kept as the primary site of this cartography. The underlying relations between truth, knowledge and power within the genealogy have been problematised in a way that can be connected to real material outcomes for people occupational therapists work with. Adopting a post-colonial lens has enabled a connection between colonial and occupational therapy practices to be made visible. The informal methods of the research that developed through the regional focus and having an insider position greatly assisted the positive endeavour of the approach and provided an essential ethical axis to the research. In order to set the scene for the analysis of information gathered through the methods a summation of relevant historical information has been provided in the following chapter. The history provided in this brief chapter provides the context in which the subsequent genealogical analysis is embedded.

Chapter 4: Contextual Background

This chapter is intended to provide some historical context to the research in relation to colonisation and the way the health services have been provided since a colonially imposed health system was developed. The way colonisation played out in the Waikato region and the influence of the Waikato-Tainui tribe are historical elements that are specific to the localised practice observations of occupational therapists working as well as the overall genealogical critique. The colonisation of Aotearoa New Zealand shaped how healthcare subsequently developed in regions like the Waikato and these elements provided an important contextual backdrop to the analysis. The way Aotearoa New Zealand was subjected to the British Empire's global colonisation project is discussed with particular attention given to the position of the founding legal documents of Te Tiriti o Waitangi and the Treaty of Waitangi in the establishment of Aotearoa New Zealand as a new colony. The chapter focusses on colonisation in the Waikato region and how the health services in the region have developed since 1840 when the two treaties were signed.

Colonisation of Aotearoa New Zealand

Although there remains some debate it is generally accepted by both indigenous and non-indigenous historians that East Polynesian explorers discovered and settled in Aotearoa New Zealand around the 13th century (Wilson, 2005). These navigators were the ancestors of the indigenous Māori people (Irwin & Walrond, 2016). The first written record of Europeans reaching the country was in 1642 by the Dutch man, Abel Tasman (Wilson, 2016). In 1769, the English navigator James Cook made a much more substantial reconnaissance of the country. From the 1790's Europeans began migrating to and living in Aotearoa New Zealand (Phillips, 2015). James Cook's original estimation that at least 100 000 Māori lived throughout Aotearoa New Zealand has been supported in recent times through other population based research (Pool & Kukutai, 2011). Māori therefore vastly out-numbered the European immigrants living in small communities dotted around the country and the country remained an

independent Māori controlled realm. Britain considered New Zealand to be a frontier outpost. Due to the coalescence of several factors²², before long the uneasy relationship between the British and Māori deteriorated. In 1835, many Chiefs from northern New Zealand responded to their perceived erosion of authority by signing He Whakaputanga o te Rangatiratanga o Nu Tirenī (Declaration of Independence of the United Tribes of New Zealand) to assert their kingitanga (authority or sovereign power) over Aotearoa. The Declaration was recognised by the British monarch (William IV) at the time of signing, though, within a matter of five years through an extensive legal campaign the Declaration was superseded with a new Treaty, driven this time by British interests. The new Treaty was signed in 1840 by many Māori rangatira (chiefs) and representatives of Queen Victoria (Orange, 2012). There were two versions of this founding document, a Māori language version known as Te Tiriti o Waitangi and an English version, the Treaty of Waitangi. The English language version was adopted as the founding legal document of Aotearoa New Zealand and enabled the establishment of a Westminster system of parliament with a judicial system that followed English common law. The enactment of the Treaty of Waitangi was the beginning of formalised and ongoing processes of colonisation that primarily occurred through the legal structures and power the Treaty gave to the governing parliament.

The two versions of the treaty have significantly different meanings with the concept of sovereignty a particularly crucial difference (Bargh, 2007a; Hope, 2004; Orange, 2014). The Māori text agreed to the British having 'kawanatanga', the right of governance, whereas in the English text, Māori were to cede 'sovereignty' and two other articles guaranteed to Māori the unqualified exercise of chieftainship over their lands, settlements, and all their treasures, and gave them the same rights and duties of citizenship as the people of England (Ministry of Justice, 2016; Orange, 2012). Since 1840 these (other) major discrepancies

²² These factors included an increasing lack of law and order involving unruly British subjects with no way of controlling them, Europeans privately purchasing vast tracts of land from Māori in no planned or controlled way, and the government sanctioned intent of the London based New Zealand Company to establish organised settlements on either side of the Cook Strait (Orange, 2012).

between the two versions have led to ongoing disputes involving the power the law has over Māori and things Māori (Bargh, 2007a; Belgrave, 2014). These discrepancies as well as the annulment of the Declaration of Independence have been articulated and resisted by Māori since 1840.

During the period of 1840-1860's there were many military conflicts between Māori and the Crown throughout the North Island to enforce Government plans for land acquisition and property ownership. The tribes that fought in these wars had vast tracts of their tribal land confiscated. The violent enforcement of colonial rule and the imposition of Euro-normative methods of governance and control of the population had lasting and devastating effects for Māori. By 1900 the population had halved to just over 40 000 (Pool & Kukutai, 2011). Although the number of Māori has recovered substantially from this low point they remain a significant minority at only 15% of the residing population²³. People of European descent rapidly became the largest proportion of the population and established their ways of life as the cultural norm throughout the country. In the current era 74% of residents identify as European with the remainder a range of other ethnicities from around the world (Statistics New Zealand, 2013b)²⁴. The processes used to colonise the country have left lasting traces with deep social effects that are visible in the present day. To discuss these in more depth, the Waikato region, where this research was conducted, has been examined in more detail.

Waikato context.

The Waikato region provides an example of what occurred through the processes of colonisation immediately after the Treaty of Waitangi was signed. As a white woman I acknowledge that it is not my place to document the indigenous history of the colonisation of Aotearoa New Zealand. I have my own place in this history as the Waikato is where I grew up and spent my formative years. I was

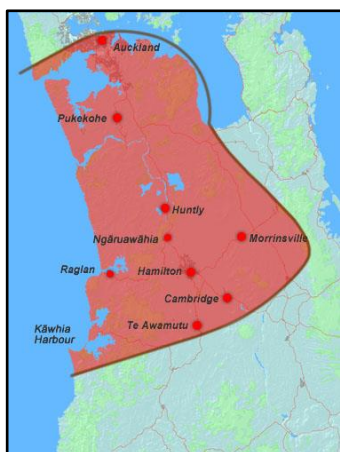
²³ In the latest national census figures there are now 712 000 people who identify as Māori.

²⁴ The census allows people to identify with more than one ethnicity which makes these figures somewhat meaningless. However the number of Māori compared to non-Māori has dramatically changed from when the country was colonised where Māori were by far the dominant ethnic group.

researching my own history as an English speaking white woman who has benefitted from the practices of colonisation. As I learnt more, the way my ordinary white life was associated with colonising practices became apparent. In particular I grew up on farms owned predominantly by Europeans. These farms were on land that once belonged to local iwi Ngati Koroki Kahukura but was alienated through Native Land Court processes established under legislation between 1865 and 1873 (New Zealand Government, 2016). My lack of awareness of this fact, along with a cultural ignorance of growing up with no understanding of how the surrounding geography such as the Waikato River and Maungatautari mountain, represented tupuna (sacred ancestors) for the iwi, starkly demonstrated how quickly colonising practices are dismissed and forgotten by the dominant culture. Investigating the history of the Waikato region became an important element in the research as it helped identify local colonising practices which related to the way health services in the region were delivered.

The Waikato region is the ancestral land of the tribal confederation Waikato-Tainui. It spans much of the central North Island and the Waikato River that flows through it is a central landmark both geographically and culturally for Waikato-Tainui. The river is also an important landmark for the Crown²⁵ as it is a major source of hydro-generated electricity. Much of the land is farmland, predominantly dairy cow farming but also sheep, beef and forestry. The only city in the region, Hamilton, is the fourth largest in Aotearoa New Zealand, with 141,612 residents (Statistics New Zealand, 2013a).

²⁵ Due to the colonial order imposed by Queen Victoria the term 'the Crown' has been used to indicate the politically sanctioned governmental interventions in this history.



Map 1: Waikato-Tainui Rohe

Te Puni Kokiri, n.d.



Waikato Region

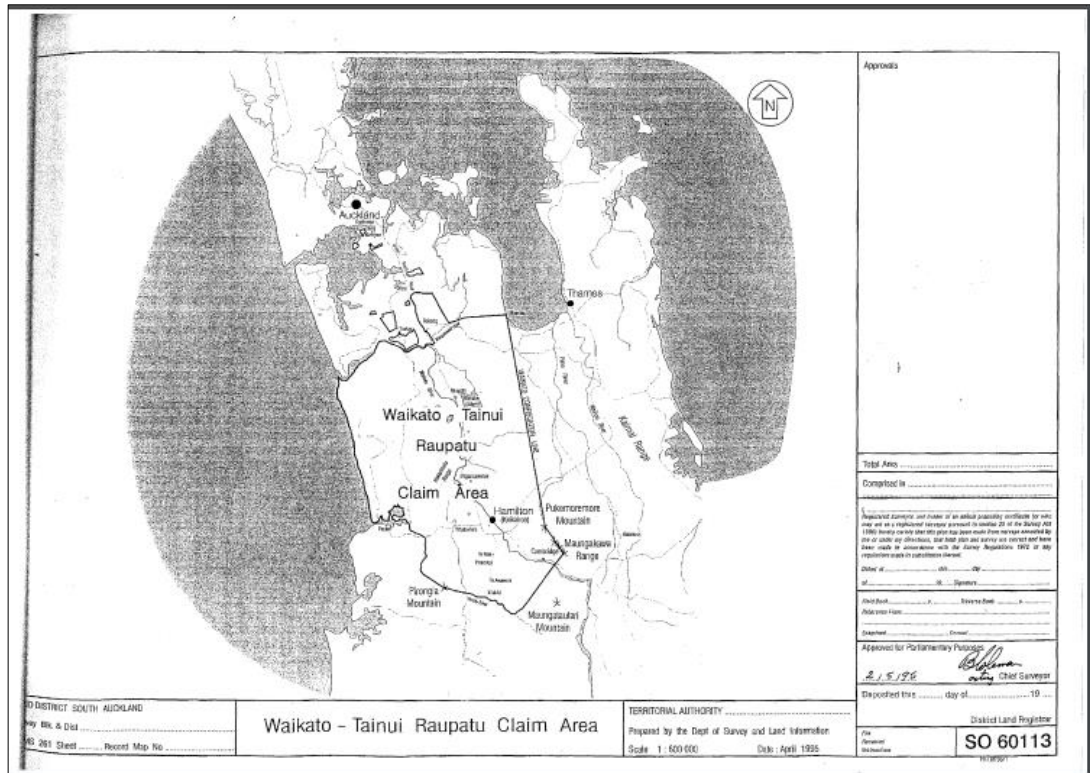
**Reproduced with permission from
Waikato Regional Council**

Waikato-Tainui is one of the largest tribal groups in the country making up 8.4% of all Māori (Statistics New Zealand, 2013c). The Waikato-Tainui confederation of tribes has had a unique and significant role in Māori politics and activism since the signing of the Treaty of Waitangi. Soon after the Treaty of Waitangi was signed a counter movement called Kingitanga was formalised with the coronation of the first ever Māori King, Pōtatau Te Wherowhero, of Waikato-Tainui, in 1858. Kingitanga was formed as an inter-tribal political coalition to provide some unity and a leadership structure that was equivalent to the British sovereignty. The Kingitanga movement was an attempt to resist the rapid colonisation that was occurring, particularly in response to the increasing loss of tribal lands. At the time Pōtatau Te Wherowhero was considered the most powerful chief in the land by Māori and Pākehā (non-Māori) alike. The position of Māori sovereign is a hereditary title and Te Arikinui Tūheitia Paki, King Tūheitia, the 7th Māori King was crowned in 2006 after the death of his mother and longest reigning monarch, the much beloved Queen Te Ātairangikaahu (Papa & Meredith, 2012). Waikato-Tainui are considered the kaitiaki (guardians) of the Kingitanga movement.

Despite the status and power of Waikato-Tainui, the tribe suffered terrible loss during the land wars with the Crown in the 1860s. Much of their tribal land was confiscated (raupatu) as punishment for fighting against the Crown (Boast, 2015). The confiscation took in approximately 800 000 hectares

of land in the heart of the Waikato region. The Māori King and his followers were compelled to retreat from their ancestral lands and resided for the next 20 years in exile in the southern end of the Waikato in land belonging to the Ngāti Maniopoto tribe. This region is still known as the King Country. Since this time Waikato-Tainui have sought recompense for the devastating effect of losing their ancestral land and the effect of the land wars.

Along with Waikato-Tainui many other tribal groups were also seeking redress for the Crown's failure to meet its obligations under the Treaty. In 1975 the Waitangi Tribunal was established as a legal mechanism for Māori to seek redress for Crown actions that breached the promises in the Treaty of Waitangi and Te Tiriti o Waitangi (Ministry of Justice, 2016). However due to the length of time the claims took to be dealt with by the Waitangi Tribunal some claimants chose to deal directly with the Crown. Waikato-Tainui were amongst the first tribes to reach an agreement in this way. In 1995 the Waikato Raupatu Claims Settlement Act (1995) was passed and Queen Elizabeth II formally apologised to Waikato-Tainui, the first time the British Crown had ever apologised to indigenous peoples (Hill, 2012). Part of this apology stated: "The war caused loss of life among Waikato Iwi and the effect of the raupatu both immediately and over time has had a crippling impact on the welfare, economy and development of Waikato-Tainui" (New Zealand Government, 1995, p. 4).



**Map 2: Waikato-Tainui Raupatu area
(New Zealand Government, 1995)**

After the Waikato Raupatu Claims Settlement Act (1995) was enacted many Crown owned public properties (such as the Airforce base, University of Waikato, many schools, the courthouse and police stations) were transferred back to Waikato-Tainui ownership (Fisher, 2015)²⁶ and the tribe received \$170,000 000 in financial compensation. Waikato-Tainui leaders remain actively involved in mainstream national politics with Waikato-Tainui Tukoirangi Morgan the president of the Māori political party until his recent resignation in December 2017. The tribe is also a strong business leader and has a strong economic presence and influence in Hamilton City²⁷ as well as throughout the country and offshore²⁸.

²⁶ The land in which the Waikato Hospital was built in the early 20th century is not one of these and the site of Tokanui Hospital, which was the other main colonial healthcare institution in the region, is still subject to unresolved Treaty settlement processes since its closure in the mid 1990's.

²⁷ Waikato Tainui Holdings owns significant shares in the region's Huntly Power Station, 4000 hectares of farmland, has investment in public transport and infrastructure of the city, and owns

The history of war and land confiscation that occurred in the Waikato region played out in other parts of Aotearoa New Zealand. However, across most of the country, the acquisition of land for colonisation was achieved through Crown purchasing processes that often disregarded traditional ownership systems and were no less damaging to Māori communities. Such processes deprived Māori of their economic base, undermined tribal structures, and are now accepted as being a central cause of contemporary social marginalisation and the erosion of rangatiratanga (self-determination) that Maori are now struggling to regain (Joseph, 2014). One of the ways self-determination is stymied is through the much poorer health outcomes Māori have compared to non-Māori²⁹. The disproportionate presence of Māori in these statistics places a great burden on whanau (family) to support and manage the repercussions of poor health. As clearly articulated in a commentary by Dr Bev Lawton within a recent analysis of determinants of health for Māori children and young people:

These health discrepancies are not about being Māori but about systems that don't perform for those who are poorer or disadvantaged due to multiple factors including health literacy, racial discrimination, economic deprivation, poor housing, availability of transport or services and possibly differential levels of service (Craig et al., 2014, p. 103).

As such the health system is an important contributing part of this colonial landscape. It is a major social and institutional structure that supports and forms dominant discourse and practices. As a region the Waikato developed its own style of healthcare provision that centred around two institutions, the general Waikato Hospital and the mental health institution Tokanui Hospital. The Waikato Hospital was established in 1887 (Armstrong,

several major commercial property sites, hotels and sites of recent housing development within the City. Retrieved from <https://www.tgh.co.nz/en/home/>

²⁸For a recent example see newspaper article "Befriending the Dragon" which discusses a presentation by Tukoroirangi Morgan about a recent Waikato-Tainui multi-million business partnership with South Island iwi, China and Papua New Guinea. http://www2.nzherald.co.nz/the-country/news/article.cfm?c_id=16&objectid=11807082

²⁹ For details see <https://www.waikatodhb.health.nz/assets/about-us/Future-focus/Waikato-DHB-Profile-Final.pdf>

2009) with Tokanui Hospital opening in 1912 (Coleborne, 2012) when the Waikato was becoming a thriving farming district and Hamilton town was experiencing significant growth (Armstrong, 2009). The Waikato Hospital is sited on confiscated land in the heart of the raupatu area, whereas Tokanui Hospital was outside the boundary of the raupatu. The subsequent changes to these institutions have mirrored the way healthcare provision changed over the next 100 years, including the emergence of occupational therapy as a healthcare practice.

Health Service Provision in Aotearoa New Zealand

During the early days before 1840 European style healthcare was provided primarily by private medical doctors. Immediately after the signing of the two treaties, four hospitals were rapidly established and by 1850 the main towns of Auckland, New Plymouth, Wanganui and Wellington had government funded hospitals. These hospitals were built specifically to provide free health care for Māori and impoverished Europeans (who had to apply for consent from the Colonial Secretary to be admitted) but as the population rapidly grew by the end of the 19th century admissions to hospitals became much wider (Armstrong, 2009). ‘Lunatic asylums’ for people with mental health and neurological needs were built at this time. To manage the standards of healthcare received by the public the government implemented the mechanism of regulation (Burgess, 1984) with medical doctors becoming a regulated profession in 1867 (Jones, 2000) and nurses in 1901 (French, 2001). Occupational therapy followed some 50 years later in 1949 with the passing of the Occupational Therapy Act, at the same time as the closely allied profession of physiotherapy.

Along with all other major public service buildings these hospitals were built on colonially acquired land. As well as this commonality the geographic isolation of towns also was a common element in how these small cottage hospitals formed. A strong parochialism had developed throughout the country, every established community formed a different structure of healthcare provision so that “by 1908 hospital services in New Zealand were provided by 27 separate institutions, 13 Hospital Boards, and 23 Hospital and Charitable Aid

Boards, as well as institutions run by the Public Health, Lunatic Asylums, and Hospitals Departments” (Department of Health, 1974, p. 20)³⁰. The ability for central government to have some control of healthcare provision was seriously limited by this fragmented and highly localised arrangement and from these early days there have been successive health reforms to enable more centralised control of hospitals and healthcare provision.

The reforms primarily were formalised through various legislative changes that occurred from the 1920s, continuing to the current day. However due to the persistence of regional differences in how services are delivered, along with the historical position general practitioners (and some medical specialties) have had as private providers of medical care practice rather than public servants, there never has been a completely nation-wide streamlined health service in Aotearoa New Zealand (Department of Health, 1974; Easton, 2002). Regional differences in service provision remain, and a parallel private health service continues to thrive outside the public health sector. The economic crisis in the 1970s and 80s initiated a more radical alteration in how the health system was managed and this reformation continues to be a seminal event underlying how the health system operates in the current era.

In 1984 the new Labour government implemented widespread economic reforms that involved corporatization of state sector industries, privatization of state services, de-regulating industries, such as finance and transport from government controls (Larner, 1997) and altering monetary policies in order to enter the global finance market (Jesson, 1999). These reforms were driven by the emergence and global uptake of neoliberal ideologies, which relied on the market to drive the supply and demand for resources and services, theoretically lessening the involvement of central government in the planning and direction of the economy. To enable such extensive economic reform, major new legislation was introduced that allowed an implementation of policy into the public service

³⁰ As a comparison in 2018 the publically funded health service is delivered by 20 District Health Boards (DHB's) who each have an associated hospital(s). The DHB's fund the majority of health services provided in each district through a variety of contracting out arrangements and direct provision of services. Retrieved from <https://www.health.govt.nz/>

sector, including healthcare (Easton, 2002). These included the State Sector Act (1988) and the Public Finance Act (1989).

To re-structure the health system so that it was sensitive to market driven forces a funder-provider split in health service accounting was implemented (Tenbenschel, Mays, & Cumming, 2011). Regional health services were expected to run as businesses, which initially included expectations to generate a profit. This expectation was removed within three years due to the inability of any of the new Crown Health Enterprises to even come close to breaking even (Gauld, 2001). At the service and employment level, forms of business management such as contracted service provision, service level agreements, and quality assurance processes such as key performance indicators (KPI's) and performance appraisals were introduced throughout all areas of healthcare provision (Gauld, 2001).

Since the 1980's a continual tinkering with how health services are funded and managed has occurred, but the enterprise oriented business model remains the underlying economic model. The free-market model has evolved into a complex arrangement where central government remains the primary funder of free healthcare and a vast array of local, national and regional providers are contracted to provide services. These include many Māori for Māori (kaupapa) community healthcare providers, non-government organisations as well as for-profit businesses. Over time this has produced the current situation where healthcare providers are negotiating and managing many different power relations. In a not dis-similar situation to the fragmented systems of the early twentieth century a vast array of providers are simultaneously accountable to central government, local stakeholders and communities (Tenbenschel et al., 2011) in uniquely regional ways. There has become a greater multiplicity of accountability including "government funding and regulatory agencies, the communities from which third sector organisations arise, practitioners and their professional and occupational associations, board members, volunteers and sector peak bodies" (Tenbenschel, Dwyer, & Lavoie, 2013, p. 926). As a profession which emerged in 1940, occupational therapy and

its associated professional and regulatory activity was introduced into this evolving health landscape.

The most recent tinkering with how the health system is delivered commenced in 2009-10, after the National political party resumed power in late 2008 following a nine year stretch of being in opposition. The new model informing the management and funding of the health system is called the Triple Aim Approach. The Triple Aim Approach remains grounded in market driven service economic policy and advocates population level planning and funding, based on centralised evidence and data analysis (Institute for Healthcare Improvement, 2016b). Recent new policies and plans for re-structures to implement this approach involve the health workforce (Ministry of Health, 2014e), mental health and addictions service (Ministry of Health, 2014b), disability support service strategies (Ministry of Health, 2015a), and the new overall health strategy (Ministry of Health, 2016b)³¹.

From these brief histories, reformation of the health system has been a constant element in the way healthcare services have developed since the introduction of publically funded hospitals. Adding to this continually shifting and evolving macro-level landscape are the complicated relationships between health professions that play out at the meso-level. The introduction and emergence of many new health professions (such as occupational therapy) altered the historical domination of the medical profession in the way services are delivered. These conditions of emergence are discussed in more detail as part of the analysis in chapter five, which traces lines of the law and sovereign power. They are also examined again in chapter seven in relation to subjugating and subordinating practices that emerged over time in relation to occupational therapy and the practices analysed in the research.

³¹ The recent national election in September 2017 has ushered in a new coalition Labour government, altering the political landscape considerably. How this coalition chooses to manage the public service reforms currently still being implemented remains to be seen.

Summary

This background chapter is intended to provide a historical context in which the research is situated. The colonial past of Aotearoa New Zealand is intertwined with the way the healthcare system was established and the localised processes of colonisation have influenced how healthcare subsequently developed in regions like the Waikato. The most recent health reforms are following a pathway that operationalises new institutional structures through the enactment of new laws. Occupational therapists entered this pathway after it had been well established and are generally positioned at the street-level of these reforms where outcomes are materialised at the micro-level. What their individual doing does is a micro-capillary of power through this materialisation. The following four chapters analyse this doing in terms of power and how the specific examples of practice seen in the research support the operation of power at many levels.

Chapter 5: Sovereign Power and Legal Practices

In the genealogical analysis the increasing involvement of the law in occupational therapy is an intersecting thread to the colonial history of Aotearoa New Zealand. The law as practised in Aotearoa New Zealand is based on a founding understanding of Euro-normative sovereignty and the exercise of power as a right of this sovereignty. The adoption of English common law as the legal framework for the country was a major mechanism of this sovereign power. The same law has become part of everyday occupational therapy through a variety of guises that have become part of practice, through legislation, regulations, policies, standards and codes. In this research a variety of these legal and quasi-legal documents and processes that operationalised the law were studied. These were direct connections between occupational therapy practice and the way the law holds a primary position of power in the management of Euro-normative democracies (in comparison to other discourses such as magic or religion) (Foucault, 1977/1980). In Aotearoa New Zealand this foundational positioning of the law has far reaching implications because it was imposed through the colonisation of an indigenous people.

As summarised in the previous chapter, the imposition of the foundational place of the law occurred through the signing of a treaty in 1840 between the indigenous Māori people and the colonising nation, England. Ongoing acts of colonisation were enabled by many different pieces of legislation and have had lasting effects on the population. In her address to the OTNZ-WNA annual conference Kingi (2007), describes how the loss of land, cultural knowledge and control has resulted in the minority status and continued health disparities between Māori and non-Māori since the signing of the Treaty of Waitangi and Te Tiriti o Waitangi. The law has been directly implicated by Māori legal scholars in creating these disparate outcomes, with land title and ownership, family law, relationship property laws and environmental law allowing English common law to direct Māori lives in ways that are contrary to their cultural beliefs and ways of living (Ruru, 2005, 2009; Te Aho, 2006).

The inseparable connections between the law and colonisation are also linked to legal structures that occupational therapists are part of. As part of introducing a colonial order, legal structures evolved that were tightly connected to the provision of public health services. A close network between medical practice, sovereign power and the law formed through the health system and associated institutions. Examining the resulting nexus provides insight into how a macro-dispositif of power relations overlays the medico-legal status of health professionals in Aotearoa New Zealand. Medico-legal practices draw on common understandings of positivistic medicine and science and the foundational position of English common law. Dominating practices such as these are how Moana Jackson, an indigenous rights lawyer and scholar, explains the law (along with other dominant forms of power such as the economic reliance of market forces) enables the social and cultural assumptions of colonisers to subordinate indigenous beliefs (Jackson, 2007).

Applying Foucauldian concepts to analyse these power relations was not straightforward. Foucault did not directly critique the law in his work (or processes of colonisation) and as noted in chapter two, this absence has been a criticism of Foucault's interpretations of power. Foucault considered the law as one of many forces in the wider networks of power and did not have a "master theory or thesis" (p. 25) about its position (Gordon, 2013). A productive deployment of this de-centering of the law allows an analysis of power that does not take the law as a starting point, which as Lincoln (2013) argues, allows a clearer view of the power relations being examined and this is the approach taken in this chapter. This de-centering primarily has occurred through the incorporation of post-colonial and indigenous perspectives on how sovereignty and its associated legal practice support ongoing colonising practices that maintain material deprivation. The other way the law was de-centred was engaging with the concept of sovereign power as part of a moving dialectic of practices of sovereign and economic-governmental power rather than being a separate line of force (Dean, 2013).

For theoretical guidance on how to consider the law in this way, the edited text *Re-reading Foucault on law, power and rights* (Golder, 2013) has been drawn on. In this text, Hunt (2013), in his revised critique of Foucault's approach to the law, suggests that the growing assemblages of the law and associated judiciary combine with other knowledge to form new practices and power relations. For occupational therapists, the legal structures involved with the regulation of health practitioners combined with the administration of specific legislation and policies in practice have combined with occupational therapy knowledge in ways that form such an assemblage. Subject positions are offered in this assemblage where occupational therapists are part of legal structures that impact on people who they work with as well as on themselves as legal subjects. These regulations and pieces of legislation are also part of the wider legal assemblages that maintain the structures and institutions that direct and control health care provision and the role health professionals have in how it is delivered.

The underlying assumption of these legal assemblages is that those who are delegated sovereign power are entitled to make decisions that affect other people's lives. When this entitlement is combined with health and human science related knowledge, the line of sovereign power has become closely intertwined with the position health professions have in managing the needs of the wider population. The close inter-dependence of sovereign power and these methods of governmentality form a complex medico-legal line of power that occupational therapists have been part of since the profession was introduced to Aotearoa New Zealand. The way occupational therapy has been closely connected to the law since its inception has been problematised in this chapter through a close reading and examination of its practice based legal documents and processes. The analysis has then been contrasted with the everyday practices of the occupational therapists in the case studies and the implications these elements have for the way local level legal structures support ongoing processes of colonisation.

Genealogy of Legal Practices

Occupational therapists' work has been directed in some way by the law since the profession was established in Aotearoa New Zealand. After the signing of the Treaty of Waitangi institutional local level political and legal structures formed to uphold the English law that this version of the Treaty enacted. Critical sociologist Pavlich (2013) contends that these local level structures are how the power of sovereignty acquired through colonisation is retained in perpetuity. Colonial power remains due to the micro-level control the legal structures have on those who are subjected to the law. Adherence to the law supports colonising mechanisms because they reflect Eurocentric beliefs and values, benefitting those who subscribe to these. For occupational therapists, the Occupational Therapy Act (1949) was the beginning of a connection to such legal structures.

The Occupational Therapy Act (1949) was passed not long after the first training school was established in 1940 (Skilton, 1981). Having the profession legally sanctioned in this way was a natural professionalising strategy for a new health profession, following a traditional path established by medical doctors who had been regulated in Aotearoa New Zealand since 1867 (Jones, 2000) and nurses in 1901 (French, 2001). By becoming regulated, occupational therapy cemented connections to networks of power aligned with legal structures of colonisation as well as with Euro-normative knowledge and the status of medicine and nursing. The occupational therapy profession was recognized by the law in the same way as medical doctors and nurses. Regulation was also a political act. Central government was using the mechanism of regulation to provide a standard of healthcare for the public (Burgess, 1984) and by doing so was using the law to define what professions were necessary to provide this care and the responsibilities expected of these chosen experts. Since 1949 the Occupational Therapy Board of New Zealand (OTBNZ or the Board) has developed a wide network of capillaries that connect to a larger legal assemblage made up of various institutions and structures that health practitioners are legally governed by.

The Occupational Therapy Act (1949) included powers to enforce standards for the education of occupational therapists, a requirement to record and administer a register of therapists and discretionary options for censuring incompetence or misconduct. The Act also prescribed how the administration of the OTBNZ was overseen; the Chair was appointed by the Minister of Health and had to be a medical doctor. These early connections to the law and the way the medical profession was seen as the authority in healthcare bound the profession to legal and medical codes of behaviour. Having an appointed medical doctor, who in the early years was certainly a man, the OTBNZ chair also established a subordinate subject position for occupational therapists due to the power relations involved with hierarchies of knowledge and gender. The overwhelmingly female profession of occupational therapy was positioned in subordination to the male dominated medical profession, a position that was condoned and supported by the law through being a legislated requirement. For approximately forty years the OTBNZ operated in this way.

During these years there was little formal accountability for both the training and practice of occupational therapists. To remain licensed to practise a small fee was paid annually to the Board. There was no monitoring of competence of practising therapists and little public engagement with the profession. The profession did not have specific Aotearoa New Zealand formal expectations for the training or education of occupational therapists, instead relying on its colonial based roots using the World Federation of Occupational Therapists' standards (1958) to guide the curriculum of the occupational therapy school. In the 1980's this changed considerably. Led by a group of Auckland based practitioners there had been a growing dissatisfaction with the training and standards of practice of graduating occupational therapist (Boyd, 1984; Wilson, 2003) which culminated in a review of the education of occupational therapists, conducted jointly by the Ministry of Health and Ministry of Education in 1988. The review, led by two occupational therapists and supported by nursing and education practitioners, was critical of the OTBNZ's performance, stating: "in not exercising its authority to prescribe educational standards vested in the Act,

the Board has failed in its responsibilities” (Ryan, Wright St Clair, Preddey, & Grant, 1988, p. 79) and that it should “carry out its functions as prescribed in the Act” (p. 12). Through 128 recommendations, the review used the law to change the way the profession was organised and structured in Aotearoa New Zealand. Two new occupational therapy schools were established, one in Auckland and one in Dunedin and the school in Wellington was closed (New Zealand Occupational Therapy Board, 1989). The first bachelor degree programmes were established by the new schools and in time, post graduate qualifications at Masters and Doctorate level followed.

The law had been used as a tool to assist a strategy of professionalisation that many other highly feminised health professions were also adopting. By increasing the level of education and standard of qualification required to be an occupational therapist, greater recognition of the profession’s expertise and status as a health professional was expected, a tactic which Adams (2010) found also occurred in Canada and North America during this time. By utilising the power of the law in this way, occupational therapy strengthened its connection to legal structures as a means to contest the patriarchal and hierarchical nature of medicine in healthcare provision. At the same time it also modified the direction of the profession towards the increasing array of local level, legal structures that were further strengthening the position of the law in healthcare.

One of the significant ways this modification occurred was through another major recommendation from the Educational Review: to produce entry level competencies required of new graduates (recommendation 122 Ryan et al., 1988, p. 12). The resulting unique competence framework used the legal status of the document to influence practice. Having specific competency requirements provided a form of accountability that has become an increasingly dominant practice in health professions where not “only are academic seminars, keynotes, and workshops devoting large amounts of time to discussing variations on the theme of competence, but entire regulatory, licensure, and certification organizations around the world owe their existence to it” (Hodges & Lingard, 2013, p. 5). For occupational therapy the use of a competency framework to

guide practice has become a link between the law, knowledge and political contexts due to the quasi-legal status of the Competencies for Registration documents, the professional knowledge within the content and the ongoing re-creation of the document in response to political change.

The competencies as a legal document.

The first Competencies for Registration were completed in 1990 and provided a professional accountability both in the educational standards for training occupational therapists and for what was expected of practitioners.

Accountability had been an expectation within the Occupational Therapy Act (1949) but the OTBNZ had not used the power vested in it to hold occupational therapists to account in any tangible way. Writing and producing a formal legal competency framework was a way of connecting the power of the law to individual practitioners. By becoming part of everyday practice expectations the law was inserted as a normalised part of occupational therapy. From the first version of the Competencies for Registration the law was highly visible, named and referred to frequently throughout the ten roles³² in the specific skills and knowledge requirements detailed in the document.

In the Clinical role therapists were expected to “ensure treatment environments comply with regulation safety requirements” (1.3), in the People Manager role they needed to distinguish “between tasks which a registered occupational therapist must perform and those which occupational therapy support staff can carry out” (5.1) and in the Politician role they were required to use “information from relevant legislation and regulations at a national, regional and local body level” (10.1) and operate “within the New Zealand Occupational Therapy Act (1949) and its amendments” (10.5) (New Zealand Occupational Therapy Board, 1990). Occupational therapists were positioned as subjects of the law and adhering to the law was integral to providing healthcare. There were no references to the Treaty of Waitangi or Te Tiriti o Waitangi in this document. The understandings of sovereignty and the sovereign power

³² The ten roles were: Clinician, Self-manager, Communicator, Colleague/Team member, People manager, Resource manager, Professional developer, Health advocate, Occupational therapy marketer and Politician.

embodied in the law as espoused in the Treaty of Waitangi were not questioned. Despite privileging the law in this way however, this subject position was not wholly accepted, indicating some resistance to the law directing how occupational therapy should be provided.

In the first two iterations of the Competencies, the statement: “identify and acknowledge situations in which practice may compromise the relevant legislation” (1.15) was included in the Clinical role (New Zealand Occupational Therapy Board, 1990, 1995). By including it there is an indication that the law may not in fact always be congruent with what occupational therapy would understand as acceptable practice. As a site of resistance this statement is a marker of power relations at play and is a place where the profession has attempted to dissociate these relations (Foucault, 1982, p. 780) by contesting the power of the law to decide occupational therapy practice. The contestation provided in the first two versions of the Competencies formed a weak line of resistance however, and in the third version of the document written in 2000 the statement disappeared. As well as breaking the line resisting the law, this version introduced a raft of new legal assemblages, reflecting the enormous changes in government ideology and political reforms that had occurred during the 1990’s.

The weak contestation of the law in the initial documents was replaced by repeated expectations to follow the law. The words “comply” (2.1, 2.2, 2.3, 2.11, 5.3, 6.6), “adhere to” (6.4), and “practise within” (6.2) appeared frequently when referring to legal obligations. The legal nature of the obligations was emphasised by referring to specific laws such as the Occupational Therapy Act (1949) and the Privacy Act (1993). Legal obligations were also implied by the frequent use of the terms standards, regulations, protocols, guidelines and procedures throughout the document (Occupational Therapy Board of New Zealand, 2000). Along with this insertion of the law into a variety of occupational therapy roles, the references to human attributes such as tact, diplomacy, sensitivity, empathy, sense of humour and rapport were removed. These terms had appeared frequently throughout the previous two versions of

the Competencies (New Zealand Occupational Therapy Board, 1990, 1995). By removing them, the knowledge associated with other approaches to healthcare became hidden, positioning what was visible in the Competencies as dominant knowledge. From a perspective of indigenous rights, the reforms opened new avenues for colonisation to occur through local level legal structures such as the OTBNZ and practice documents such as the Competencies. The legal requirements that were expected became practices that extracted central government from the responsibility to provide services, but at the same time strengthened its ability to direct what these services should entail. Occupational therapy responded to the new exertion of sovereign power in direct ways through its legal entity, the OTBNZ.

Health regulation as a legal structure.

As part of the economic and legislative changes of the 1990's many local level legal institutional structures emerged to operationalise the newly introduced laws and policies. One of these was the establishment of a self-managing health regulatory system, separate from the Ministry of Health. Instrumental to the changes to health regulation was the establishment of the Health and Disability Commissioner (HDC) in 1994 and the enactment of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations (the Code of Rights) in 1996³³. A new legal structure was created that continues to have legislated power over all health professionals, regulated or not. The Code of Rights firmly placed the health care user as a consumer of services at the centre of healthcare. These two pieces of legislation allowed central government to extract itself from the direct governance of how

³³ These legal entities were created after the highly politicised and critical Cartwright Report inquiry into "allegations concerning the treatment of cervical cancer at National Women's Hospital and into other related matters" that primarily was concerned with the way medical doctors conducted themselves and practised. From this inquiry Dame Silvia Cartwright recommended radical reforms for health regulation and monitoring of practitioners that included an independent complaints commission as well as a code of rights for those receiving health services (Cartwright, 1988). These recommendations were rapidly implemented, which as Sandra Coney comments in her recollections of being one of the two journalists who instigated the enquiry, coincided with the political agenda of the government at the time. Coney suggests this agenda was to dis-empower the medical profession and its control of health care services to pave the way for a new enterprising style of managing the health system (Coney, 2009) a view that other accounts of the health reforms support (Doolin, 2002; Easton, 2002).

healthcare was provided. The law was used instead to define how health professionals should practice and the health care user was positioned as a market force to determine what health professionals provided. One of the responses of the OTBNZ to these new laws and legal structures was the production of a new governing document, a Code of Ethics for occupational therapists.

When the HDC Code of Rights was enacted, the occupational therapy profession was using the World Federation of Occupational Therapists Code of Ethics as a professional standard. After the Code of Rights came into effect, a Code of Ethics was written for Aotearoa New Zealand occupational therapists in 1998. The new Code of Ethics was commissioned and became part of the legal structure of the OTBNZ (Occupational Therapy Board of New Zealand, 2004a) rather than the professional association. By the OTBNZ assuming responsibility for the production of a unique code of ethics, ethical practice became part of a local level legal assemblage, rather than a professional concern. There are direct references in the Code of Ethics to the legal assemblage it is part of, such as: “In situations where clients have diminished competence, the occupational therapist shall be guided by the HDC Code of Rights” (Clause 1.3.2 Occupational Therapy Board of New Zealand, 2015a, p. 5). These interconnections and linkages imbue the Code of Ethics with legal authority, and along with the Competency documents strengthened the connection occupational therapy has with how the law is operationalised through practices. The law had been given a privileged position in both the Competencies and the Code of Ethics, one that encouraged therapists to fall back on the law when justifying their actions and making ethical decisions. Another major change in how occupational therapists were legally governed further strengthened this legal subjectivity. In 2003 a new piece of legislation was enacted which added a new line into the medico-legal assemblage. A mandatory requirement to provide an ongoing monitoring of competence of health practitioners became a new legal responsibility of the Regulatory Authorities.

Legal monitoring of occupational therapists.

Some ten years after the HDC was formed, the Health Practitioners Competence Assurance (HPCA) Act (2003) was finally passed into law. The HPCA Act (2003) provides an overarching legal framework for the HDC to apply the law to regulated health practitioners, primarily by directing how health regulatory authorities such as the OTBNZ must function. The OTBNZ is required to protect public safety when receiving health care services. One of these processes is to monitor the ongoing competence of its certified practitioners. To do this, the OTBNZ chose to administer a process through an online individualised system. The initial Continuing Competence Framework for Recertification (CCFR) for occupational therapists was released in October 2004 and was implemented for the 2005/06 practising year. It was designed “to monitor and ensure the professional competence and fitness to practise of all registered practitioners, to protect public safety” (Occupational Therapy Board of New Zealand, 2004b, p. 2). The framework was (and still is) an online platform where therapists input information into a central system which can be viewed and assessed by the OTBNZ. It was the first of its kind used by any regulatory body in Aotearoa New Zealand and apart from a recent adoption by the Medical Council of a similar system, a permanent digitalised record to monitor competence is not used by the other 14 regulatory authorities³⁴.

Through annual audit and review processes therapists need to annually assess their own competence against each of the roles in the Competencies for Registration. They then are required to formulate professional development goals in each of the competency areas to ensure the maintenance of their continuing competence. There is a self-declaration about fitness to practice and an endorsement of this by an external third party occupational therapist and the therapist’s professional supervisor (Occupational Therapy Board of New Zealand, 2016b). The online monitoring system is a micro-level system in which legal power is dispersed to the profession. The HPCA Act (2003) is enacted by having

³⁴ The Medical Council supports several different pathways of demonstrating competence. For medical practitioners with a general scope of practice they must enrol in an online programme provided by a contracted service called “inpractice” (Medical council of New Zealand, 2016).

this system in place. The actual material practices involved with the system have developed a particular local level legal structure. Through the now re-named ePortfolio, the OTBNZ has formed a legal network between individual occupational therapists, supervisors, auditors and nominated peer 'third party sign off' practitioners. The autonomy provided by the move to self-regulation enabled this network to form, one that is unique to occupational therapy. However this autonomy remains conditional on higher level legal structures which retain the sovereign position of the law in the way the OTBNZ operates.

Although the OTBNZ is delegated legal power to administer the ongoing governance of occupational therapy practice the way it does this is still accountable to the HDC and the Minister of Health. All complaints of misconduct by occupational therapists are required to be reviewed and adjudicated by the overarching HDC before the OTBNZ is allowed to manage the complaint (Health Practitioners Competence Assurance Act, 2003). The OTBNZ is also required to report annually to the Minister of Health about its activities which include an annual independent Auditor General appointed financial audit. Both of these requirements are part of compliance with the HPCA Act (2003) and particular information, data, statistics and financial performance are expected in the annual reports (Occupational Therapy Board of New Zealand, 2015a). These requirements encourage the OTBNZ to operate in particular ways, which privilege compliance with the HPCA Act (2003). The law governs occupational therapy in ways that have been normalised in all the regulated health professions through the HDC and the Code of Rights. Other knowledge that had previously been important aspects of being an occupational therapist (such as human attributes and professional interpretations of ethical practice) has been subjugated by the dominance of the law.

The one exception to this position of subjugation has been a constant line of resistance generated by Māori occupational therapists, who have maintained a steady stream of publications (Gilsenan et al., 2012; Henare, 1992, 1993; Hopkirk, 2010; Hopkirk, 2013; Jungerson, 1992, 2002; Te Rau Matatini, 2009) advising how the profession could meet its obligations under Te Tiriti o Waitangi.

As well as publishing their work, these therapists have been involved in bicultural training, consultancy and executive level involvement in both the professional association and OTBNZ (Silcock et al., 2016). These therapists' persistent resistance to how practice was supported within the legal structure within the profession is another marker of power relations at play. The activism of the Māori therapists culminated in significant changes in the most recent version of the Competencies and Code of Ethics. These changes introduced other lines of power into this local level legal structure that offer another type of legal subjectivity, opening up other possibilities to negotiate the dominance of the law.

Contesting colonially interpreted law.

The first three versions of the Competencies for Registration documents and the Code of Ethics explicitly and increasingly supported the local level legal structures of the OTBNZ, the HDC and the numerous other Acts occupational therapists had to comply with (such as health and safety and privacy legislation). However in the current version of the Competencies, the strong position these structures had was markedly weakened. Reference to the law is confined to one competency only: "your actions comply with the legislation, regulations, service standards, and professional and ethical guidelines relevant to your area of practice. You can justify your actions" (4.11) (Occupational Therapy Board of New Zealand, 2015d) and there is no longer any mention of specific Acts such as the HPCA Act, Privacy Act or Health and Safety Acts within any of the practice based competencies. By diminishing the presence of the law it has taken a less dominant place in what is considered competent occupational therapy practice (echoing the earlier versions in the 1990's that also challenged the place of the law as central concern in occupational therapy). Instead, a different legal subjectivity is offered through the authority of Te Tiriti o Waitangi.

The new legal subjectivity is offered by re-framing both the Competency document as well as the Code of Ethics as being directly accountable to Te Tiriti o Waitangi. Both documents commence with the contextual statement:

Te Tiriti of Waitangi is the founding document of Aotearoa New Zealand. It shapes the diverse historical and socio-political realities of Māori and all other settlers and their descendants. Understanding how Te Tiriti affects all our lives is essential for helping people participate in their desired occupation. Such understanding helps occupational therapists see how systemic and individual issues can breach people's rights and limit their opportunities to participate in their chosen occupations (Occupational Therapy Board of New Zealand, 2015b, 2015d).

Te Tiriti o Waitangi is also referred to directly in performance indicators of competence: "you understand the effects of Te Tiriti o Waitangi The Treaty of Waitangi on Māori health and social outcomes", (2.1); and "you take your responsibilities under Te Tiriti o Waitangi The Treaty of Waitangi seriously" (2.13). The insertion of Te Tiriti o Waitangi as the primary legal reference point throughout the Competencies and Code of Ethics offers a different legal subjectivity where occupational therapists are subjectified by a different legal structure at a constitutional level rather than local level. Privileging Te Tiriti o Waitangi over other law opens opportunities for occupational therapists to legally justify their practice in a different way.

Despite privileging an alternate constitutionally based legal position in this way, it remains a tenuous line of contestation due to the maintenance of opposing legal practices within the document. The fragility of this emerging position is perhaps reflected in the inconsistent use of language. "Te Tiriti o Waitangi", "Te Tiriti", and "Te Tiriti o Waitangi The Treaty of Waitangi" are used interchangeably throughout the document. The lack of clarity makes it unclear that the two treaties are different, an important distinction in relation to sovereignty and the constitutional level understandings in the two treaty's. The other discursive practices that make the contestation of sovereignty within the Competencies tenuous connect with much wider legal assemblages and economic-governmental power. These legal connections involve how sovereign power is exercised through rights based legislation. The legal structures that

have formed to enact these rights actively compete with the local level structure of the Competencies.

Sovereign Power and Rights Based Legislation.

The neo-liberal political and economic reforms in the 1980s and 90s prompted the formation of local level legal structures at the micro-level through documents such as the Competencies for Registration and Code of Ethics. At the same time there was an introduction of rights-based legislation that connected occupational therapy to the law in macro-level ways. These pieces of legislation included the Education Act (1989), the Mental Health (Compulsory Assessment and Treatment) Act (1992) and the Health and Safety in Employment Act (1992). As well as these radical new pieces of rights based legislation, the unique government owned Accident Compensation Corporation (ACC) was also extensively reviewed in the late 1980s and amended in 1992 and 1996 (Accident Compensation Corporation, 2010). The ACC is a public insurance no-fault scheme that provides health and disability services as a right for all citizens and visitors to the country if they are accidentally injured. Along with these specific Acts, the New Zealand Bill of Rights (1990) and the Human Rights Act (1993) were also enacted at this time. Together these pieces of legislation politically defined the general rights of citizens and are the guiding legal frameworks for many workplaces and services that occupational therapists work for, including those in this research.

New forms of everyday bureaucracy and material practices were required to operationalise these new laws which, as American legal scholar and social theorist Turkel (1990) described, primarily focus on individual rights. Street-level bureaucrats, such as occupational therapists, are delegated power in these laws in order for the rights enshrined in them to be realised. The case studies in this research provided a view at the street-level, of how occupational therapists negotiate the sovereign power that is constantly at play in their everyday decision making. The occupational therapists were positioned in between the institutional structures of the law, health industry regulation, educational policy, health policy, service level agreements, and the people they worked with. They

had to be accountable to these, at times competing, governing processes while at the same time managing the power relations at a micro-level with the people involved in these processes. They had to tell people they could not receive equipment or may have to wait long periods of time before they could get it. They assisted in making decisions that involved people's rights to participate in ordinary daily activities. They were required to provide therapeutic interventions in physical buildings that incarcerated personal freedom to the extent of the law. The occupational therapists were in situations involving high levels of sovereign power being exercised. Power relations such as these operate from the bottom-up (Pavlich, 2013) and as Gofen (2014) contends, can influence policy changes.

Sovereign power at the street-level.

The school based occupational therapists were involved in enabling the right to receive State funded education until 21 years of age as defined in the Education Act (1989). They were involved in operationalising the Act because of the delegated power they had as a recognised Specialist. Delegation was part of a wider apparatus of sovereign power where the other practices that define sovereign power, the ability to make exceptions and to be annulled were also at play. In section 9 of the Education Act (1989) all three of these practices were evident. The law could decide what form of education and specialist help a student would receive through a use of delegating authority to parents or by making exceptions to this authority if deemed necessary:

- If satisfied that a person under 21 should have special education, the Secretary shall
- (a) agree with the person's parents that the person should be enrolled, or
direct them to enrol the person, at a particular State school, special school, special class, or special clinic; or
 - (b) agree with the person's parents that the person should have, or direct them to ensure that the person has, education or help from a special service (Education Act, 1989).

Both of these decisions could also be annulled through the auspices of a review panel under section 9 of the Act. The review panel adjudicates when parents or carers do not agree with the Ministry of Education decisions while the review

panel support the right to education, this remains conditional on how sovereign power is exercised. As well as this visible pathway there were less visible ways that the sovereign power of exception and annulment were practised. In special education operational policies, specialists (including occupational therapists), are listed as the first resource for students throughout the *Resources for Students in the Ongoing Resourcing Scheme* webpage (Ministry of Education, 2015a)³⁵. When the application of the scheme is examined further however, the provision of specialist services for eligible Ongoing Resource Students (ORS) is with the proviso: “note that although these are the approved specialists for ORS, this does not automatically mean they are available across the country” (Ministry of Education, 2015a). The right for these students to have specialist input is clearly acknowledged but at the same time there is a normalised use of the practice of exception. It is acceptable for this right to not be enabled if students live in certain places. The ability to make exceptions to the rights based legislation is given to the ORS provider, which can be an individual school, private contractor or the Ministry of Education.

The material operationalisation of the ORS funding scheme limits the ability of the rights espoused in the Education Act (1989) to be enacted. The limitations have been accepted, supporting the underlying assumption that sovereign power can make exceptions in the law. Also at play is the economic-governmental power relation of contracted services in special education provision. The insufficiency of resources to fulfil legislated rights is also an accepted practice of annulment through sovereign power. The same ability of the economic-governmental axis to annul sovereign power was also very evident in the forensic occupational therapists practice.

In the forensic service, most people in the ward were generally held against their will, positioning rights based legislation right at the surface of

³⁵ To meet Ongoing Resource Scheme criteria, students must have: ongoing extreme or severe difficulty with any of the need areas, or moderate to high difficulty with learning, combined with very high or high needs in any two need areas. Need areas are defined as learning, hearing, vision, physical and language use and communication (Ministry of Education, 2016).

practice. What happened inside the ward was clearly directed by the Mental Health Act (1992) which details the rights of people who are subjected to compulsory treatment and confinement. Such rights involve the right to assessment and treatment. There was a high ratio of occupational therapists allocated to the ward to help realise these rights but, at times, they were very limited in how much and what they could provide due to safety policies that required two staff members to every one inpatient. Due to staff shortages, for most of the week of observation the occupational therapy assistant was required on the general ward to meet the required staff ratios there. This meant the therapists had to adapt their work significantly to provide only group work or a very few one-to-one interventions each day as they needed to be the second staff member for each other, seriously limiting what they could do. As they were the main provider of non-pharmaceutical therapeutic input on the ward, the legislated rights to receive this form of assessment and treatment under the Mental Health Act (1992) were difficult to enact. Economic-governmental practices that involved resources and operational management were creating conditions where sovereign power was legitimately annulled.

The wheelchair therapists were part of a different set of power relations but these also showed how sovereign power allowed exceptions and annulment of the law. Although the therapists had the power to enable rights for disabled people through their delegated authority to prescribe and fund essential equipment, their ability to do this was reliant on the availability of products, timeframes and bureaucratic requirements. Legislated rights were often seriously compromised through mandatory mundane processes that could take weeks, if not months, to enable the material outcomes necessary for these rights to be realised. There were very detailed processes the therapists had to follow to access certain types of equipment. These involved lists of specific products they had to try before they could access more individualised or specialised equipment. The process to try these was highly dependent on sales representatives and the availability of products. Often the wheelchair therapists were competing with other therapists elsewhere in the country to try a

specialised piece of equipment. Many products were also imported or made to order, which created other delays in terms of time and access to equipment they needed to assess and recommend what the person involved needed. The people they worked with were dependent on the wheelchair therapists for essential equipment to enable sometimes very basic rights such as moving independently or leaving their house. The operationalisation of rights based legislation contained in the ACC Act, the Human Rights Act and the policies under the Disability Strategy was defining what life was possible for the people involved rather than what was espoused in the legislation. The egalitarian ideals behind the rights based legislation were not trickling down to the level of the individual. Instead the opposite was occurring. The rights of wheelchair users were further encroached on by the enactment of operational policy. The occupational therapy practices in these examples demonstrate ways in which sovereign power is exercised at the street-level by therapists through legal practices. The legal subjectivity at this street-level operates within wider legal assemblages where sovereign power is in constant interplay with the normalisation of economic-governmental practices over-ruling rights based legislation. The macro-level overlay that these power relations form is where the constitutional level legal position that is offered in the Competencies document is opposed by other legal practices.

Post-colonial Implications

As argued above, occupational therapy has become increasingly connected to legal assemblages through practice. These connections have formed both at the level of the profession, through the introduction of the new health regulatory local level structures (that include the occupational therapy specific Competencies for Registration, the Code of Ethics and the ePortfolio system) but also through being specialists, assessors or providers in the rights based legislation and policies that have also been introduced since this time. These increased legal connections have bolstered the line of power of the law through practice. Practices such as those discussed above further legitimise occupational therapy in the eye of the law, solidifying the sanctioning of the delegation of

sovereign power to the profession. The circumstances where this legal sanctioning occurs often involves the individual and the material reality of other people's lives, making occupational therapy closely connected to how sovereign power is exercised at the micro-level of material outcomes. Viewed through a post-colonial lens, the street-level position that occupational therapy holds is a site where the imperial code laid out by the law and institutional structures of public services is enacted (Smith, 2012). According to Smith, following this code is how the ongoing effects of colonisation occur with the reproduction of material hardship, inequality and marginality. In occupational therapy the danger of supporting the imperial code is high, but equally, the ability to contest is a real possibility.

The Competencies document has provided a new line for occupational therapists to fall back on which makes available a legal subjectivity that is not following the imperial understanding of sovereignty in the Treaty of Waitangi. However for occupational therapists to understand how to do this within the highly politicised space of deciding who deserves what requires targeted reflection and thought. The practices of sovereign power that delegate, make exceptions, or annul the law are also lines of opportunities where occupational therapists can negotiate the imperial code of sovereignty. Again this requires cognisance of sovereign power and the imperial code that it represents. Indigenous rights legal scholar Robert Joseph (2014), suggests that for self-determination to occur that is coupled with material equity, there needs to be changes in the intersection of governance, the law and practice. Occupational therapy is positioned at this intersection through its structures of governance, legal obligations as a regulated health profession and in its delegated powers in practice. Through a close examination of what happens in practice, this intersection can be broken down into smaller power relations. The power relations can then provide insight into the struggles and negotiations that occur that support or contest the imperial code and politically defined rights.

Summary

The law has become increasingly central to how healthcare is provided through the legal assemblages that have developed through legislation, regulation, policies and local level structures such as the HDC and the OTBNZ. For occupational therapists these assemblages have intertwined with their delegated sovereign power through their position as regulated practitioners empowered to enact government policies and human rights legislation. The ability to utilise the expertise necessary to realise the freedoms espoused in these policies and rights-based Acts is highly contingent on how sovereign power is exercised and operationalised. The ability for material and economic elements to annul sovereign power and the way practices of exceptions to the law were acceptable in the case studies signalled ways that sovereign power is present in everyday practice. Added to this is how occupational therapy has attached itself to the law since its establishment in Aotearoa New Zealand in the 1940s. Using the law in this way has had consequences that would have been difficult for the early occupational therapists to predict. The law has become an increasingly influential force in how occupational therapists practice and has become part of the complex interplay between sovereign and economic-governmental power. The increasingly individualised tactics used to administer health regulation through the HPCA Act (2003) has mirrored the way individual health care users are also subjectified by the law in increasingly personal ways. A productive use of power using the existing capillaries of power between the law, the OTBNZ, the profession and the individual requires close attention to how sovereign power travels through these capillaries and how this connects to material outcomes for the people occupational therapists work with. Before connections such as these can be made however, the economic-governmental axis of power needs to be examined. The practices of this form of power are intimately involved with maintaining the presence of sovereignty in day to day power relations and the material outcomes that this dialectic relation supports.

Chapter 6: Economic-Governmental Power and Governmentality

As argued in the preceding chapter, the reforms of the 1980s and 90s required much new legislation and the introduction of many new legal structures, including those that occupational therapists were required to practice under. The ensuing legal assemblages supported the foundational position of English common law by privileging the sovereign power of the law in decisions related to how public services are provided. The practices of sovereign power; delegation, the ability to make exceptions and the annulment of laws, as defined by Mitchell Dean (2013), could be seen operating in the practice examples from the case studies. The occupational therapists in the case studies had been delegated authority to make judgements that affected other people's lives; the policies they worked under had clauses that allowed exceptions to the law; and the existence of circumstances such as geography and resource allocation were able to annul the law and policy. Inseparable from these practices of sovereign power is the concurrent and co-existent relation sovereign power has with economic-governmental power. Dean describes this co-existence as a "di-polar" power relation that, rather than being oppositional, is a force field where "polarities attract and repel one another" (Dean, 2012, p. 108). Dean elaborates on this argument in a later publication (Dean, 2013) where he concludes that a contemporary analysis of power needs to consider the interplay between economic and governmental strategies and the way this interplay supports underlying positions of sovereignty. To carry out such an analysis he advocates focussing on material-institutional practices of both economic-governmental and sovereign power because:

The art of government not only directs conduct and seeks particular ends, and attempts to find ways to end economic and financial crises and prevent or prepare for potential catastrophes (today, environmental ones in particular), but also enacts a concrete judicial-political order based on appropriation, accumulation, and exploitation (Dean, 2013, p. 235).

Accordingly this chapter describes material-institutional practices that have enacted economic and governmental rationalities in occupational therapy

practice as part of attempts to fiscally manage the public service sector. The way these practices have simultaneously supported a solidification of sovereignty based on free-trade agreements and globalisation of healthcare that is in turn based on the accumulation of capital acquired through colonisation is then discussed.

The analysis has drawn on Marilyn Strathern's (2000) work and uses her term 'enterprising up' to describe how the public sector was modified to become part of a market place model of economic management. The sectors that the case studies in the research are situated in provided historical trajectories where the market driven model could be traced to the current era. These trajectories have been problematised through a governmentality lens to extend the analysis to how individual conduct, subjectivities and behaviour become implicated in macro-level economic change. Because of the highly personal nature of occupational therapy and the strong involvement the profession has with material outcomes, regimes of knowledge and practices of economic-governmental power can travel onwards to the people occupational therapists work with (Miller & Rose, 2008). These regimes of knowledge and practices are also imbued with the sovereign power occupational therapists have been delegated, as well as being subject to exception and annulment of the law.

To untangle this tricky inter-play of power relations the chapter has been divided into three sections. The first will problematise the enterprising up of occupational therapy by tracing an historical path of the profession in the public service sector, particularly focussing on changes after new legislation was introduced in the 1990s that mandated a funder/provider split in public service provision. To do this, the problematisation centres on the closure of a large colonial institution, Tokanui Hospital in the 1990s and the subsequent devolvement of the services it provided to multiple community providers, including the case studies in this research. The second section then traces the underlying sovereignty supported by the implementation of the funder/provider split and the ensuing enterprising up of public services through an examination of the way the economic-governmental practices of the Occupational Therapy

Board of New Zealand changed over this period. The material-institutional practices used by the Board were a common link between the occupational therapists in the case studies and demonstrated how forms of governmentality spread to individual practitioners regardless of service sector. The third section then discusses how the profession has responded over time to the re-configuration of the relations between economic-governmental and sovereign power. These responses have then been problematised using the concept of this di-polar power relation being in a state of constant flux but one where sovereignty retains an underlying influence.

Enterprising up the Health Sector

Occupational therapists in Aotearoa New Zealand have been employed across a diverse range of health, education and social service settings from the time the first therapists practised. Two of the first four therapists who were trained in 1940 were sponsored by community based organisations, the Red Cross and the Crippled Children Society (Skilton, 1981) and the diversity of practice settings continues to the present day. By being spread across multiple sectors and employed by a wide variety of funding bodies, the profession is exposed to a variety of market forces that shape the wider public and private service sector. As an example of this diversity this table reproduced from Linda Wilson's oral history project (2003, p. 86) provides a snapshot of where occupational therapists worked from 1940.

Table 1: Service Locations by Decade

(Table reproduced with permission of author)

1940-1948	1949-1958	1959-1968	1969-1978	1979-1988	1988-1999
Mental hospitals	Plastic surgery units	Psychiatric units	Disabled re-establishment league	Community health centre	Community and social services
St Dunstons (services for the blind)	Specific associations e.g. Blind association, IHC	Industrial therapy units	Neighbourhood living skills centre	Volunteer services Abroad	Community organisations for psychiatric patients
General hospitals	Prisons	Rehabilitation centres	Girls remand home	Aids and Appliance centre	Schools/units for physically disabled
Tuberculosis sanatoria	Domiciliary	Hand injuries	Youth centre	Psychotherapy units	Privately owned and operated services
Crippled Children's Society	Civilian rehabilitation centres	Physical disability units	Children in mainstream schools	Renal units	Rehabilitation unit in Masonic village
	Aged peoples welfare councils	Church and private hospitals	Community mental health services	Toy libraries	Commerce
	Long stay hospitals	Domestic rehabilitation units	Church run homes and hospitals	Pain clinics	Forensic units
	Cerebral palsy schools				Rural community based vocational rehabilitation

In the year 2000, approximately 53% of therapists worked for the public health sector, 13% as private practitioners with the remainder working in education, community organisations or other public service sectors. These statistics are much the same as those pertaining to 2017, where 49% work directly in the public health sector and 15% in private practice, with the remainder spread through education and the community sector (Occupational Therapy Board of New Zealand, 2017). This suggests that occupational therapists have always had significant representation in non-government funded organisations as well as being employed as public servants. With this context in mind, the health reforms that occurred in the late 1980s introduced a new economic regime in public health care funding which changed both of these sectors considerably. The publically funded institution Tokanui Hospital was closed in the 1990s as part of these reforms³⁶ and many services that occupational therapy was heavily involved with were transferred to the community sector. The process of transferring the healthcare the hospital provided to a variety of contracted service providers is an example of what was occurring throughout the country in the re-structuring of the major health services following the economic reforms and changes in what was considered acceptable practice. To examine how these economic-governmental practices impacted on occupational therapy, the changes in service provision after Tokanui Hospital closed have been traced from the three case studies to how they were provided before the funder/provider split.

Enterprising practices at the service level.

The services studied in the research were all small community based services that had emerged and survived since Tokanui Hospital closed and the health reforms had taken local effect. In the case of the wheelchair service and special school, the marketplace environment had enabled significant growth of these

³⁶ The process of closing large custodial institutions began in earnest in the 1970s, initially in the form of planned reductions of inpatient bed numbers and moratoriums on any expansions to the institutions (Brunton, 2001), reflecting the change in community and healthcare practices of care for people with long term disabilities and illnesses. Although cost saving was a planned outcome it was not the main driver of these closures, in fact it was estimated to cost more in the short-term to facilitate the closures than it was to continue funding the institutions (Department of Health, 1993).

organisations. The way all the case studies had incorporated enterprising practices in similar ways despite the diversity of services provided and funding streams, provided a way to see how the changed economic-governmental practices of the reforms were implemented at the ground level of the market model. Two of the workplaces were in the so called third sector, where the government was the predominant source of funding through ongoing service level contracts and bulk funding arrangements. These were the for-profit wheelchair service and the not-for-profit self-managing school. The forensic mental health ward was funded as part of the public health system. Despite these different economic scenarios however, all of these workplaces were managed through enterprising strategies that had similar practices to ensure accountability and to meet financial constraints.

There were many different processes of audit, performance management and information management that the workplaces had developed that linked to central government, the service as a whole, and the individual practitioners. The therapists spent a lot of time complying and engaging with these practices and their work was directed towards meeting contractual obligations. As a comparison, occupational therapy had been provided at Tokanui Hospital prior to the late 1960s to anyone who could not work on the hospital farm (Dey, 2012; Paul, 2009; Robinson, 2011). After the farm closed therapists worked with whomever needed it, whenever they needed it, and however the therapists saw fit (Dey, 2012). There were little formal auditing or accountability measures in place, with occupational therapists documenting their work in individual occupational therapy files that were unlikely to be read by many other people. The wheelchair therapists' work showed how much these practices have changed.

The ongoing viability of the wheelchair service depended on large service contracts with the Ministry of Health, the ACC and occasionally with private health insurers. These contracts were for fixed terms and for the supply of clearly specified services. They involved minute details such as time frames for initial contact (by telephone or in person), the regularity of assessments, reviews

and reporting, the qualifications of therapists and bicultural expectations when working with Māori. Meeting the requirements of the contracts was an important factor in an occupational therapist's day to day time management. Ensuring the service met the expectations of the contracts and could prove this, was carefully managed through service wide strategies such as the collection of daily statistics, clear referral processes, routine scheduled review clinics, the role of a duty therapist to manage unpredicted demand and monthly 'check ins' all staff had with management staff. These strategies created work expectations that had to be incorporated on a daily basis in a therapist's work. For example they needed to schedule their duty therapist's day and the weekly follow up clinics around their own caseload management, time use statistics had to be inputted at the end of each day, and new referrals had to be seen regardless of other caseload commitments.

As well as these continual reminders of the business as an enterprise, there was a distinct language that emphasised these enterprising conditions. The ACC system used language such as Case Owners, ACC Contracted Suppliers, and Assessors (Accident Compensation Corporation, 2015). The Case Owner 'owns' the ACC claimant and is responsible for what is provided for them. The occupational therapists were Contracted Suppliers, depersonalising and reducing the relationship between the two parties to a business transaction. Further to this language use, communication is carried out via specific online forms and prescribed processes, with little personal communication in the form of phone calls about these transactions. They are considered as business transactions that follow certain processes directed by specific bureaucratic rules and guidelines. These enterprising conditions placed the therapist and the claimant as part of the supply and demand of the marketplace.

The special school was enterprised up in a different way and as part of the education system it demonstrates how the underlying principles of creating a marketplace in healthcare were also connecting with other public services. As the school was self-managing through a bulk funded system based on enrolments, it was highly susceptible to market forces. The school's funding was

directly related to the number of high or very high ORS students who were enrolled. The occupational therapists were part of the marketing of the school, with a dedicated section on its website promoting their services. The special school has grown and flourished over its 50 years of existence, becoming one of the largest in the country. It had a major re-build in 2015 allowing it to accommodate more students and open more satellite and transition to work units (Tantau, 9 December 2015). The success of the school is dependent on parents and guardians choosing a special school over a mainstream school for their children's education. The occupational therapists were employed to meet this market driven demand as all the children enrolled at the school were entitled to specialist services on a regular basis. The therapists had detailed work expectations to meet this demand, such as not working in their offices in school hours (9-3), providing a learning record once a term for each student's individual portfolio, and modifying their work to fit into the curriculum and education based pedagogies.

The way a market driven model was applied in the forensic ward was less individualised but in some ways more enterprising. The forensic service is funded per bed, and there are detailed national performance indicators related to bed occupancy rates, length of stay, contact post discharge and readmission rates that are linked to this funding³⁷. These details are collected through electronic patient records and the administration of the mandatory centralised outcome measurement, HoNoS³⁸ (Waikato District Health Board, 2015a). The occupational therapists were involved throughout their working day in inputting information for the successful application of these systems. The strong use of

³⁷ The Ministry of Health developed policy driven mandatory expectations through the development in 2006 of key performance indicator (KPI) framework for all mental health workers (Counties-Manukau, 2007). This KPI programme now encompasses the 20 District Health Boards in Aotearoa New Zealand. The KPI's aim to provide national standardised data of services and outcomes (Northern Region Alliance, 2015) in order to improve safety and quality of mental health services and are explicitly linked to the successful implementation of the Triple Aim economic approach through the Health Quality and Safety Commission of New Zealand (2016).

³⁸ HoNoS stands for Health of the Nation Outcome Scale. This scale has been developed in the UK by psychiatrists, and has become mandatory to administer on admission, discharge and/or within 91 day periods of receiving mental health services in Aotearoa New Zealand (Te Pou o Te Whakaaro Nui, 2016).

KPI's and the standardised HoNoS outcome measure were part of an overall population based strategy that assumes that with the right information and data, services can be planned for and managed successfully and economically through homogeneous methods. The involvement of central government in how the forensic service operated is not unexpected given that it remains a part of the hospital based public health service. However both the wheelchair service and the special school were also part of centralised auditing systems which collected data, assessed performance and reviewed the financial management of the services in much the same way.

The school based therapists were part of three yearly audit cycles to monitor the education based Specialist Service Standards (Ministry of Education, 2015b), as well as the school wide Education Review Office auditing system (Education Review Office, 2016). The wheelchair service was required to provide quarterly reports to its two main funding bodies and as a contracted service had routine auditing processes to comply with. The forensic therapists had a different type of audit environment due to the nature of their work. The particular service they worked for was under constant scrutiny and review due to several tragic incidents that had occurred in 2015. The Minister of Health had ordered an inquiry and review of the mental health service, particularly the acute secure wards (Ministry of Health, 2016d). Extensive auditing and reviewing of the service had taken place, and complying with policy was an ongoing overlay to the day to day practice of the therapists.

All three of the services demonstrated many practices necessary to participate in the contemporary health marketplace and the demand for the services they provided had ensured their survival and growth. The survival and growth of these services was despite the special school being contrary to government policy of inclusive education, and many of the wheelchair service users not being in a position of being able to self-manage their own healthcare, as per the aims of the Health and Disability Support Services strategies. The place where these services exist is where the hard edge of the interconnection between economic-governmental and sovereign power can be clearly seen. The

material outcomes of admission to a forensic ward, attending a special school or relying on a service for basic mobility and freedom are a result of how the power relations of both economic-governmental elements and delegations of sovereign power are played out at the ground level. The healthcare marketplace has shaped how this interplay is negotiated in terms of types of services that are available and how these are accessed.

Enterprising up the market.

From the late 1980s as the closure of Tokanui Hospital became imminent, there were three significant not-for-profit organisations established to provide community based services in the Waikato-King Country region. They were the Community Living Trust, primarily established to provide accommodation and support for people with intellectual disabilities who had lived at Tokanui Hospital, Enrich+ (previously Gracelands Trust) which provided vocational, educational and work placement services for people who have a range of disability and health related support needs, and the Wise Group Ltd which was established to support people who had mental illness³⁹. All of these services have survived in the reformed economic environment and are still successful organisations, employing at least one hundred people each. However, the Wise Group has by far exceeded the other two in growth. The Wise Group's work now "spans health and wellbeing services, education and training, workforce development and research, information services and software development, employment and navigation services and business support services" (Wise Group, 2016). It has become one of the largest providers of mental health and wellbeing services in Aotearoa New Zealand, employing approximately one thousand people. In comparison to the successful corporate trajectory of the Wise Group, the Community Living Trust functions in ways similar to its original purpose, supporting people with intellectual disabilities in the local region it was

³⁹ As an aside, an occupational therapist established Gracelands Trust in the 1980s and the current CEO is also an occupational therapist. Many occupational therapists were employed by the Community Living Trust (including me in 1994-5) from the outset and occupational therapy remains one of the main therapy services provided by the Trust. The Wise Group does employ occupational therapists, but runs on a much more generic model and does not market occupational therapy as a specific service.

established in (Community Living, 2017). Enrich+ also has kept within its original scope of service provision, focussing on participation, work and education for people requiring ongoing support because of intellectual disability, mental illness or other health related conditions, primarily in the greater Hamilton region (Enrich+, 2014). All three of these organisations were established with similar motivations, to support people who had been dependent on State funded services provided at Tokanui Hospital. The Wise Group has particularly flourished in the marketplace by expanding outside its original vision of supporting people with mental illness “to live happier, healthier and more fulfilling lives” (Wise Group, 2016). The way the Wise Group has been successful demonstrates how the funder/provider spilt and the adoption of enterprising up strategies form material-institutional practices that combine sovereignty with economic-governmental power.

The Wise Group expanded so successfully by developing into a large corporate structure with skills in infrastructure, training, and service provision in mental health services. The skills the Wise Group have amassed have enabled it to develop a strong presence in the mental health and social services sector, and it holds several large and influential contracts with the Ministry of Health. An example of this is Te Pou o te Whakaaro Nui (Te Pou), the main government funded provider of workforce development programmes for mental health and disability services (Te Pou o te Whakaaro Nui, 2016). One of the quality assurance tools Te Pou provides is the access and training for the HoNoS outcome measure for mental health clinicians through software provided by another of the Wise Group’s corporate family, IT developer Wild Bamboo (Te Pou te Whakaaro Nui, 2016). The HoNoS tool has become mandatory for all admissions to mental health services, public or NGO, and is an important aspect of meeting government generated Key Performance Indicators (KPI’s) for these services. Providing quality assurance products such as education, training and outcome measures situates the Wise Group as an influential stakeholder in public health policy and strategic planning. In this way large corporate structures such as the Wise Group Ltd are able to compete with multi-national

companies whereas small locally driven services such as Enrich+ and the Community Living Trust do not have the capacity. The inevitable effect of this was referred to by the CEO of Enrich +, Wendy Becker, in 2013: “one of the newest challenges to businesses such as Enrich+ is the Government’s moves towards national or larger regional contracts for various types of services” (Enrich+, 2014, p. 8). Becker also alludes to what this means on a global scale, “this move has opened the door for some Australian based companies to compete for what has previously been the domain of local small to medium sized businesses” (p. 9). The outcome of this is that successful corporate structures become market forces, not just market players. The market is influenced by the way they provide services due to the economies of scale and increasing dependence of publically funded services on what they provide. A recent submission made by the Wise Group to the Productivity Commission about delivery of social services gives some indication of how community based corporate structures become influential in policy level decision making:

There is enormous potential to direct private investment toward social outcomes. Trusted mechanisms and investment vehicles which provide a realistic financial return relative to risk, need to be established quickly and efficiently. The appropriate sharing of risk between providers, investors and underwriters is a key to success (Wise Group, 2014, p. 4).

The local environment in which the Wise Group emerged was based on closure of Tokanui Hospital. Through a successful adaption to the market model, the Wise Group had become an important and influential element in the market place. The delivery of essential infrastructure and systems for both the public and non-government sector are economic-governmental practices that connect both government and non-government services at the level of policy and service delivery. These connections were evident in the forensic ward case study through the requirement of the therapists to participate in the HoNoS measurement system. Their daily work contributed to the overall KPI’s of the service that the Wise Group designed and provided contracted education and administration for. They were also eligible to receive free extraneous mental

health education through Te Pou. These less overt connections provide other ways that the Wise Group as a market force was able to influence the delivery of this form of healthcare, at both the planning and funding level and the types of knowledge being utilised by practitioners. As well as these local examples of how the market model was implemented in practice, there were other ways that the funder/provider split also aligned occupational therapy practice to macro-level power relations involving capitalism and the financialisation of healthcare on the global stage.

Commodification of healthcare.

Occupational therapists, along with other disability related equipment assessors, have historically been gatekeepers of the funding for assistive equipment and environmental modifications (Ministry of Health, 1997). In the case studies the provision of equipment for people to access education and to remain independent and safe was a large part of the wheelchair and school therapist's work. Through this work they were connected to the huge global growth in medical and healthcare equipment companies where the generation of profit and global financial interests are primary driving forces. The growth of these companies in Aotearoa New Zealand was dramatically assisted by a radical overhaul in how funding assistive equipment and environmental modifications was provided and accessed as part of the funder/provider split in the wider economic reforms. Since then there has been an explosion of companies, both multi-national corporations and domestic, that import and produce medical and disability related equipment⁴⁰.

Ebos Group Ltd is an Aotearoa New Zealand company that is an example of the transformation possible because of globalised consumer demand for healthcare equipment. Originally founded in 1922 it was a domestic trading

⁴⁰ Ebos Group Ltd, Invacare, Smith & Nephew, and Fisher & Paykel Healthcare are examples of multi-national companies that are very successful in Aotearoa New Zealand. There are many more domestic examples where companies have developed niche markets for highly specialised equipment, both producing and importing these, e.g. Allied Medical, Cubro, Medifab, and Medix - 21 are all domestic companies that have been established and grown significantly over the last 30 years. These domestic companies tend to be privately owned businesses, though Smith and Nephew, Fisher and Paykel and Ebos Group Limited are listed on stock exchanges internationally.

company until the late 1980s when it expanded its market reach significantly through mergers, expansion to Australia and becoming listed both on the New Zealand (NZX) and Australian (ASX) stock exchanges. In 2008 Ebos Group Ltd's revenue was more than one billion New Zealand dollars, by 2017 this has increased to seven billion (Ebos Group Ltd, 2017). It was the best performing business in Aotearoa New Zealand in the Deloitte 200 in 2015 (Adams, 2015) and remained one of the NZX's top performing companies in 2016 (Underhill, 2016). The development of Ebos Group Ltd into a large successful multi-national business supports McKee and Stuckler's (2012) view that the health sector has become a target for the financial sector to generate revenue due to other sectors such as housing and industry becoming less secure. Targeting the health sector in this way is only possible through globalisation and free trade agreements. These agreements enable the flow of trade and services between countries, consolidating the positions of sovereignty of the countries involved.

Tracing the success of the financialisation of the medical equipment industry through the connections seen in the case studies showed how multiple inter-linking economic-governmental practices were consolidated by an underlying understanding of sovereignty which trickled to the micro-level of practice. The medical supply manufacturing sector has also become a market force rather than just a market player in a similar way to the Wise Group Ltd. Rather than being strongly linked with governmental policy and models of healthcare delivery however, this market force is attached to capitalism and global multi-corporate companies. The increased demand for technologies that provide safe, reliable, efficient, life-giving healthcare by healthcare users and health professionals alike has driven this market. Due to the capacity of these technologies to save costs, create efficiencies and support the productivity of the population, the globalised healthcare market is also able to influence the healthcare sector due to its increasing dependence on commodities provided by multi-national corporations.

Before the health reforms occupational therapists who worked at hospitals such as Tokanui Hospital used the institutions' carpenters, engineers,

painters, orthotists, electricians and wheelchair technicians to fabricate many items of equipment they needed. There was a limited range and availability of commercially produced assistive equipment and these were generally not directly marketed to the healthcare user. The opening up of the market to the community and business sector has introduced market forces that influence supply and demand and occupational therapists and the public sector are no longer significant drivers of the delivery of equipment and environmental modification services. The public sector no longer manufactures or produces equipment; these trade-related services are now contracted out to the private sector. Occupational therapists are also no longer privileged holders of knowledge about how to access equipment and environmental modifications, as the healthcare user and service providers have become direct markets for the private sector.

The 'Show your Ability' trade roadshow that the wheelchair therapists attended in Hamilton in 2016 during the week of observation was an example of this direct marketing. The annual trade show travels the country and involves over 50 different companies which sell a multitude of products. It is a free, public event targeting consumers and assessors alike.



**Figure 2: Show your Ability, Hamilton, Aotearoa New Zealand, 2016
(personal collection)**

The limited public funding available to purchase many of the products showcased supports the success of events such as Show your Ability and fit well with the objectives of the recent public health and disability strategies where the individual is increasingly positioned as responsible for ensuring their own health needs are met⁴¹. The continued success of companies that sell healthcare equipment has also become much more dependent on consumerism and the direct marketing of new technologies to the public.

Underneath these economic-governmental practices which are significantly shaping the market, are the material outcomes when people are not

⁴¹ In the latest Health Strategy (2016) and Disability Support Services Strategy (2014-2018) there is a strong emphasis on “People Powered” healthcare that relies on the healthcare user taking greater responsibility for their own health decisions, including self-funding and purchase of support services.

eligible for public funding, do not have the private means to purchase what they need, or do not have the ability or legal status to choose the material conditions of their life. The commodification of healthcare services supports a certain type of healthcare user and healthcare service to flourish. People who can take responsibility for meeting their own healthcare needs have access to a much greater range of services and material outcomes. Like the healthcare services that are aligned with corporate homogenous styles of service delivery, businesses that have embraced the market-model of medical equipment provision have flourished in the national and international marketplace and have become driving forces in what is provided and who can get it. At the school and wheelchair services the occupational therapists could not avoid supporting the corporate structures that manufacture and facilitate the provision of this equipment. They could easily suggest and facilitate the private purchase of equipment through their contacts with equipment companies, sales representatives and knowledge of processes and also were able to access public funding for people who met the eligibility criteria. There were also less obvious ways that material-institutional practices further supported the way sovereignty and economic-governmental power were continually connected.

The funder/provider split also enabled the enterprising up of equipment and environmental modification through introduction of competition into the service delivery model. There are two competing intermediary companies, Enable New Zealand and Accessable⁴² which manage the budget for the public funding and provision of disability related equipment. They both provide the bulk funded standard equipment that is available for therapists to prescribe. There are large recycling depots for equipment in the main centres, but due to the growth of the medical equipment industry this equipment becomes outdated quickly and is difficult to reissue when better models are available. Therapists are pressured through a variety of disciplinary tactics to reissue this equipment

⁴² Enable New Zealand manages the funding for all regions except Auckland and Northland, and Accessable is contracted to provide for these two regions. These contracts come up for tender, requiring constant competitiveness for renewal. The ACC funding system also utilises these two service providers in another competitive contractual cycle.

or only prescribe the basic bulk funded models of equipment by both of these companies. These tactics include warning letters, publication of prescribing patterns by assessors by region, complex processes to access funding outside the standard prescriptions, and constant changes to what is available as a commonly provided item⁴³. Outside these publically funded options there are new innovations and inventions being produced and introduced to the public marketplace. People who have insurance or private wealth are able to purchase or upgrade to these often more suitable or desirable products whereas people who cannot need to make do with what is standardly offered or what is in the recycled depots. If they are ineligible for funding⁴⁴ or cannot afford to upgrade to what will provide a better option for their life conditions, they become positioned outside of the State funded or personally funded pathways. The material outcomes for these people can impede basic life functions such as having a shower, leaving the house or communicating independently as well as the ability to work, participate in education, access public space or buildings or live in their own home. The competitive nature of the marketplace silences these material outcomes. Poor outcomes or unsuccessful solutions are commercially sensitive statistics - especially as it may be interpreted as a lack of performance or not meeting targeted goals. There are complexities of providing care and support to people who sit outside the mainstream pathways of service provision.

The school and wheelchair therapists worked with many people who were dependent on others or were not allowed to make decisions about their life outcomes. In these situations the outcomes for the person can involve where they live, what they do during the day and the type of ongoing support they receive. Prior to the reforms large institutions such as Tokanui Hospital and

⁴³ For instance electric beds and lift out armchairs have been put on, then removed from the standard common list after it became evident that occupational therapists were funding too many for the budget to sustain.

⁴⁴ In-eligibility occurs in situations such as transience, when a landlord will not agree to environmental modifications, a house does not meet building code compliances, hours of education or work per week are under a threshold of 20 hours, and mobility and restrictions to participation in life are not assessed as being severe enough (Ministry of Health, 2014c; Ministry of Health, 2014d).

local level funding arrangements provided or delivered many of these material outcomes in relatively loose bureaucratic arrangements. There were several pathways an occupational therapist could take to fund and access material solutions. As part of the commodification of the health system material outcomes are now more reliant on economic-governmental practices that are connected to global financial concerns and are much more dependent on the market deciding what is possible to provide.

The commodification of healthcare that has formed over the last thirty years has enterprised up the wider macro-context of healthcare delivery through a variety of inter-connections between market forces. As argued in this section, services provided in this market have become connected in much closer ways to the financialisation and capitalist motivations of a globalising health marketplace and extend to complex and morally sensitive areas of healthcare. Large corporate companies such as the Wise Group, Ebos Group Ltd, Enable New Zealand and Accessable, become active market forces shaping how and what services are provided. The case studies provided a snap shot of how occupational therapy has responded to this re-configuration of sovereign and economic-governmental power since the funder-provider market model was implemented.

The same market model principles have been applied at the level of governing how health professionals practice. There was also an enterprising up of healthcare regulation as part of the health reforms. Through the enterprising up of the OTBNZ, economic-governmental practices connect the regulation of occupational therapists in Aotearoa New Zealand to the global health regulation industry and are heavily dependent on the exercise of sovereignty between countries. The micro-capillaries of power that have formed through material-institutional practices of regulation have become more connected to these elements and is another way the day to day practices of occupational therapy enables power to travel to the micro-level.

Enterprising up Regulation

As discussed in the previous chapter occupational therapy had a regulatory Board in place from 1949. Up until the political reforms in the 1980s the way the Board operated had come under little scrutiny and was completely funded and administered by the then Department of Health. After the reforms, health regulation was an activity that the Ministry of Health wished to extract itself from. The process of this extraction was visible in the Board minutes from the early 1990s. By 1994, after many communiques from the Ministry of Health, along with the ten other Health Regulatory Authorities, the OTBNZ was directed to be self-funding (Occupational Therapy Board of New Zealand, 1994a). After this initial administrative step towards self-regulation, the Authorities then were required to become legal corporate entities (Occupational Therapy Board of New Zealand, 1994b), which, although against the OTBNZ's wishes (Occupational Therapy Board of New Zealand, 1997), was passed into law with an amendment to the Occupational Therapy Act (1999). The amendment changed the OTBNZ's constitution, created registrar and deputy registrar positions and legally defined the Board's responsibilities for the financial management of fees, expenses and levies.

The Occupational Therapy Amendment Act (1999) formalised the separation of the Ministry of Health from the day to day responsibility for the profession while at the same time allowing it to maintain an overall control of how the OTBNZ operated through the inclusion of financial and auditing requirements, annual reports and Ministerial oversight of the Board members. The changes took some time to bed in and adapt to but by 2008 the Board had formally moved to a governance model of operating (Occupational Therapy Board of New Zealand, 2008) where a Chief Executive Officer (CEO) was employed to manage the day to day operations of regulation and was answerable to the governing Board. From 2011 the CEO, and the Chair submitted separate annual reports (Occupational Therapy Board of New Zealand, 2011) reflecting the separation of the responsibilities in this governance model. During this time the OTBNZ also had employed accountants and lawyers to assist

in meeting its operational functions. In comparison to how the Board had operated prior to 1990, it had transformed into an enterprising corporate body that utilised governance, financial and accounting measures to manage its performance in similar ways to the direct providers of healthcare. However the process of enterprising up that the OTBNZ underwent formed a different set of networks which developed from these new enterprising practices. The way the OTBNZ connected to other governmental structures and to the international industry of health regulation introduced new lines of economic-governmental and sovereign power into occupational therapy. By examining these new lines Rose and Miller (2010) suggest that “we can begin to understand the multiple and delicate networks that connect the lives of individuals, groups and organizations to the aspirations of authorities in the advanced liberal democracies of the present” (p. 274).

OTBNZ and governmental structures.

One of the lines that created new networks of accountabilities after the public sector reforms was the requirement for the OTBNZ to work with newly established governmental structures. Initially this began with a relatively informal relationship with the new Health and Disability Commissioner (HDC) in 1994 which then became formalised and legislated once the HPCA Act (2003) was enacted. The Board was then legally required to pass all complaints of misconduct or incompetence to the Commissioner for assessment and review before it could address them⁴⁵. Although the Board was theoretically self-managing it was still controlled through the sovereign power bestowed on the institutional structure of the HDC and the legislation in the HPCA Act (2003). A connection was formed by this practice between the HDC and the OTBNZ where sovereign power of the law is supported through processes of audit and accountability. In more recent years there have been more practices of this lateral nature driven by the most recent economic rationalities introduced to the public sector system, the adoption of the economic model, the Triple Aim

⁴⁵ There are situations where the OTBNZ can invoke its powers pending this step in the process where there are immediate concerns for the public’s safety.

Approach⁴⁶. In relation to the health sector new government structures have been established under the auspices of implementing the Triple Aim Approach, Health Workforce New Zealand (HWNZ) in 2009 and the Health Quality and Safety Commission New Zealand (HQSC) in 2010. These new entities provide additional connections to a growing network of economic-governmental practices which support the position of sovereignty in power relations associated with healthcare delivery and governance of the population.

Material-institutional practices of governmentality.

The HWNZ was set up as part of the Ministry of Health “to provide national leadership on the development of the country’s health and disability workforce” (Health Workforce New Zealand, 2015) whereas the HQSC was established through legislation in the form of the New Zealand Public Health & Disability Amendment Act (2010). This legislation directs the Commission’s functions, which include leading, co-ordinating and reporting on safety and quality in health care (Health Quality and Safety Commission of New Zealand, 2015). In order to implement the Triple Aim Approach effectively, the Ministry of Health has used its sovereign power to introduce new legally enforceable mechanisms into the healthcare sector. Health regulators have become a target for these mechanisms due to the knowledge and information they hold related to the health workforce and healthcare quality and safety, both essential components in applying the Triple Aim Approach. Since the HWNZ and HQSC were set up, all the Health Regulatory Boards have come under significant pressure to enterprise up in ways that make the knowledge they hold easily accessible for economic and governmental strategic planning.

⁴⁶ The Triple Aim Approach consists of considering three triangulated principles: Population Health, Experience of Care and Per Capita Cost in order to inform decision making. The approach was developed in North America by a private Institute for Healthcare Improvement (IHI) which:

..is an influential force in health and health care improvement in the US and has a rapidly growing footprint in dozens of other nations, including Canada, England, Scotland, Denmark, Sweden, Singapore, Latin America, New Zealand, Ghana, Malawi, South Africa, the Middle East, and elsewhere (Institute for Healthcare Improvement, 2016).

The main pressure was for the sixteen Regulatory Authorities to form a single organisation from which to access reliable and consistent data. This pressure has met with considerable resistance from the Authorities. There have been various configurations and proposed plans about how the individual Regulatory Authorities' could share costs and operational systems, led by a range of different alliances and independently contracted organisations: the Dental Council (Occupational Therapy Board of New Zealand, 2012a), a Single Secretariat Group comprised of ten Regulatory Authorities', one of which was the OTBNZ (Occupational Therapy Board of New Zealand, 2012c), the PricewaterhouseCoopers financial consultancy, funded by HWNZ (Occupational Therapy Board of New Zealand, 2013b), the unofficial body Health Regulatory Authorities New Zealand (Occupational Therapy Board of New Zealand, 2013a), and most recently the Nursing Council (Occupational Therapy Board of New Zealand, 2014b). The Nursing Council's proposal involved ten Regulatory Authorities' only and in 2016 was agreed to by this collective group. By becoming part of a combined regulatory service the OTBNZ lost some control of its operational functions (such as accounting and payroll, physical location and office space) (Occupational Therapy Board of New Zealand, 2017). The ten Regulatory Authorities involved have been modified into a governing structure that can produce information required to assist in adhering to the economic principles of the Triple Aim Approach. The limits on self-regulation for the OTBNZ have been tightened again, with the Nursing Council, by virtue of being vastly larger than the other members of the collective, able to influence the financial actions, material environment and infrastructural operations of the Board. By pressuring the regulated health professions towards regulatory practices that are uniform and can be measured and judged in homogeneous ways, further enterprising up has occurred that moves the OTBNZ toward international practices of meta-regulation.

Meta-regulatory structures for the health professions are becoming the norm globally. In the United Kingdom, Ireland, South Africa and Australia large overarching regulatory bodies which govern individual occupational therapy

Boards, along with several other regulated health professions have been created over the last few years⁴⁷. The increasing global nature of health regulation is a newer line of significant influence in the enterprising up of the OTBNZ.

Globalised health regulation has underlying assumptions that include both economic rationalities attached to international trends in healthcare economics, risk management and service delivery but also to the exercise of sovereignty.

Added to this macro-level context are the historical power struggles amongst the health professions. The serious resistance to the idea of forming one large meta-regulatory body by the sixteen self-regulating Boards in Aotearoa New Zealand ended up with a situation where two different collective groups of regulators

have formed, reflecting a traditional hierarchy of health professions. The

inability to work collectively is indicative of the landscape of the healthcare

sector. It is not one unified sector working towards mutual goals and the regimes

of knowledge within the sector are difficult to access and translate into any one

pathway⁴⁸. The ten Boards that occupational therapy has chosen to co-locate

with were described as “a community of like-minded regulators” (Occupational

Therapy Board of New Zealand, 2016a, p. 5) by the Board Chair and include the

professions of Nursing, Midwifery, Podiatry, Osteopathy, Dietetics,

Psychotherapy, Optometry, Psychology, and Chiropractic. The remaining

Regulatory Authorities share a different building and back office functions and

are more aligned with traditional patriarchies associated with Euro-normative

practices of medicine. This group is made up of the Medical Practitioners,

Dentists, Pharmacists, Physiotherapists, Medical Laboratory Science, Anaesthetic

Technology, and Medical Radiation Technology. The co-existence of these two

⁴⁷ There is a variety of configurations of these meta-regulatory entities. In 2007 the United Kingdom formed one central government funded independent watchdog called the Professional Standards Authority which oversees smaller collectives of regulators similar to those recently formed in Aotearoa New Zealand. This regulatory model has been replicated in Australia in 2009 with the formation of the Australian Health Practitioners Regulation Agency to oversee several different collections of regulators. In Ireland a multi-regulatory authority named Coru has been recently established as a single regulatory authority for 15 regulated health and social care professions but excludes medical practitioners and nurses, and the Health Professions Council of South Africa regulates 12 different professional groups which includes medical and dental practitioners but not nurses.

⁴⁸ The inter-professional power struggles within health professionals, and how these play out in different ways in different settings, are expanded on in chapter eight in relation to this research.

regulatory collectives creates additional localised and nuanced power relations in the way the economic-governmental practices of central government are actualised. The outcomes of these power struggles surfaced in the way a single regulatory body could not be formed. But as seen in the UK and Australia, where a similar situation has transpired, the traditional ordering and power of medical hierarchies has been overridden by the introduction of umbrella entities that through legislation can control all the regulatory bodies in uniform ways towards economic ends. The globalised trends towards this form of health regulation is a site of danger for the OTBNZ as this trend supports certain understandings of sovereignty and how Aotearoa New Zealand operates globally as a nation state.

OTBNZ and globalisation.

The Chair and CEO of the Board started attending international conferences about health regulation not long after the move to a corporate governance model was adopted by the Board in 2008. In 2010 the Chair attended the World Health Organisation health regulation conference in Geneva (the only occupational therapist present) (Occupational Therapy Board of New Zealand, 2010). In 2013 the international Council on Licensure, Enforcement and Regulation (CLEAR) conference in Edinburgh was attended by the Chair, and in 2014 the Chair and CEO attended an international Occupational Therapy regulator conference in London, funded by the American National Board for Certification in Occupational Therapy (Occupational Therapy Board of New Zealand, 2015a). As well as the connections with American and European health regulation, the OTBNZ has had a long standing formal relationship with the Australian occupational therapy regulators. The OTBNZ attended regulatory events in Melbourne in 2012 (Occupational Therapy Board of New Zealand, 2012d), a Directors training with OTC (Occupational Therapy Board of New Zealand, 2012b), the National Regulatory Authorities Health Professionals Conference in Australia (Occupational Therapy Board of New Zealand, 2013a) and a regulatory risk management conference in 2015 (Occupational Therapy Board of New Zealand, 2015e).

Before the global regulatory industry had developed, the OTBNZ had also had a long standing legal linkage with Australian occupational therapy authorities. This was through the education of occupational therapists. After the Trans-Tasman Mutual Recognition Act (1997) was passed, graduates of the two countries were automatically eligible for registration in either country. There has been Aotearoa New Zealand representation on the Occupational Therapy Council (OTC), an organisation which accredits Australian occupational therapy education programmes and internationally trained therapists since the Council was established in 1996 (NSW Rural Doctors Network, 2017). The practices that developed because of this legal obligation were part of wider economic strategies to stimulate free trade and regional economic growth. The accredited qualification of an Australian occupational therapist was assumed to be equivalent to that of an Aotearoa New Zealand therapist. An assumption of sovereignty has been made where a free-trade of occupational therapy occurs through an application of the law, supporting economic-governmental practices designed to accumulate capital, generate wealth and increase productivity.

Due to the increasingly open international labour market and the increase in the number of free trade agreements between countries, health regulation has needed to become globally responsive. The global health marketplace has produced practices where health practitioners are positioned as international commodities that are part of international positions of sovereignty. In Aotearoa New Zealand this directly confronts the understanding within Te Tiriti o Waitangi of Māori rights to participate in any constitutional level negotiations. For the OTBNZ, this oppositional positioning of sovereignty is played out at the micro-level of practice in the current Competencies for Registration.

Micro-level material-institutional practices.

The legal assemblages that the OTBNZ relies on for its legitimacy as a health regulator (the HPCA Act, the HDC, the Trans-Tasman Mutual Recognition Act), and the more recent addition of the HWFNZ and HQCS to this network, strongly support the Treaty of Waitangi and a British interpretation of sovereignty rather

than Te Tiriti o Waitangi. At the same time, at the micro-level of the current Competencies for Registration document, all occupational therapists must recognise Te Tiriti o Waitangi as a founding document which refutes this understanding of sovereignty. The enterprising practice of implementing a competency based and ongoing monitoring system of regulation continue to support an underlying position of sovereignty that is not aligned with this recognition. The constant interplay of sovereign and economic-governmental power could be seen in the practices the OTBNZ deployed in order to administer its sanctioned duties as part of the legal assemblage of healthcare delivery and regulation. The way occupational therapy as a collective responded to these practices enabled the analysis to be opened up beyond the conceptualisation of a macro-level di-polar field to one that incorporated the power relations at the street-level of practice.

Enterprising up at the Street-level

At the time of the health reforms the OTBNZ radically changed how it interacted with and governed occupational therapists. There were two primary ways that this occurred, one by producing the Competencies for Registration that all practising therapists were accountable to and the other through the practices that the OTBNZ implemented to monitor individual therapist's conduct and competence. Both of these actions were significant changes to the regulatory practices of the profession and remain keystones of how the OTBNZ operationalises its responsibilities. The Competencies for Registration documents were written expressly to pull the profession up into the marketplace of healthcare from a position of subjugation and poor legitimacy amongst the other health professions. They were produced because of a lack of participation in professionalising activities such as post-graduate education and competency based frameworks as well as a lack of compliance with the law and how health professions were expected to regulate themselves⁴⁹. They have quasi-legal status and, in terms of global regulation, internationally educated occupational

⁴⁹ This history is detailed in the previous chapter in relation to the Ministerial review of the education of occupational therapists and the functions of the Board.

therapists must comply with and demonstrate they have the skills the competencies describe.

Responding to enterprise.

As already discussed, the way the OTBNZ was required to ensure the public was safe from occupational therapists became increasingly legislated after the introduction of the HPCA Act (2003). Although the new legal assemblage overtly inserted sovereign power into how health professions practised, the way that the individual professions provided the assurance to the public was an opportunity for the economic-governmental rationalities of self-regulation to be used in productive ways. How the professions chose to monitor the ongoing competence and conduct of individual practitioners was undefined in the Act. The OTBNZ chose to implement an online continuous monitoring system that was based around the Competencies for Registration. A Continuing Competence Framework for Recertification (CCFR) was designed in 2004 which the Board described as a “high-trust model” that emphasised “individual responsibility, flexibility and choice” as the key principles of accountability (Occupational Therapy Board of New Zealand, 2004b, p. 3). Individual accountability was in the form of a self-declaration about fitness to practise and an endorsement of this by a ‘third party’ occupational therapist. As well as these formal declarations there was a requirement for occupational therapists to annually assess their own competence against the competency roles within Competencies for Registration. Therapists were encouraged to use critical reflection and regular supervision to assist with this process.

The OTBNZ was utilizing trust based relationships within the profession to deliver a legislated requirement rather than more prescribed tactics such as points based continuing professional development records that many of the other health professions adopted. The high trust model and reliance on the content of the Competencies, reflective practice, supervision and ongoing permanent methods of audit to ensure public safety, remain underlying components in the rebranded and upgraded CCFR, the current ePortfolio. Reflective practice, supervision and trust have become tools of enterprise

connected to cultures of audit through the mandatory ePortfolio. The combination of the ethical self with the professional self that this requires is how methods of governmentality become linked to the ethical conduct of healthcare practitioners (Millar & Rose, 2008). Links such as these in turn create new subjectivities and relations of power not only for the practitioner but also, because of the highly personal nature of healthcare practice, for the people they work with. In each of the four iterations of the Competencies, the skills and competencies described have changed in ways that track the changing macro-level dynamics between sovereign and economic-governmental power and demonstrate how these filter to the social body through practice.

Enterprising up practice.

The first Competency document was written right in the midst of the health reforms, in 1990, and overtly reflected the way health services were being divided into funders, providers and consumers. Occupational therapists were required to become health professionals who could operate in a health system where competition between Government funded, private for profit and private not for profit providers was encouraged (Tenbensen et al., 2011). In order to compete in this environment, occupational therapists needed business skills. Accordingly, one of the ten competency roles was 'Occupational Therapy Marketer'. This role required skills such as those outlined in 9.2:

A range of communication skills to develop marketing strategies and to promote occupational therapy; use a range of methods to promote and sell occupational therapy products and services; and assist in evaluating and reviewing the outcome of occupational therapy marketing projects (New Zealand Occupational Therapy Board, 1990, p. 46).

Throughout the other nine competency roles there was also an insertion of business skills in the performance indicators. For example, "select and use documentation format (for example memo, contract, report)" (3.1); and "justify and rationalise the use of resources and communicate to all concerned "(6.1). These examples involve language and skills that enterprise up occupational therapy and occupational therapists, re-configuring how occupational therapy

framed its practice to align with how a marketplace functioned. By positioning the profession and individual therapists as responsible for the success of the services they provide, as Paul duGay (2004) contends, the notion of public service was eroded, with market forces left in its place. The underlying acceptance of sovereignty and its authority to decide how to provide public healthcare has been modified in reaction to economic-governmental power. These economic-governmental practices are where connections with much larger global forces of capitalism and political ideology that involve individualism and self-responsibility for life outcomes are made. The changes in the Competencies between 1990 and 1995 illustrate how this reframing of public service was introduced in occupational therapy.

The 1990 version of the competencies positioned occupational therapists in ways that still had traces of a public service ethos, where public servants were considered as representatives of, and responsible to the benevolent State. They were to “function as an autonomous practitioner with appropriate suspension and with accountability for actions” (New Zealand Occupational Therapy Board, 1990, p. 20). Using appropriate suspension indicated that therapists were expected to make practice judgements that were congruent with the position of the sovereign via the Ministry of Health. In the second version of the Competencies, this statement was re-framed to “function as an autonomous practitioner with appropriate occupational therapy supervision and with accountability for actions” (New Zealand Occupational Therapy Board, 1995, p. 16). The subtle change re-frames the profession and the individual therapists into market players who were reliant on each other rather than the sovereign power of the State to judge what was acceptable practice and legitimate knowledge. The transfer of responsibility to the profession was further strengthened with the addition of “maintain performance in accordance with the New Zealand Association of Occupational Therapists Standards of Practice” (2.2) in the second version (New Zealand Occupational Therapy Board, 1995, p. 17).

The Competencies were forming a central link in a developing professional network between individual practitioners, the OTBNZ, the

occupational therapy schools and the professional association. These linkages supported occupational therapists as accountable to each other through self-regulation, curriculum development, and professional standards. However these strong professionalizing links were still accountable to the law and the various legal assemblages that are part of healthcare delivery. The retention of the position of the law as an over-riding power maintains the historical position of a sovereign deciding what is acceptable conduct for health practitioners, how healthcare should be delivered, and by whom. As argued by Tenbenschel et al. (2011), instead of a more collaborative and shared arrangement of power with the players in the marketplace, in practice the health reforms ended up more as a re-configuration of traditional hierarchical structures of power.

Other changes in the successive versions of the Competencies demonstrate the way power was re-configured through expectations of practice and competency. Core understandings of occupational therapy knowledge were removed and were replaced by practices that created a regime of knowledge clash between the discursive practices of the profession and the legally sanctioned definitions of how health practitioners should practice. In the first and second versions of the Competencies many performance indicators were indicative of the moral-humanistic origins of the profession. There were many indicators that involved the personal self and human attributes such as empathy and rapport as important for competent practice including even the expectation to maintain an appropriate sense of humour (3.1) (New Zealand Occupational Therapy Board, 1990, 1995). However in the third version of the Competencies (produced in 2000) these skills were replaced with objective, measurable terms: “negotiate mutually agreed, prioritised goals” (1.2) and “communicate all relevant information to colleagues and consumers in a timely manner” (4.7) (Occupational Therapy Board of New Zealand, 2000). De-humanising the Competencies in order to enterprise up the profession introduced a form of moral regulation into the profession where a particular type of occupational therapist was encouraged (Dean, 1994b). In response to these changes there has

been a visible resistance to the disciplinary nature of the Competencies by practising therapists.

Resistance at the micro-level.

Research carried out with occupational therapists to evaluate their ability to be self-directed learners found that therapists were generally not engaging with the Competencies or the reflective practice oriented CCFR as they were intended, disliking the process and the mandatory nature of it (Penman, 2013). Instead most therapists tended to adhere to the minimal requirements of the system once a year in the month before annual re-certification (J. Murphy, personal communication, 19 October 2015)⁵⁰. The lack of engagement with the way OTBNZ was ensuring public accountability suggests that the power relations in the process had changed to an uncomfortable balance. Therapists were resisting the subjectification of the re-configured power relations by remaining as underground as possible.

There were also other ways occupational therapists resisted how the profession was disciplining them in relation to the OTBNZ structures. When the CCFR process was introduced in 2005-7, there were significantly fewer occupational therapists applying for annual practising certificates, enough to concern the Board about its financial position (Occupational Therapy Board of New Zealand, 2005a, 2005b, 2006). A number of occupational therapists were choosing to no longer practise occupational therapy. The trend has been reversed, with a steady increase in the number of practising therapists each subsequent year from 1493 in 2000 (Wilson, 2003, p. 76) up until 2435 in 2017 (Occupational Therapy Board of New Zealand, 2017). However the increase in the number of practitioners is much less each year than the number graduating⁵¹

⁵⁰ The new ePortfolio system was introduced in 2016 and follows a two year cycle, thus registrant behaviour in relation to the new system is yet to be evaluated as the first cycle reaches its conclusion in April 2018.

⁵¹ In 2017, 221 therapists graduated and the number of practitioners increased by 141, the biggest increase since 2012. In 2016, 149 therapists graduated and the number of practitioners increased by 65. The other increases were approx. 30 practitioners each year, with 2015 actually recording a net loss of 102 practitioners (Occupational Therapy Board, Annual Reports 2012-2017).

and the difference is not reflected in an increase in the register of non-practising therapists. These statistics suggest that occupational therapists are choosing not to participate in the OTBNZ regulatory processes and are not working using the title occupational therapist (Occupational Therapy Board of New Zealand, 2016a).

The other way that occupational therapists have resisted subjectifying forces has been the lack of participation in the professionalising activities of the professional association. By 1979 less than half of the 350 practising therapists belonged to the association and this statistic remains the same in the current day. Therapists have consistently used the freedom they have to choose not to be part of the institutional structure of the association. Alongside the lack of collective professionalising action is the fact that approximately half of occupational therapists practice outside the public health sector where more traditional disciplinary tactics and structures related to medical hierarchies and institutions support certain ways of practising. All of these discursive practices were stable conditions for the profession for 15 years (2000-2015) where the Competencies and the CCFR system were administered in the same way, the professional association represented only half of practising therapists and half of the growing number of occupational therapists worked outside public health institutions in an increasingly commodified health marketplace. In 2015 this stable position was altered with the introduction of significantly different new version of Competencies for Registration.

Resistance to sovereign power.

The current fourth version of the Competencies was written with the intention of incorporating biculturalism and Māori indigenous rights into occupational therapy practice. To do this, the responsibilities that occupational therapists have under Te Tiriti o Waitangi have been foregrounded rather than the Treaty of Waitangi⁵², and overt skill descriptors of what this practice should look like are

⁵² The fourth version of the Competencies for Registration document for occupational therapists had been discussed since 2007 (Occupational Therapy Board, 2007). There was significant work going on at the time by the Māori occupational therapist roopū (group), culminating in a Māori occupational therapist workforce development report being published (Te Rau Matatini, 2009)

provided. The preliminary statement⁵³ that was inserted at the beginning of the Competencies provides a context where the different understanding of sovereignty within Te Tiriti o Waitangi is applied. The alternate understanding does not involve a ruling sovereign and the individualism that is required for the exercise of English common law, rather it involves the concept of kawanatanga and a constitutional right to self-determination of Māori. In a similar way the document offers opposing legal subjectivities, there are expectations of practice that remain which are contrary to honouring the self-determination espoused in Te Tiriti o Waitangi. Practice is described as the responsibility of the individual and is presented as part of delivering a service that is a commodity and part of the market-driven model. As previously discussed the connection between material outcomes, material deprivation and ongoing colonising practices is strong. The commodification and market driven model of healthcare that has become increasingly connected to these material outcomes through professions such as occupational therapy is also closely connected to globalisation and financialisation made possible through the exercise of sovereignty that does not honour kawanatanga. One of the repeated ways these underlying assumptions

which was drawing more concentrated attention to biculturalism and the profession's incorporation of cultural safety in its practice. Before this there had been many other activities spanning over 20 years that had been raising occupational therapists' concerns about how occupational therapy was being practised in terms of biculturalism. This consisted of published articles in the New Zealand Journal of Occupational Therapy by Henare (1992, 1993), Jungerson, (2002), Gordon (1994), Jeffery (2005), and Hopkirk (2013); the organisation and participation in consultative hui with the OTBNZ in 1997, 1998, 1999, 2000 (Occupational Therapy Board of New Zealand meeting minutes, 1997, 1999, 2000b); and formal contracted consultancy services to the OTBNZ in 1998 (Occupational Therapy Board of New Zealand, 1998). The professional association also was part of these attempts to legitimise biculturalism. The then president Christine Rigby (1999-2001), established a Māori Perspective position within the New Zealand Association of Occupational Therapists (now Occupational Therapy New Zealand-Whakaora Ngangahau Aotearoa), with the incumbent nominated by the Māori members rather than voted in by the membership at large. Since 2012 the president of the professional association OTNZ-WNA has been Māori (Molyneux & Gilsenan, 2014) and currently under this leadership the Association has trialled and subsequently introduced a bi-cultural governance model for the association where two co-presidents, one representing Tangata Whenua (Māori) and one Tangata Te Tiriti (non-Māori) are now required (Anderson, 2015).

⁵³ "Te Tiriti of Waitangi is the founding document of Aotearoa New Zealand. It shapes the diverse historical and socio-political realities of Māori and all other settlers and their descendants. Understanding how Te Tiriti affects all our lives is essential for helping people participate in their desired occupation" (Occupational Therapy Board of New Zealand, 2015d, p.1).

were maintained in the Competencies was through the repetitive language in each performance indicator of competence.

Each performance indicator under the five competence roles start with the word “you”, for example, “you enable and empower your clients/tangata whaiora to improve their own occupational performance and participation” (1.4) (Occupational Therapy Board of New Zealand, 2015c). In the previous versions the performance indicators had started with a variety of verbs such as identify, establish, comply, use and demonstrate, the personal pronoun “you” was never used. The word “own” occasionally appeared as in “assess the effectiveness of own communication” (4.9 Occupational Therapy Board of New Zealand, 2000), but generally the indicators were written from an objective de-personalised perspective. By adopting an active voice that targets the reader personally, the current Competencies position the occupational therapist as an individual rather than part of a collective profession. The responsibility for occupational therapy is passed to occupational therapists rather than the profession as a whole. The change of focus to the individual in this iteration of the Competencies was inadvertent and illustrates how underlying regimes of truth creep into taken for granted understanding.

The pronoun “you” was added to the published Competencies after the Board approved the final draft document (Occupational Therapy Board of New Zealand, 2014a). The change to the wording occurred after the document had been submitted to a plain English process of translation by the company Writemark (Writemark, 2010a). Writemark’s translation was accepted as appropriate by the OTBNZ and the Competencies were published using this version. The process occurred despite there being little evidence that re-writing legal documents into plain English removes doubts about the meaning of these documents (Barnes, 2010). Converting important documents into plain English has, however, become accepted as a good business practice in many public and private sector settings. The widespread acceptance of the need to use plain English has come about through the energies of the worldwide plain English movement. The use of plain English has become mandated in some American

legislation (Barnes, 2006) and the Professional Standards Authority in the UK (the independent body that oversees health regulatory authorities) train all their staff in using plain English (Council for Regulatory Excellence, 2009). Here in Aotearoa New Zealand the use of translation to plain English has been taken up by many private and public sector organisations such as ACC, the Ministry of Social Development, the ANZ bank, insurance companies, early childhood centres, the NZ Police and Inland Revenue (Plain English Awards, 2016). Despite its original social and emancipatory intentions, market conditions and the commodification of public services has propelled the plain English movement itself to become an enterprise and commodity.

Placing the Competency document through a commodified plain English process accepts the need to market the document as a product⁵⁴. The OTBNZ was responding in an enterprising way to a perceived problem, that the Competencies may be misunderstood. Having the Writemark tick on the Competencies document indicates the OTBNZ has met their corporate responsibility to ensure this does not happen. The implications of any changes in language were not considered despite the process for developing and choosing the words in the document having taken over two years of collective effort (Occupational Therapy Board of New Zealand, 2014a). The repetitive use of the word “you” was not the only way the underlying assumption of individual accountability rather than the profession or the State responsibility was emphasised in the current version of the Competencies.

A removal of any reference to the professional standards advocated by the professional association, OTNZ-WNA, and a vastly reduced reference to the law and legal obligations also strengthens the individualism within the document. Occupational therapists are positioned as individually responsible for upholding standards and making decisions that are safe, legal, ethical and culturally appropriate. The sovereign power that occupational therapists possess

⁵⁴ Converting important documents into plain English is presented predominantly as a marketing strategy by Writemark, which markets itself with statements such as: “using plain English builds trust and loyalty, and gives you a clear competitive advantage. WriteMark approved documents make your organisation stand out from the rest — for all the right reasons” (Writemark, 2010b).

becomes connected in stronger ways to individual judgement rather than collective decision making. Due to the underground nature of occupational therapy and the instrumental place it has in delivering material outcomes, how this sovereign power is exercised becomes an ethico-political practice of each therapist. The new Competencies have introduced opportunities to contest the Treaty of Waitangi's understanding of sovereignty on one hand but have supported economic-governmental practices that individualise and support enterprising and globalised ways of providing healthcare that consolidate the way sovereignty is maintained on the other.

The multiple layers of enterprising up and continual connections between economic-governmental practices, sovereignty and sovereign power discussed in this chapter demonstrate the complexity in which occupational therapy practice is historically situated. The line of analysis so far has followed the theoretical work offered by Mitchell Dean, Nicholas Rose and post-colonial scholars Smith, Joseph and Pavlich. In order to shift the focus of the analysis to one that involved a broader reading of power the next two chapters consider the occupational therapy practice observed in this research in different ways again. Despite the macro-level changes in the interplay of sovereign and economic-governmental power the profession of occupational therapy has retained historical discursive practices that have successfully resisted many of these new power relations. These resistances have not jeopardised occupational therapy's position as a regulated and legitimate profession. The stability of occupational therapy's existence indicates that other regimes of knowledge and power relations are operating in a different power game. Many unsaid practices remain at the level of the street and these practices could also be traced back from the case studies to Tokanui Hospital.

Summary

Over the last thirty years the context of how health services are delivered changed radically from large publically funded, institutionally based services to a plethora of community situated providers funded through a variety of contractual and financial structures. The healthcare marketplace that formed

over this time has extended to the provision of the most high-levels of support to the most vulnerable people. In the last ten years some of these market players have reached a position where they have become a market-force, influencing both how the government funds services and what it funds. These corporate organisations also compete in the global healthcare marketplace and are becoming increasingly part of the international financialisation of the health sector and trade of healthcare as a commodity.

Concurrent with the commodification of healthcare services was a corporatisation of health regulation in order to extract the responsibility for regulating health professions from central government, transferring it to the professions, the law and the health care user. The corporatisation of health regulation has also enabled regulators to connect to a global industry. Issues of sovereign power become foregrounded on the global stage when international trade agreements also cover reciprocal regulation agreements. These macro-level economic-governmental practices are a backdrop to the micro-level disciplinary strategies adopted by the OTBNZ in the current Competency document. The individualising nature of and support for the market-driven model of healthcare delivery in many of the strategies are contrary to the overarching statement which places Te Tirit o Waitangi as the founding legal document of both the Competencies for Registration and Code of Ethics. By doing this the economic-governmental practices that the Competencies are perpetuating are based on underlying assumptions of sovereignty rather than kawanatanga.

Chapter 7: Unsaid Practice

Occupational therapy as a profession has been surprisingly resilient throughout all the economic and political changes since its introduction to Aotearoa New Zealand in 1940. It is surprising because although occupational therapy was introduced as a new progressive human science alongside similar health professions, it did not take long to lose visibility as a profession in terms of both the general public consciousness and as part of the greater health care landscape. Occupational therapy also rapidly assumed a position of low status amongst other health professions. As outlined in chapter one, the persistence of this positioning has attracted much professional concern and there has been significant academic energy spent on how to change the status and visibility of occupational therapy. The outcome of this invisibility is that many occupational therapists continue to practise in a liminal space where most people do not know exactly what they do. The power relations that support this underground position are the focus of this chapter.

Gillies Deleuze (1991) likened untangling lines of power to doing a cartography or surveying an unknown landscape, and he refers to what Foucault called 'working on the ground' as a method to do this (p.159). In order to work on the ground and untangle the lines that were interconnecting and intersecting between the three methods of the research, Tokanui Hospital has again been used to provide the grounding on which to identify and trace the lines of historical practices of occupational therapy in the region. My insider perspective was an asset in this task as I had worked at the hospital as a new graduate in 1994-5. Having returned to live in the Waikato 20 years later, the traces of its institutional history were still evident to me when carrying out this research. These traces were generally unknown to most of therapists who were involved in the research as they were largely unaware of the institution's history or how it had operated.

The hospital provided many on the ground examples of discursive and extra-discursive practices that had continued into the current era. Using the hospital as a centre enabled the analysis to remain on the surface at the level of

practice but in a way that opened up a heterogeneous array of elements of power, the “discourses, institutions, architectural arrangements, regulations, laws, administrative measures, scientific statements, philosophical, moral, philanthropic propositions – in short, the said as much as the unsaid” (Foucault, 1977/1980, p. 194).

Tokanui Hospital

Tokanui Hospital was a large mental health institution built in 1912 as a hospital farm as part of the Mental Hospital Department. From as early as 1876 the provision of mental health institutional care had been the responsibility of this government department, which operated autonomously from the Department of Health. The separation of the two strands of healthcare provision did not alter until 1947 when the Mental Hospital Department became amalgamated with the Department of Health (Campion, 2012). Despite this policy level amalgamation the separation of mental health care from mainstream health care continued in the Waikato region for many more years through two separate institutions providing healthcare and the continuation of many practices that maintained the divisions between mental and general health care.

When Tokanui Hospital was built The Mental Defectives Act (1911) had been recently passed due to a growing number of people requiring publically funded care, control or supervision. The Act allowed people of “unsound mind, mentally infirm, an idiot, imbecile, feeble-minded or epileptic” (p. 19) to be legally sectioned and held in an institution (Campion, 2012). Under this Act children with severe and complex disabilities were admitted to Tokanui Hospital to live (but often died before the age of 5), as well as people who were considered unable to care for themselves adequately or their families were no longer able to care for them (Hoult, 2012). From the mid-1920s forensic care of both mentally ill and intellectually disabled people who had committed crimes was also provided at the hospital (Hoult, 2012). Tokanui Hospital rapidly grew and by the 1940s was one of the largest hospitals in the country with over 1000 people living there (McLaren, 1997). The overall number of people living at Tokanui Hospital slowly decreased after the 1970s, to 760 in 1984. By this time

people with complex disabilities and neurological or dementia related illness were the majority of residents, numbering 511 (McLaren, 1997).



Figure 3: Tokanui Hospital, 2014

Reproduced with permission from wildboyz 18/5/2017.

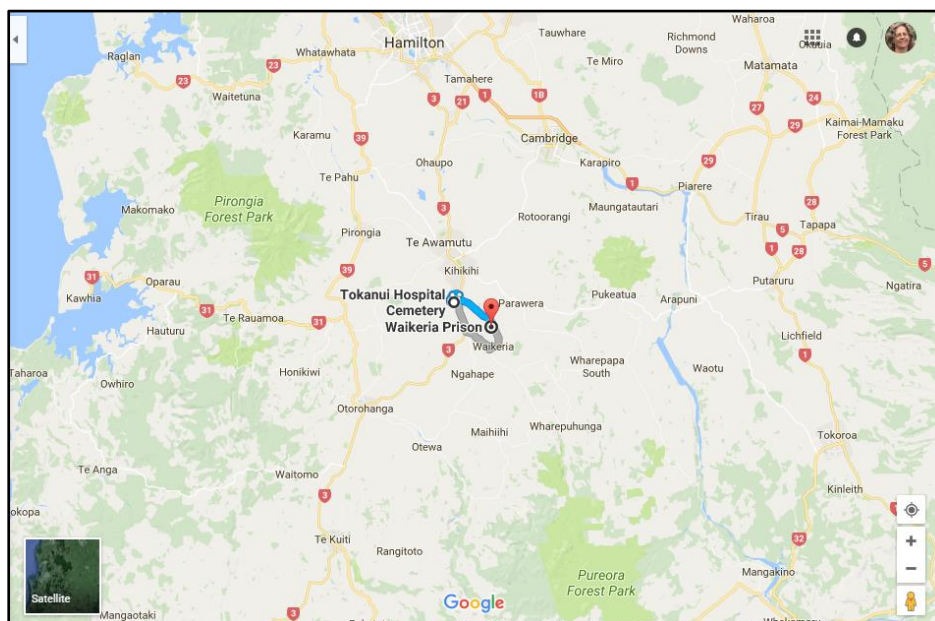
Occupational therapists worked at Tokanui Hospital from 1946, very soon after the first occupational therapists were trained in Aotearoa New Zealand (McLaren, 1997). Occupational therapy had become a well- established department of the hospital by the late 1940's and any person, regardless of diagnosis, who was unable to work outside on the farm or gardens fell under the occupational therapists' domain of care (Dey, 2012). Nursing staff were trained on site until the late 1980s⁵⁵ when nursing training was finally combined into one comprehensive qualification rather than separate general and mental health programmes. As well as the training of nursing staff, all the medical care,

⁵⁵ Although it had a significant population of intellectually and physically disabled people who also lived at the hospital, it never provided the equivalent 'psychopaedic nursing' training for people with intellectual and multiple disabilities (Prebble, 2012). This training was provided at other similar institutions elsewhere in the country.

therapeutic services and education for children was provided within the grounds, as was all the administration and management of medical records. These institutional practices of Tokanui Hospital are historical elements that had traces still visible in the work of the occupational therapists observed in this research, suggesting the institution has shaped how occupational therapy is practised in the region. One of these highly localised elements was the connection Tokanui Hospital had with the other two major institutions in the region, Waikeria Prison and Waikato Hospital.

Institutional history.

At the same time as Tokanui Hospital was built, just 10km up the road, Waikeria Prison was also constructed, with the institutions opening in 1912 and 1911 respectively. Waikeria Prison was also established as a working farm and was equal in size and capacity to Tokanui Hospital (Clayworth, 2013). These two institutions were sited 40 kms south of the main urban centre, Hamilton, and the general Waikato Hospital.



Map 3: Tokanui Hospital and Waikeria Prison

There was a close relationship between the institutions from the time they were built. People who had committed crimes, had mental illness or were considered mentally defective (or a combination of these categories) were managed

collaboratively by the two institutions (Coleborne & Waikato Mental Health History Group, 2012; McLaren, 1997). As both the hospital and the prison used large farms as the focus for rehabilitation or reformation they assisted each other with the operation of the farms (Clayworth, 2013; McLaren, 1997). This reciprocity extended to the expertise of managers and specialists. In the 1920's the prison and hospital were both overseen by the same superintendent (Poole, Wellington, Symonds, & Tapsell, 2012) and psychologists provided services to both institutions (McLaren, 1997). The relationship between the two institutions remained very close until Tokanui Hospital closed in 1998 (Coleborne & Waikato Mental Health History Group, 2012). Waikeria Prison is still an active penal institution within the justice system although since 2011 the population in the prison has halved to 607 inmates recorded in 2016 (Department of Corrections, 2017). The previous connections it had to mental health service provision through Tokanui Hospital have now been transferred to the regional forensic mental health service, which the forensic occupational therapists in this research were part of.

In the early 20th century medical and penal practices both considered work as a primary route for reformation and rehabilitation. Farm work was ideally suited for this purpose, and a rural locality also met medical requirements for placing the sick and infirm in open spaces, away from disease carrying miasma, the unclean air of urban centres (Armstrong, 2009). The placement of hospitals on sites that allowed for ventilation of pure air originated in 18th century Europe, and whilst it was a medical practice, it also had the effect of removing people who lived at these hospitals from public sight (Foucault, 1972/1984). The shared geographic location of people with mental illness, people who had been convicted of criminal activity and people with complex illness and disability connected the diverse services that the differing needs of these people required through the operationalisation of health policy and the law. The services and the lives of the people who happened to reside at Waikeria Prison and Tokanui Hospital were well out of view of the public gaze through the geographic locations of the institutions. The choice of geographic

location on which to site these institutions also has significance because of the history of colonisation in the region.

Institutional custodial care and colonial practices.

Tokanui Hospital and Waikeria Prison are located at the northern end of what is colloquially titled the 'King Country'. Although officially part of the Waikato region this unofficial demarcation was created after the major land wars in the 1860s. The King Country became acknowledged by both colonists and Māori after the eviction of many of the Waikato-Tainui tribe from their traditional rohe (land). To recap the history outlined in chapter four, this eviction was a punishment for fighting against the Crown in the 1864 Waikato land wars (Maniapoto-Anderson, 2012). The second Māori King, Tāwhiao, Tukaroto Matutaera Potatau Te Wherowhero was one of those evicted (hence the name King Country), and he lived in exile from his tūrangawaewae (place to stand) in Ngaruawahia (near Hamilton) for two decades. Because of these occurrences, Ngati Maniapoto, the tribe of the King Country effectively closed the region to European settlers and the Crown until 1882. It was not until the successful negotiation to construct a main railway line through the King country, that the region was opened to industrial development and colonial influence (Pollock, 2012). The main railway line through the central North Island was not completed until 1909 and shortly after, the Crown built Waikeria Prison and Tokanui Hospital, alongside the main trunk line, inside the boundary of the King Country.

The decision to build two large institutions for the Crown in the King Country region rather than the Waikato region was contentious as a further acquisition of land from the local tribe, approximately 10,000 acres, was required (Maniapoto-Anderson, 2012). These events reflected colonising practices of the time that were enabled by the New Zealand Settlements Act (1863). The current ownership status of Tokanui Hospital remains an unresolved land claim that is currently lodged with the Waitangi Tribunal⁵⁶ (Maniapoto & Maniapoto, n.d;

⁵⁶ Set up by the Treaty of Waitangi Act 1975, the Waitangi Tribunal is a commission of inquiry that makes recommendations on claims brought by Māori relating to Crown actions which breach the promises made in the Treaty of Waitangi. See background chapter four for more detailed discussion.

Waitangi Tribunal, n.d). The colonial history of the institutions adds another layer to the geographic location of Tokanui Hospital and Waikeria Prison.

The geographic locations of both Tokanui Hospital and Waikeria Prison are important regional elements that have influenced the development of certain healthcare practices in ways unique to the region. Initially very few Māori were admitted to the Hospital, with only 45 out of 1000 identified as Māori in 1942. However, there were many Māori employed as staff. Ron Baker, a mental health nurse, refers to the large number and how it was probably the biggest ratio in the country (Elliot, Baker, & Maniapoto-Anderson, 2012). Similarly historian Helen Robinson (2011) cites the high Māori staff numbers at the hospital, attributing this to its locality. The strong influence of Māori culture at the hospital enabled a Māori for Māori (kaupapa) approach to be developed within a Euro-normative medical hospital setting. Tokanui Hospital led Aotearoa New Zealand in the development of Māori led mental health care with the opening of a dedicated bicultural ward, called Whai Ora in 1984 (Robinson, 2011). Not long after this, at the end of the 1980s the Hamilton based comprehensive nursing school also led the development of kaupapa Māori nursing education and were an instrumental element in the recognition of a need for cultural safety in all health professions' education and practice (Nursing Council of New Zealand, 2013). Occupational therapy was one of the other professions who were actively involved in incorporating cultural safety into education and professional practice at this time, with one of the leaders of the profession attending a seminal hui (meeting) in 1988 run by the Nursing Council. Not long after this a paper was published locally about the importance of incorporating bicultural practice in occupational therapy in Aotearoa New Zealand (Jungerson, 1992), with another two about how this could be done (Henare, 1992, 1993).

Occupational therapists were very present at Tokanui Hospital during the time Whai Ora emerged, but there is little trace of how occupational therapy responded to the strong influence of Māori culture and ways of providing healthcare at the hospital. The few memoirs of therapists who worked there are

from the very early days (the 1940s) when few Māori were admitted to the hospital. Recollections of staff about the Whai Ora unit and Tokanui hospital never mention occupational therapy (Coleborne & Waikato Mental Health History Group, 2012; Gordon et al., 2009). In the wider occupational therapy historical context there is a similar lack of reference to Māori and how occupational therapists practised with Māori in the few historical texts that exist. One snippet referring to the 1960s was located amongst an account of the creative practices of the profession:

The resurgence of Māoritanga, and the graciousness of our Māori sisters, who have been more than willing to share their skills and knowledge, has enabled us to revive our interest and we are weaving again: kete, bags, backpacks, belts, mats, hats and wall hangings, with a medium that is abundant and readily available (Gordon & Creighton, 2009, p. 179).

The recollection is referring to traditional flax weaving and the authors state that the craft was taught to therapists as early as 1949.

Occupational therapists presumably worked in the Whai Ora unit at Tokanui Hospital if requested as they were a resource for all services within the institution⁵⁷. As a profession occupational therapy was actively participating in the move toward incorporating bicultural practices into mainstream healthcare. However what occupational therapists did in practice in relation to these changes is largely unsaid. The geographic location of Tokanui hospital, the connections with colonisation and the strong bicultural mental health practices that emerged at the Hospital are unsaid layers of the occupational therapy practice seen in the case studies of this research.

Occupational Therapy at Tokanui Hospital

Occupational therapy was introduced to Tokanui Hospital when the profession was in its infancy. The hospital had been operating for nearly forty years and was operating at its greatest capacity. As such the profession was entering a

⁵⁷ From my brief time working at Tokanui Hospital during the 1990s the mental health occupational therapists definitely worked at the Whai Ora unit when requested.

well-established institution that had developed its own regime of practices. Tokanui Hospital had developed ways of providing healthcare for people with complex illness and disabilities that were specific to the geography, institutions and socio-cultural context, particular to the region. How occupational therapy negotiated a place in this well-established landscape provided insight into the discursive practices and discourses that were forming current practices of the occupational therapists in the three case studies.

As discussed in chapter one, occupational therapy emerged in the move toward alternate more humane therapeutic practices in the asylums of the late 18th and 19th century (Reed, Hocking, & Smythe, 2013). A century later, this was also the case in Aotearoa New Zealand. Occupational therapy was the first new style therapeutic practice to be formally delivered at the hospital (McLaren, 1997). Social workers were not employed until the 1950s, psychologists and music therapists in the 1960s and dietitians not until the 1970s (Fitchett, 2012; Knight, 2012; McLaren, 1997). Initially the department had a small shed and worked with people in the day rooms of individual wards. This arrangement did not last long and two buildings, one for males and one for females were made available for the occupational therapists' express use in 1949 (Dey, 2012)⁵⁸. From this beginning the occupational therapy department expanded as the knowledge the profession used and institutional practices changed.

An important institutional change was the closing of the hospital farm in 1967. Before this time, excepting occupational therapy, much of the staff's work and staffing allocation revolved around running the farm (Prebble, 2012). With the changing focus of institutional care on shorter stays and rehabilitation, combined with an increasing number of children being admitted to the hospital, the role of occupational therapy also changed. Children had been increasingly admitted to Tokanui Hospital between the 1950s and 80s necessitating a school to be built for them (McLaren, 1997). By the 1980s occupational therapy was providing a wide range of services including industrial, woodwork and creative

⁵⁸ The wards in the hospital were segregated by gender until the early 1970s and many of the male staff only worked in the male wards until this time (Prebble, 2012).

workshops, physical therapy rooms, a wheelchair workshop, horse riding facilities, as well as assisting with the development of eating, communication and education based skills. It is difficult to ascertain how many occupational therapists were employed to provide these services as there are no publically accessible records of staffing available. What is certain, is that the services provided by the occupational therapists were substantial and required a significant allocation of resources in terms of buildings, equipment, staff (occupational therapy assistants, technicians and recreational officers) and ongoing budgetary consideration. In comparison to the large physical presence of occupational therapy, other therapeutic professions were very scarce. At one stage there were eight psychologists, (the most ever employed at one time) who were housed in one building (Young, 2012). There was only ever one music therapist until she was made redundant in 1989 (Knight, 2012) and physiotherapists, dietitians, social workers and speech-language therapists were very difficult to retain, often with only one (if any) representative of these disciplines practising at a time.



Figure 4: Occupational therapy staff at the Creative Workshop, Tokanui Hospital, 1995 (personal collection)



**Figure 5: Hydrotherapy pool with occupational therapy staff and me, 1995
(personal collection)**



**Figure 6: Seating and wheelchair staff and me, 1995
(personal collection)**

When the hospital closed in 1998 (after a lengthy period of transitioning people into community based services) occupational therapy was one of the only remaining allied health professions left at the hospital and was the only regulated allied health profession to have any dedicated operating facilities. Due to its professional capability and continuing presence, occupational therapy was very involved with the de-institutionalisation process and the corresponding emergence of services in the community (Midland Health, 1993). Now, twenty years later, the case studies in this research all had traces of this institutional past in the form of unspoken but strongly held practices.

Current unsaid practices.

When Tokanui Hospital closed the occupational therapy services provided at the hospital were transferred into the new model of healthcare delivery discussed in the previous chapter. The forensic occupational therapy service was transferred to the acute mental health services provided at the Waikato Hospital campus. The special school at Tokanui Hospital was closed and the children who attended it were transferred to similar schools in the community, and the wheelchair workshop and service was transferred to the Waikato Hospital occupational therapy department. The closure of Tokanui Hospital finally actualised the amalgamation of the Department of Health and Mental Hospital Department that had occurred back in 1947 for the region. The provision of occupational therapy in the case studies in this new institutional and social environment indicated the way historical extra-discursive and discursive practices remain in play. For all the case studies, the extra-discursive element of the physical environment was one of these historical practices.

To relocate the mental health services that were provided at Tokanui Hospital, new premises were built, including several wards dedicated to forensic mental healthcare, one of which was where the occupational therapists worked. The therapists had a dedicated occupational therapy space that was part of the new design of the building. In similar ways to the past, the therapists worked in this allocated space or on the wards, with anybody admitted who was well enough to engage with them.



Figure 7: Mental health ward, Waikato Hospital, 2016

The new geographic location of mental health services bridged the historical separation of mental health care and general medical care. The rural and isolated site of Tokanui Hospital, 40kms away from the Waikato Hospital, had kept the institution out of view of the public gaze. Now, it was part of the Waikato Hospital. However, despite the new location being in plain sight and part of the mainstream hospital, much of the care, including occupational therapy, remains out of view and separate from general health care provision.

The forensic occupational therapists practised in ways that echoed how therapists at Tokanui Hospital practised. There was a continued disconnection between forensic mental health care and general medical care through material practices that separated the service from both the public and other health care workers. The safety precautions required by the service meant there were locked doors, passkeys and authorisation to organise and obtain to enter and move within the buildings. As well as this a staff member needed to be present with any visiting person. The practical inconvenience of entry/exit and the requirement for certain staff ratios, encouraged wider health service communications and collaborations to occur predominantly via email. The occupational therapists seldom left the ward complex and their interactions were mainly with ward based colleagues and people admitted to the ward. These practices are not dis-similar to those of the self-contained Tokanui

Hospital where all services were provided on site. The physical environment had transferred historical practices into the new model of amalgamated health services.

The special school had also retained practices that were attached to the buildings and physical management of the facility that kept how they delivered education separate from public view and mainstream services. The school was built in 1965 and is sited in a suburban cul-de-sac. It is also a locked facility with passkeys required throughout the complex. Although the special school was located in the community in a much more visible position compared to the school at Tokanui Hospital, the occupational therapists' work remained separate from the general health and education services.



Figure 8: Special school, 2016
(personal collection)

Most of the students received their education and therapeutic input at the base school site or in separate satellite units sited in mainstream school campuses. The occupational therapists' work generally took place in these

separate classroom settings. As they were employed directly by the school, they worked only with students who were eligible to be enrolled at this one provider, limiting their engagement to the range of services provided for children with high and very high educational support needs. This professional silo was further strengthened by high level contractual arrangements between the Ministry of Education and Ministry of Health. If a student was entitled to receive occupational therapy from the special school, the student was not entitled to receive services from other publically funded occupational therapists. In practice this meant the school based occupational therapists were the primary occupational therapist for the student. Despite this responsibility they did not have access to medical notes and did not attend any routine meetings about the students with other services. The geographic location of the special school and its associated satellite units opened up possibilities of physical integration of health and education for the students with mainstream services. However other material practices kept integration difficult to achieve. The outcome was that the work the occupational therapists did remained contained at the special school, out of view of the mainstream healthcare and education systems.

In a different way the wheelchair service had also remained out of the public gaze despite also being re-located into Hamilton City. The service operated very like the wheelchair workshop had functioned at Tokanui Hospital except it had severed many ties with most other healthcare services. The service was located on an industrial street, alongside recycling depots, car dealers and plastic fabricators. The service revolved around a substantial workshop, where the wheelchairs and equipment were stored and the technicians worked. The location of the wheelchair service physically connected it with industrial provision rather than healthcare, breaking ties it had with both traditional health based services provided at a hospital⁵⁹ and with other providers of disability

⁵⁹ There is a large warehouse elsewhere in Hamilton where Enable New Zealand refurbishes, collects and stores publically funded equipment, including wheelchairs. There is also a large Disability Resource Centre in the city close to the Waikato Hospital that is the base for the private provision of equipment and the Needs Assessment service.

equipment⁶⁰. By geographically locating itself outside traditional spheres of health or disability related work sites, the wheelchair service was using the extra-discursive element of geography to forge new networks and regimes of practice that built on the way the therapists' work mainly took place at people's houses, schools or other community based facilities rather than at clinics or hospital based sites.



Figure 9: Wheelchair service, 2017
(personal collection)

The physical location of the services provided by the case studies is an extra-discursive element that has supported the way that these occupational therapy services have remained generally out of the public view and separate from mainstream healthcare and education provision. Despite the re-location of

⁶⁰ The hospital based wheelchair service was closed when the contract for complex wheelchairs and seating was tendered out to the private sector. Elsewhere in the country the large non-government providers Enable New Zealand and Accessable won this tender and provide the equivalent wheelchair and seating outreach services. Both of these organisations have national contracts and deliver a large range of services, not just wheelchairs.

these services to the community rather than as part of an institution, they remained separate from mainstream public services through historical regimes of practice. Both discursive and extra-discursive historical practices seen in the case studies ensured the sovereign power the therapists were delegated with was exercised generally out of view and part of different power relations than of those in the mainstream public service. These alternate power relations have formed outside dominant regimes of knowledge and open up possibilities and opportunities for occupational therapists to take up different subject positions in relation to dominant discourse. Sovereign power enters these regimes of practice at many levels, including policy and rights based legislation and at the street-level. Occupational therapy in the case studies operated at this street-level and these practices are explored in the next chapter. This chapter continues the line of inquiry into unsaid practice. As well as the significant extra-discursive element of geography there were other practices that could be traced through the case studies that support what Sunderland et al. (2009) call a silent discourse. These historical discursive practices were also largely unspoken and were identified by absence rather than presence in practices related to Tokanui Hospital and the case studies.

Archival Silencing

While medical history is a growing discipline, a very limited number of formal histories about large institutions like Tokanui Hospital are available. The two published histories of Tokanui Hospital (Coleborne & Waikato Mental Health History Group, 2012; McLaren, 1997)⁶¹ while extraordinarily useful, both have large gaps where entire services are not mentioned or periods of time have not been accounted for. These historical accounts offer a version of history where many practices remain unrecorded. What does remain becomes how these institutions are remembered and thought about. In perhaps a more stark

⁶¹ Coleborne and the Waikato Mental Health History Group published a collection of memoirs, personal reflections and academic analysis of mental health services in the region over the period 1910-2012. McLaren has self-published a historical chronological record of major events that occurred at Tokanui Hospital until its closure. These records were principally extracted from accounting and meeting minutes of administrative records.

example, in the substantial commissioned historical account of Waikato Hospital's development (Armstrong, 2009)⁶², Tokanui Hospital is seldom mentioned despite it being a much larger institution than Waikato Hospital, and falling under its financial jurisdiction from 1955 after the amalgamation of mental health care with the general department of health (McLaren, 1997). What was visible was mainstream general and medical based hospital provision. The way these general archives only record certain information is a silencing practice that collaborates with other silencing practices to produce silent discourses. This silencing is not intentional but is reproduced by the fact that if the historical records and archives examined by historians do not mention something it is not there to be noted. The absence of Tokanui Hospital and by default, services like occupational therapy which were provided there, in historical archives collaborates with the way there is also a marked absence in the general public consciousness of certain sectors of the social body. The absence of some people and some services in public consciousness is another collaborative silencing practice, and is how material realities of others are not registered or known to others despite being right at the surface of everyday life.

In relation to the formal archival material that has recorded the history of Tokanui Hospital there was a layer of silencing within the silenced. In individual oral recollections and memoirs collected from twenty-one staff who had worked at the hospital, the hundreds of intellectually and physically disabled people, who by the 1980s were the majority of those who lived there, were seldom recalled (Coleborne & Waikato Mental Health History Group, 2012). The recollections generally focussed on people with mental illness and the services that developed to provide this part of the institution's care. A similar absence also occurred in relation to occupational therapy, despite it being a highly visible service that was involved with all aspects of healthcare at the hospital, it was also seldom remembered. What was rendered visible then becomes associated with what Tokanui Hospital provided, further silencing what was not recorded.

⁶² The history was the result of an oral history project and examination of administrative records such as Hospital Board meeting minutes, annual reports, financial accounts and communications related to implementing policy.

These specific examples are localised to Tokanui Hospital but there is evidence of this form of archival silencing occurring outside this institutional history in relation to the case studies in the research, carrying on this form of collaborative silencing.

There are no public documents available that record the history of the special school or the wheelchair service. They are noticeably absent in the historical archives that do exist. For example, although the special school was opened in 1965 (Tantau, 9 December 2015), in a 1977 list of all the Hamilton schools it is not included (Gibbons, 1977). This oversight continues in the current era as the same list has been re-published on the Heritage Hamilton website as an archival record of past school life in the city (Hamilton City Council, 2011). The only education visible in the archive is mainstream education. The wheelchair service provides a different example of archival silencing. It is an example of how the hundreds of people who use a service are overlooked, along with a service itself, in formal and grey archival documents.

The Tokanui Hospital based wheelchair service was one of the first of its kind in Aotearoa New Zealand, established by occupational therapists in the 1980s. It provided specialised custom wheelchair solutions for the residents of Tokanui Hospital as well as for the Waikato and Bay of Plenty regions, in much the same way as the wheelchair service in this research does. As the requirement to move people out of Tokanui Hospital permanently became more pressing, the workshop became a central resource, instrumental in how fast people could leave the hospital⁶³.

⁶³ Some residents at the hospital did not have their own wheelchairs until they moved into the community.



Figure 10: Doniella, in a wheelchair fabricated at Tokanui Hospital.

Permission received to publish photo 15/11/2017, (personal collection)⁶⁴

Despite this pivotal position, the service was never mentioned in the plans for how the de-institutionalising process would occur (Midland Health, 1996; Ministry of Health, 1993a, 1993b). Where it is mentioned is in an analysis of costing for this process (Price Waterhouse, 1994). The materiality of how people at Tokanui Hospital received services and what this entailed was absent in the main official reporting, silencing this aspect of healthcare provision. Other regimes of knowledge become dominant because of this absence, with the knowledge of material healthcare provision subjugated in the process. The strong connection occupational therapy has with material practices and materiality bundles it up with this subjugation. Similar archival silencing continues for occupational therapy in the current era.

Occupational therapy is often omitted from public documents and remains generally absent in medical and health related archives. For example, in a 2011 Ministry of Health rehabilitation workforce planning document the

⁶⁴ Doniella was a personal friend until she passed away in January 2013 aged 26. Her parents expressly asked for her face to not be anonymised as they felt she would have loved to have been visible in any research I was carrying out.

workforce is described as “nurses and allied health professionals (including physiotherapist, chiropractors, and osteopaths)...”(Health Workforce New Zealand, 2011, p. 5); and in the more recent Care Closer to Home information booklet, occupational therapists were similarly omitted in the list of who provides this care, “doctors, nurses, midwives, pharmacists, physiotherapists and other health professionals working in our community...”(Ministry of Health, 2014a, p. 1). This type of omission does not exist just in health related grey documents. In a Ministry of Education publication describing special education services occupational therapy is not mentioned “the Ministry of Education employs around 800 full-time equivalent specialist staff with a wide range of expertise, including psychologists, speech-language therapists, advisors on deaf children and early intervention teachers (Ministry of Education, 2014, p. 17). Another government example, Te Ara, the online encyclopaedia of Aotearoa New Zealand exemplifies how this public sector absence spreads into general public consciousness. When describing who is considered to be a health practitioner, eleven other professions were chosen as examples over occupational therapy: “Historically, health practitioners included doctors, nurses and pharmacists. By the 2000s the practitioner list included midwives, radiographers, psychologists, dietitians, and speech and language therapists, as well as alternative practitioners like chiropractors, osteopaths and medical herbalists” (Kirkman, 2012, p. 1). As well as these government generated documents, academic publications also overlook occupational therapy in the same way. For example when discussing funding streams for special education services, McMenemy (2008) writes of “a cash component to fund support from specialist therapists such as speech language therapists, physiotherapists and sign language interpreters” (p. 186).

The connections between these formal and informal archival absences and the way the services studied in this research remain positioned outside mainstream services indicate that silent discourses continue to operate in ways that enable productive collaborations of silencing practices. These silencing practices subjugate knowledge and awareness about what is silenced. The power

relations involved with this subjugation are particularly relevant to occupational therapy due to its subordinate status within the health professions. The absence of occupational therapy, along with many other things, in historical archives such as those recounted above, has enabled this form of silencing practice to travel to the operational level of the grey archives, further strengthening the silent discourse.

The grey archives.

In the recent report 'Demographic Information of Clients Using the Ministry of Health's Disability Support Services' the demographic data excludes nearly double the figure of 33,804 used for the analysis, making the information a poor representation of the population:

In addition there were 63,856 disabled people allocated equipment and modification services [EMS]. It is important to note that Client data for EMS are obtained from the two providers of these services and do not include the level of detail available from the Ministry's Socrates information system. For this reason, overall Client demographics referred to in this report exclude EMS Clients (Ministry of Health, 2017a, p. xii).

By excluding these people and not specifying who, how many or what happens for this group of people, they fall into a gap of silence. As the principal audience of the report is "the staff and managers of DSS who are involved in developing and implementing strategic and annual plans for the procurement of services" (p. 1), the absence of this large group of people has consequences for the funding and operation of services. Occupational therapists such as those in the case studies are particularly essential for the equipment and modification service, being the only health profession who can become a credentialed assessor in seven of the eight processes that provide these services (Enable New Zealand, 2014a). Along with the lives of the people who are absent in this grey archive occupational therapists and other staff who work to provide the EMS services are also absent. This is presumably not intentional but has combined and strengthened certain practices and regimes of knowledge over others by rendering only some types of healthcare visible. In the case studies there were

also other ways that operational practices based on dominant regimes of knowledge were silencing occupational therapy. These silencing practices involved the changes in service delivery models where generic health pathways and contracted service agreements have become dominant methods of managing public service provision.

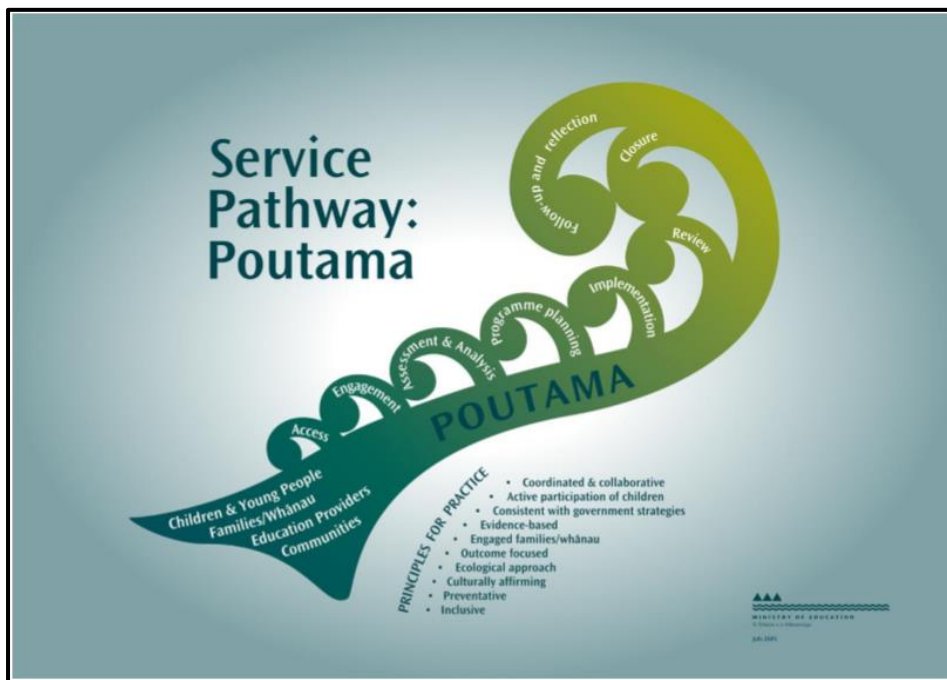
Generic Silencing

Practising as part of a generic pathway of service delivery was the norm for all the occupational therapists. This was a different silencing practice to being out of view or absent in the archives, but had a similar effect of subjugating occupational therapy knowledge. The therapists were all functioning as assessors, providers or specialists as part of generic pathways of care in ways that operationalised higher level policies. Occupational therapy was absorbed into service wide practices that met contractual expectations based on the pathways. Although the different pathways all had different objectives they all had a similar effect of making certain practices more visible than others. All three of the workplaces provided examples of how this occurred in public education, public health and the community sector.

In the education sector the Ministry of Education uses the title specialist to encompass fourteen different professional groups (Ministry of Education, 2012, 2014)⁶⁵ and refers to this group in policy documents as a generic group. For example when explaining the Ongoing Resource Scheme (ORS) for high and very high need students, the Ministry states “children and young people receiving ORS funding have access to additional teacher time, specialists, teacher’s aide support and a small grant to cover necessary costs” (Ministry of Education, 2014, p. 21). The Ministry of Education has produced Specialist Service Standards that guide the practice of these professionals (Ministry of

⁶⁵ These are: physiotherapist, occupational therapist, speech language therapist, educational psychologist, Maori or cultural adviser, conductor in conductive education programme, orientation and mobility instructor, special education advisor, sign language interpreter, teacher with additional tertiary qualifications in learning, vision or hearing, music therapist (registered), early intervention teacher, Pasifika advisors, and advisor on deaf children.

Education, 2013). By referring to many professions as generic specialists, the array of knowledge that is not part of the generic pathway is subjugated. The Specialist Service Standards provide an example of how this generic subjugation occurs in practice. The standards are written for all specialists and describe what their work should entail. The standards are twenty-five pages long and specify how specialist services should be delivered as part of the Poutama pathway.



**Figure 11: Education Pathway
(Ministry of Education, 2015b)**

The pathway is very detailed and prescriptive. For example, under the Implementation standard how “specialists support the planning of a child or young person’s individual programme across settings” is detailed in sixteen descriptors. The first eight listed below are indicative of the level of detail in the standards. Planning for students by specialists:

- will be developed through shared planning processes e.g. IEP, IP
- evolves out of the assessment and analysis and is referenced to the NZ Curriculum or Te Marautanga o Aotearoa for school students and Te Whāriki for children in early childhood
- values and expresses family and whānau and/or the child or young person’s priorities
- supports culturally appropriate and affirming practice

- is based on a strengths-based framework and is underpinned by evidence-based practice
- identifies intended outcomes that are specific, measurable, achievable, relevant and reviewed six monthly (or more frequently if required)
- identifies realistic resources needed to support the programme
- identifies short and long term goals that take into account the child or young person's age, interests, learning dispositions and the family and whānau's aspirations (Ministry of Education, 2015b, p. 15)

The service standards are written for an educational context and have educational concepts, understandings and pedagogy throughout them. These standards were also supported by the schools policies and procedures. One of these policies involves the way Individual Education Plans (IEPs) were utilised at the school. IEP's absorbed occupational therapy into generic educational practice in a way that collaborated with the generic pathway and use of the title Specialist.

IEP's have been a long standing and integral component of special education practice in Aotearoa New Zealand (and throughout the world) since the 1970s (Mitchell, Morton, & Hornby, 2010). The IEP is a primary guide of each student's school day and required the occupational therapists to re-frame their work into goals and plans that aligned with the New Zealand curriculum. To guide this re-framing process the therapists utilised a manual, called the key competency pathway. The manual provided examples of how to fit individual goals into curriculum based competencies (King, 2014). They also were required to produce a formal published learning record, (which was generally a photo with narrative) of their interventions each school term for the students' school portfolios. The standards, national curriculum, IEPs and the learning records are all educational practices that were implicit in the generic pathway and had a significant influence on how the occupational therapists carried out their day to day work. There were many parts of their work that did not easily fit into these practices and remained unspoken. These often related to materiality and occupational therapy knowledge such as adapting occupations, organising equipment, making therapeutic aids and modifying environments.

Occupational therapy was also hidden in a similar way in the generic pathway used in the forensic service.



Figure 12: Forensic Client Pathway
Waikato District Health Board (2017) unpublished document

The forensic client pathway supports a higher level “Mental health and addictions integrated care pathway policy” (Waikato District Health Board, 2015b)⁶⁶. This policy is an eleven step process that is to be followed for all people referred to the variety of services under the umbrella of Mental Health and Addictions services. Occupational therapists are absorbed into this generic policy and in the simplified forensic pathway above. There is no reference to different occupational groups within the pathway, rather health-workers are referred to as the multi-disciplinary team, key workers, or circle of care members (Waikato District Health Board, 2015b). The multi-disciplinary team approach is described in very broad terms such as “there are systems to ensure that service

⁶⁶ The Waikato District Health Board has altered its strategic plan for mental health in 2016 which may mean this integrated policy has changed also. However this was the policy the occupational therapists were working under at the time of the observations.

users are assessed and managed by a multi-disciplinary team” and “multi-disciplinary team working enables the provision of a wide range of speciality inputs and resources...”(Waikato District Health Board, 2015b, p. 17). These services and the model of care to be provided is described in an expansive cover-all way as “person-centred, culturally responsive, recovery focussed, bio-psycho-social-family whānau inclusive” (Waikato District Health Board, 2015b, pp. 2,4,5,9,18). The generic silencing that is occurring in the pathway is incongruent with the discursive practices that were observed.

In practice there were highly visible distinctions between professions that involved hierarchies of both medical and legal professions. Medical doctors and lawyers were dominant and privileged professions. The facilitation of attendance to lawyers’ appointments, appearing in court, medical reviews, and mental state examinations were always prioritised daily activities on the ward. Alongside these medico-legal discursive practices, the nursing based practices of acute mental health care such as constant one-to-one observations, escorting people to leave the ward, physically secluding people from others, administering medication, supporting visitors and facilitating meals and personal care also involved significant material commitments of staff, space and time. Occupational therapy was also a distinctly visible profession in the ward. The physical presence of its separate buildings and the number of therapists employed on the ward made it noticeable in comparison to the shared spaces and numbers of other specialty professions. The historical practices of medical control of people through application of the law remained highly dominant in ways reminiscent of how Tokanui Hospital was able to function under the Mental Defectives Act (1911). The way the occupational therapists practised was also reminiscent of how occupational therapy was delivered at the hospital, in separate buildings and for anyone well enough.

The complex inter-relations between mental health workers and the power relations involved with the medical profession and judiciary were not acknowledged in the generic pathway. What was present is a generic application of mental health practice that silences the complexity and dominance of other

practices in this setting. The absence of these significant contributors to the power relations within forensic services supports silent discourses surrounding how people in acute mental health services receive services. Due to the material practices involved with safety and staffing ratios often the service observed in the case studies resulted in direct material outcomes for the occupational therapists and what they were planning to do. The material outcomes of the dominant, but silent, power relations is an unspoken discourse that is supported through the practice of using generic pathways of care⁶⁷.

There were also many unspoken practices in the wheelchair service that were subjugated by generic processes. The occupational therapists' practice was very connected with national processes for funding expensive equipment and environmental modifications through the Ministry of Health and the ACC. Both of these funders rely on generic Assessors, who can be occupational therapists, physiotherapists, speech language therapists, optometrists, ophthalmologists, audiologists and specialised deaf and vision impairment service co-ordinators (Enable New Zealand, 2014b). In order to prescribe complex, expensive equipment and environmental modifications, the health professionals must become credentialed in speciality areas through a centralised system provided by a company named Enable New Zealand. To become credentialed, specific training and practice based evidence of competence must be provided. Occupational therapists are able to become credentialed assessors of seven of the eight speciality areas (the exception being hearing assistive technology). Speech language therapists and physiotherapists are able to be credentialed in two, and specialised hearing assessors in one (Enable New Zealand, 2014a). In this way occupational therapy is the main gatekeeper of funding for expensive equipment and environmental modifications. To manage the budgets that assessors can access there have recently been major changes in the processes that occupational therapists have to follow. One of the main changes was the

⁶⁷ This silent discourse has been recently been made visible through extensive media coverage about a man, Ashley Peacock, who has been held in virtual seclusion for over five years because an appropriate pathway of care could not be sourced or provided for him. See http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11823161

introduction of the generic Prioritisation Tool that assessors must administer (Ministry of Health, 2015b).

Service Type	Required	Not Required
Equipment		
▪ Ministry of Health List Equipment (Band 1 Equipment)		✓
▪ All complex equipment not on the Ministry List (Bands 2 & 3, including refurbished items and equipment to be trialed)	✓	
▪ Like for Like replacement equipment		✓
▪ Accessories and modifications to equipment if likely to cost less than \$1,000 (excluding GST)		✓
▪ Accessories and modifications to equipment if likely to cost more than \$1,000 (excluding GST)	✓	
▪ Equipment requested through the Service Accreditation process		✓
▪ Spectacles requested through Vision Assistive Technology	✓	
▪ Spectacles claimed through Children's Spectacle Subsidy		✓
▪ White mobility canes (available through the Blind Foundation)		✓
▪ Artificial Larynges requested through Communication Assistive Technology		✓
▪ Hearing Aids (provided through the Hearing Aid Funding Scheme and Hearing Aid Subsidy Scheme)		✓
Housing Modifications		
▪ Basic housing modifications	✓	
▪ Complex housing modifications	✓	
Vehicle Purchase and Modifications		
▪ Assessment for consideration of vehicle modifications or purchase		✓
▪ Vehicle Purchase & Modifications	✓	
Equipment and Modification Services for people eligible for funding through Long Term Supports Chronic Health Conditions		
▪ All services 'Required' as outlined above	✓	

Note - Items can be grouped within the same Service Request when they meet all of the following requirements:

- a "package" designed to meet the person's specific needs, and
- they are available within the same category of accreditation, and
- the items are within the credentialed level that the EMS Assessor holds.

An equipment package covers all components of the solution, ie, the same category of accreditation, which, when combined, forms one solution to meet the person's specific needs, for example:

- a standard manual wheelchair, tray, seat cushion and backrest (Wheeled Mobility and Postural Management, Level 1)
- a power wheelchair with alternative controller and seating system (Wheeled Mobility and Postural Management, Level 2)
- a bed, mattress and bedrails (Personal Care)
- a communication device, mounting system, switch and specialist software or application (Communication Assistive Technology, Level 1 or Level 2).

1 | EMS Prioritisation Tool - When to Use the Prioritisation Tool - September 2014

Figure 13: The Prioritisation Tool
(Ministry of Health, 2015b)

The Prioritisation Tool is a computer programme that is part of a pathway which an assessor must follow to prescribe equipment. The pathway decides who is eligible for funding, what equipment can be prescribed and how it is going to be provided⁶⁸. Anything outside this pathway is not relevant for funding purposes. The assessor becomes a generic component in this process, regardless of what they do to get the information or how they have to problem-solve in order to provide the equipment or environmental modifications. The unspoken practices and knowledge required as part of being an assessor become subjugated. The generic pathway makes visible certain practices and valued

⁶⁸ Equipment can be reissued from centralised stores, ordered and delivered direct from a supplier or trialed to see if it is suitable.

regimes of knowledge that position much of occupational therapy's knowledge as part of a silent discourse.

In all of these examples the occupational therapists are positioned within generic pathways in ways that leave much of their work unsaid and unrecognised. The widespread silencing of occupational therapy through these varied grey archival documents is a collaborative silencing practice. Due to the range of archives, the reach of this silencing involves the perceptions of the public, policy makers and other health, education and social service workers. The subjectification attached to being historically subjugated in this way, where what the profession does is right on the surface but largely missing in formal archives, provides clues to what power relations support the underground nature of the profession. The historical tracing in this research suggests that occupational therapy contributes to and is affected by silent discourses that are heterogeneous, supported by discursive and extra-discursive practices. By remaining on the ground in this research, the strong historical regime of underground practice that remained in the case studies indicates that a productive use of power was at play. The common thread in the genealogical analysis that indicated a productive use of power was that of the materiality of occupational therapy practice. To understand how the materiality of practice provided an alternate line of power for occupational therapists, the doing of the therapists was examined through a Foucauldian lens of analysing what this doing does as both an instrument and product of discourse.

Summary

The historical regimes of practice that have been traced back to Tokanui Hospital from the case studies show how a combination of discursive and extra-discursive elements have supported occupational therapy's position of invisibility in the general public consciousness and low status within the health professions. The elements are generally unspoken as they involve the buildings, geography, generalized public histories, grey documents and political strategies that are largely operational. These silencing practices are collaborative with other practices such as the way statistics are presented, the widespread use of generic

pathways of care and the lack of acknowledgements of material practices and knowledge that is utilised to provide services. By silencing a large component of what occupational therapists do in this way, knowledge that is attached to this doing is subjugated. The history of Tokanui Hospital and how practices from its past have continued in the current era provide a historical trajectory that gives some insight into how occupational therapy has remained generally an underground practice.

Chapter 8: Materiality and Power

Materiality is a distinctive feature of Michel Foucault's work. As discussed in relation to methodology in chapter two, Foucault maintained a focus on material practices and the heterogeneity of power relations to move his work beyond linguistics and representation, allowing other forms of power to be incorporated into an analytical method (Hook, 2001). In his influential text *Birth of the clinic: An archaeology of medical perception* (1963/1975), clinics, hospitals, medical practice and the subjectivities of medical practitioners and those receiving health care were traced along with the way the physical spaces and environments of healthcare changed. Likewise in *Discipline and punish: The birth of the prison* (1975/1995), the evolution of the penal system was closely linked to the progression of equipment, buildings and architectural designs of facilities which were used to cement certain practices and regimes of knowledge in relation to how criminal or illegal behaviour was viewed. For occupational therapists, similar facets of materiality are part of their work. Materiality is an integral part of their practice, but unlike prisons and medical clinics often the equipment, buildings and environmental elements occupational therapists work with are not as extraordinary or obvious as scaffolds, prison cells, hospital gowns or medical charts. Occupational therapy's proximity is instead to ordinary material things which are part of the mundanity of everyday life. The things needed for cooking, eating, washing, using a toilet or sleeping are generally used out of public view and are not exclusive tools of occupational therapists.

When observing the occupational therapists work the involvement with materiality was a common thread between all three workplaces. The therapists spent a lot of time accommodating and utilising wheelchairs, houses, school buildings, cutlery, toilets, vehicles, cell-phones, clothing, computers, toys, cooking ingredients, screwdrivers, measuring tapes and filing systems, to name a few. These objects, machines and technology were invariably part of their daily practice and even though they did not mark occupational therapy like other material objects do for other professions (for example a stethoscope marks the medical profession, a fob watch the nursing profession and tape or strapping is

associated with physiotherapy), they still influenced practice through power relations. The way materiality is an important shaping force in the profession is an historically contingent element and could be seen from the early accounts of occupational therapy.

Memoirs of occupational therapists who practised in the early days of the profession often included detailed, even trivial, accounts about the material world. These suggest that these events had been significant and memorable. Judith Miller recalled the type of vehicle and the events of driving that were part of her everyday practice:

My work involved taking activities to patients to help re-establish them in their own homes. To achieve this, a former fire-engine had been converted into a regular vehicle for getting round to the patients. At one time, the back wheels of the fire engine got stuck in the gutter and no amount of revving would free them, 1960s Christchurch, New Zealand (Gordon et al., 2009, p. 208).

In another example from the same era Sunny Bowmar recalled the exact way she had designed a piece of equipment from every day materials

...to overcome the lack of a safe, functional chair to transport non-mobile children to school, I designed a Heath-Robinson style prototype chair. Using a pushchair frame and flex-a-form insert as a seat it could be collapsed and stowed in a car boot. 1950-60s Auckland, New Zealand Gordon et al. (2009, p. 148).

And in one of the large mental health institutions small details of the material environment had remained in Joyce Duncan's memories:

Upstairs was clean and bright with flowers. Proper cups of tea were served and we had a biscuit ration. In the relative peace of this area, the patients pursued their chosen crafts, played hostess, used scissors and knives... It was a joy to see them responding to the organised environment but discouraging to see them revert to madness once they

returned downstairs. 1940s, Porirua Asylum, Wellington, New Zealand (Gordon et al., 2009, p. 55).

Reminiscence like the above reflect the way materiality has been a central part of practice since the profession was introduced. This is not surprising considering that the use of therapeutic occupation was a core component of the education of undergraduates at this time. The skills and knowledge of how to use the material world to provide occupational therapy was a clear formal expectation in the education of occupational therapists until the current occupational therapy schools were opened in 1991. As part of the curriculum, therapists were required to master how to do crafts such as weaving, pottery, woodwork and leatherwork, art techniques and how to make or install basic adaptive devices such as bath boards, rails and orthotic splints (Gordon et al., 2009; Hocking, 2004; Skilton, 1981). Since the 1990s the emphasis on knowing how to do crafts, arts and other therapeutic occupations has shifted, replaced with a much greater focus on the use of everyday occupations and ordinary environments as therapeutic tools as opposed to providing specialised therapeutic activities. In this shift the association of occupational therapy with crafts and arts changed to a silent association with much less visible forms of materiality. The Competencies for Registration also had a changed emphasis on the materiality of occupational therapy that reflected these educational changes and the introduction of different regimes of knowledge into occupational therapy practice.

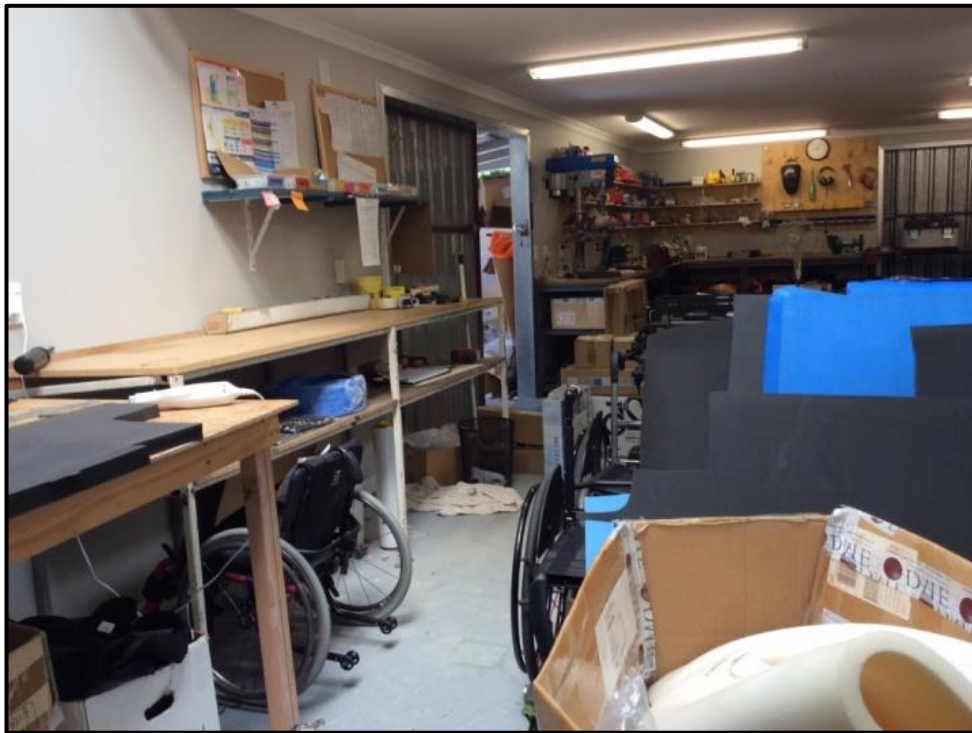
In the first two Competencies for Registration documents, (1990 and 1995), materiality remained visible in core skills, with several competencies expectations referring to use of material objects, environments and the use of specific therapeutic activities⁶⁹. In 2000 the frequency of these references declined and by the current fourth version only one statement remains that directly refers to the material world as part of practice. The one statement that consistently remained the same throughout all the four versions was the

⁶⁹ Such as having “competence in a range of treatment media” (1.5, 1990; 1.6, 1995) and having the skills and knowledge to prescribe equipment for rehabilitation or adaptive functioning (1.8, 1990; 1.9, 1995; 1.16, 2000); and “prescribe and use practical methods, skills and art (for example transferring, expressive art)...”(1.9, 1995).

expectation for therapists to know how to adapt, change or modify occupations or environments (Occupational Therapy Board of New Zealand, 1.8, 1990; 1.9, 1995; 1.15 2000; 1.11, 2015). The decreasing acknowledgement of the materiality of occupational therapy in the Competencies and the occupational therapy schools' curriculums made room for other knowledge to assume a more visible position in occupational therapy. In doing this the recognition of the regimes of knowledge that involve the material world has been subjugated. The actual doing of occupational therapists mirrored this subjugated position. Although the enterprising and legal requirements of each workplace were dominant discursive practices, the materiality of the occupational therapists' practice had remained an influential element in the way the occupational therapists role had been negotiated in their working environments. The largely unspoken element of materiality in occupational therapy has remained a strong discursive practice within the silent discourses often associated with occupational therapy. In the case studies the way these power relations were operating at the street-level could be seen in the everyday mundane doing of the occupational therapists.

Everyday Materiality

All the therapists spent large portions of their week making, organising or accommodating the material world in some way. The wheelchair therapists spent significant amounts of time tinkering, researching, and trying out wheelchairs and associated equipment. The therapists spent a lot of time down in the workshop cutting, gluing, and modifying cushions, wheelchairs and various accessories. This sort of individualised tinkering also occurred during a therapist's community visits. They ensured they always had a toolbox so they could make adjustments to the wheelchairs if required. The therapists needed to know the minute details about different products. This included the numerous makes and models of wheelchairs and the features of these, the compatibility between products, the possibilities for adaption of products, and quality/longevity of products. It included details about such things as particular brackets, tube widths, wheelchair heights, and tyre inner tube specifications.



**Figure 14: Wheelchair service workshop, 2016
(personal collection)**

The therapists spent considerable time discussing products and technical options with suppliers on the telephone. They also prioritised any visits by sales representatives from the suppliers and attending demonstrations of new equipment. It was not enough simply to order a wheelchair and have it sent to someone. The therapists needed to know and learn many skills and how to apply these in material ways in order to do their job.

In a similar way the therapists at the school spent a lot of time making highly specific, individualised visual aids to assist with communication. These aids required specific visual images which were located on the internet or from specific software, manipulating these images through publishing programmes, printing them out, laminating them and then making an accessory to hold or fasten the visual image to. As well as this, the therapists often made these aids so one could be used at home and one at school, necessitating different pictures and sequences to reflect the different visual environments the students were located in. These small pieces of laminated paper were then required to be

handy and accessible when the student needed them (e.g. having a drink card available when thirsty, having a tooth-brushing sequence visible when brushing teeth), requiring further problem solving and adaption of the material world. These visual aids had become a standard practice used throughout the school and spending substantial amounts of time making them was a highly legitimate and established part of an occupational therapist's role.

In a quite different setting, but still involving high levels of materiality, the forensic occupational therapists also spent significant amounts of time modifying and accommodating the material world. Their interventions were highly specified by safety and risk assessment policies. The legal rules included which tools or equipment someone was able to use, what type of activity they were permitted to take part in and in what sort of social situation. For example, when cooking with someone who was assessed at a high level of risk, the therapists could not use any sharp utensils and needed to work in a 2:1 staffing ratio. To meet these requirements the occupational therapists would spend considerable time cutting and pre-preparing ingredients so the person could still cook what they had chosen. The second therapist would ensure they had something legitimate to do in the near vicinity so they did not appear to be another scrutinising presence. Spending time doing these acts was highly legitimate and accepted practice; it was what occupational therapists do. A cooking session could last from 30-90 minutes due to the materiality of preparation, cooking, eating and clean up time.

The examples described above all involve practices that are not related to the rules of enterprise, the law or science. The skills and knowledge required to provide occupational therapy were based on materially influenced factors. These skills were right on the surface of everyday practice and each workplace sanctioned them and supported the therapists' role in doing them. Occupational therapy was attached to roles in the health and education services that positioned it in a similar way to the past. Despite other dominant discourses in the profession and the workplaces, the need to accommodate the material world

remained a significant requirement and was able to compete with these discourses.

Materiality and the Discursive

The influence that materiality has in how occupational therapy is perceived by others and in shaping discursive practice indicates a different set of power relations following different rules. The regime of knowledge that forms these rules bypasses other regimes of knowledge. For example, when a child's electric powered wheelchair broke down at school one day, the therapist immediately organised to take out a replacement wheelchair despite having many other tasks already planned for that afternoon. Electric wheelchairs are heavy, cumbersome, and difficult to transport. They need specialised tools and knowledge to repair. Because of these factors it was impossible for school staff or carers to resolve the problem of the broken down wheelchair. The wheelchair service was not funded to do repairs or maintenance on wheelchairs, another service was. However the therapist knew she could immediately accommodate the problem as she had a spare wheelchair sitting in the office. As it was a Friday afternoon there were serious implications for the student as they could potentially not have any mobility for the weekend. The rules of formation for the therapist's practice were being shaped by the material necessity of providing a wheelchair rather than the rules of her employer and the service contracts between providers. It was acceptable for her to do this due to unspoken understandings about the complexity of repairing wheelchairs and the importance they have for the individual who uses them. Material necessity was able to over-ride other lines of power and in doing so, offered a different subjectivity to the therapist that altered the configuration of power relations among those involved in the situation. In this situation the material outcomes for the child were highly dependent on the way the therapists exercised and negotiated the interplay between their delegated sovereign power and economic-governmental rationalities. They used their street-level bureaucratic power in a way that had an immediate material effect. This example illustrates how power relations operate at the micro-level. In the case studies these micro-level events had

collectively produced competing and productive lines of power principally through the way materiality was such a strong discursive practice of occupational therapy.

Materiality at the micro-level.

As already discussed, the wheelchair service emerged after the closure of Tokanui Hospital and the resultant contracting out of wheelchair and seating services by the public health system. Initially the service started out as a business partnership with advocacy organisation, CCS Disability Action. Since then the service has developed an influential position with the two main funders of healthcare, the Ministry of Health and the ACC, providing a regional wheelchair service (with worksites in three cities) and holding a national contract to provide ongoing credentialing and training for wheelchair therapists throughout the country. The connections between the wheelchair service, wheelchair users, funding agencies, and rights based advocacy groups occurred through a common ground of the material provision of wheelchairs. The materiality of wheelchairs and the material practices wheelchairs engender have been a significant extra-discursive element in the informal network developing. Wheelchairs have hugely liberating potential but at the same time have become complex machines. They are able to realise many basic human rights and objectives of government policy but this ability is completely dependent on services such as the one the therapists worked in. The dependency on material knowledge has produced opportunities for the wheelchair service to alter the trajectory of the lines of power formed through enterprising forces that discipline the way contracted services operate. The power of materiality has also enabled the wheelchair service to influence politically decided judgements of what is an acceptable life for people who use wheelchairs.

The wheelchair service has done this by influencing how public funding is distributed and how wheelchair therapists practise. Through its position as the national educator of how to assess and provide wheelchairs, the service has formed a competing network to the networks of enterprise and sovereign power that decided who should get what and how this should happen. Due to its

expertise and the way it has spread over several funding jurisdictions, the service negotiates its contracts directly with the Ministry of Health and ACC rather than through the local health funder, the Waikato District Health Board. The wheelchair service has assumed a new subject position that enhances its powers to negotiate. This position has enabled it to influence how these two funders budget and decide what public monies are spent on providing wheelchairs. Recently the service has been able to attract funding for a 'non-essential' wheelchair skills training service. This type of service has never been available for people using wheelchairs before, and in the current fiscal climate non-essential services such as this tend to be reduced rather than increased. The wheelchair skills training courses support wheelchair users of all ages to master the material agency of a wheelchair, allowing them much greater mobility and physical freedom. They are locally run by people who use wheelchairs with the intention of providing mentorship and social connection. Obtaining the funding for this service to be part of essential public funding has introduced a new norm in how disability support services are budgeted for and what is considered acceptable as a material outcome for the people using the wheelchairs. The materiality of wheelchair therapy enabled a form of power and subject positioning that could contest other dominant regimes of knowledge, altering the interplay between the therapists' sovereign power and economic-governmental power. The material regime of knowledge had enabled a possibility for change in life outcomes for the wheelchair user.

The school therapists had also used their material knowledge to create possibilities for change in life outcomes in ways that contested sovereign and economic-governmental power relations. They had established an informal collaborative network with other community based services. The network had formed in response to material needs rather than through sanctioned pathways of the health or education systems and included accommodation providers, non-government organisations such as Autism NZ and private early childhood centres, contracted services such as psychologists, and supported employment providers. The network had developed into a specialised local culture of how to

support and care for children and young people who have complex disabilities. The culture was not institution based, but rather had organically emerged since the closure of Tokanui Hospital. After the hospital closed, the material services required to support people with complex disabilities have been re-configured in the community. Over time the people responsible for providing the services have developed a shared knowledge of how to do this.

The sharing of knowledge was through highly localised connections at the micro-level. The connections occurred through staff members at the school working for other community based services in the school holidays and weekends, and through the broad range of educational support the school provided. The multiple types of education (i.e. satellite units, a base school site, and transition to mainstream school attendance and into employment) had developed an array of contacts with other providers who worked with people with complex disabilities. Meeting the highly individualised material requirements for the students necessitated the sharing of ideas and resources amongst these organisations and often involved occupational therapy. For example one of the students needed a customised item of clothing to wear at school. The occupational therapists knew this customisation needed to be highly specific otherwise it would not do what was required. The student lived with an accommodation provider who also had to solve the same material problem at the student's home. The therapists knew exactly who had modified the student's clothes at home as they also worked at the school. They were able to ask what they had to do, how they would do it, and where to get the appropriate fabric. They were able to borrow the home item to ensure they were replicating it exactly. Locating a person who could actually do the sewing was also achieved in the network that had formed around one student. The materiality of providing this piece of clothing was linking the school, the occupational therapists, the accommodation staff and the student. It was normalised to collaborate, borrow and share knowledge and resources. These normalised practices were part of an alternate discourse where the regime of knowledge was connected to materiality and the material world rather than hierarchies of human science or service

contracts. Similar practices also occurred that connected the occupational therapists to networks between homes, workplaces, holiday programmes, respite care situations and mobility taxis. These practices often involved extensive collaborations to support such things as access to buildings and space, managing environmental noise, modifying work spaces to accommodate equipment along with more specific issues such as seating, rails, communication aids, toileting equipment and eating utensils. These minute material modifications required significant amounts of time to organise and supported highly specialised material knowledge. The knowledge utilised was directly linked to the material outcomes for the students and the people who cared for them. The necessity for collaboration to solve material problems opened up possible networks that were able to operate within and without the formal funding system. In this way the material regime of knowledge was able to bypass or use these systems in highly productive ways.

Another example of how materiality had become a dominant regime of knowledge was how the whole school used assistive communication aids called a 'core board'. As a form of augmented communication the core boards are unique to the school, there is no reference to such a term in the literature⁷⁰. They are a satchel type device that has a core of basic universal images that a person can point to communicate their needs. There are additional individualised smaller pages that have much more specific symbols attached to the top of the main board. The students were able to flick through these pages to find what they wanted to communicate.

⁷⁰ Extensive searching of speech language therapy, occupational therapy and assistive technology literature to locate the history of core boards was undertaken but no reference to this name was found.



**Figure 15: Core board communication aids
(photos supplied by school therapists)**

The occupational therapists wore the core boards whenever they were in the classroom or were working with a student. The communication aid had overridden specific discipline based or pedagogical practices, inserting a material practice that the therapists and the entire school was drawing on. The core boards had shaped the practices of the school in a way that had normalised certain ways of providing special education through extra-discursive power relations.

The ability of the material world to shape the discursive practices within an institution was also evident in the forensic occupational therapists work, albeit involving a different set of extra-discursive elements. A major one of these related to the buildings they worked in. The occupational therapy building was separate from the main ward and having this physical space had several practice implications. The occupational therapist's practice had remained very connected to the physical buildings and spaces they could work in rather than discursive elements of policy and medico-legal roles. The buildings opened up opportunities where alternate regimes of practice were possible. When the therapists were able to conduct their work from their separate occupational therapy space their practice was able to follow different rules. These rules were

connected to historical practices of occupational therapy and the regionally specific history of bicultural mental health provision⁷¹.

The space allocated to the occupational therapists was positioned in the spiritual heart (ngakau) of the building. This relatively new addition to the complex was purposefully built to support the collaboration formalised in 2010 with the kaupapa Māori health service, Hauora Waikato and the public mental health service. The collaboration is intended to combine the values and principles of Te Ao Māori (the Māori world view) and contemporary mental health approaches in the provision of mental health services for the region (Poole et al., 2012). The ngakau (heart) of the ward is physically separated from the ward and comprises a wharenuī, Te Puna a Taane, which is a communal meeting place, gifted kohatu (rocks) from each iwi in the Midland region (Poole et al., 2012), a courtyard, gardens and the occupational therapy building. The physical location of the occupational therapists in the spiritual heart of the building materially connects them to this aspect of providing mental healthcare. In practice this meant the therapists could work in the wharenuī, outdoor courtyard, garden, art workshop, or the kitchen spaces. The materiality of these spaces allowed other power relations to enter their practice through a variety of material objects that indicated non-medical and non-legal discursive formations. There was a significant presence of Māori cultural artefacts along with plants, art projects and workshop equipment on the walls and every available work bench. The kitchen resembled an ordinary kitchen one would have at home, with a jug, fridge, oven, sink and a table and chairs.

⁷¹ As summarised in chapter seven, at Tokanui Hospital the country's first bicultural mental health ward was established in the late 1980s and the mental health nurses who worked there were leaders of kaupapa Māori health provision.



**Figure 16: Kitchen at forensic ward, 2015
(personal collection)**

The physical location of the occupational therapists placed them in something of a privileged position. They were able to carry out their work outside the view of the mainstream ward and had the support of the physical space and objects to materialise alternate ways of working. The kitchen space was a good example of this happening. It had become a central place in the therapists' everyday work in both formal and informal ways that were accepted as normalised occupational therapy practice.

The therapists used cooking and food preparation as one of their primary assessment and therapeutic activities. They would bring people from the main ward building and spend time, often an hour or more making food and sharing it with the person and cleaning up afterwards. The kitchen table and chairs were also used for staff related purposes as a lunch room and sometimes as a meeting room. Spontaneous activity that combined these clinical and staff requirements occurred in the kitchen. For example, one day some seafood had been brought to the ward. The therapists, other staff and the person they were working with had a long extended lunch where everyone helped prepare the food and sat at the table to eat it together. The kitchen and the objects within it offered a possibility for the therapists to bypass other regimes of knowledge that understood healthcare as a rational enterprising activity that adhered to legal

rules. There was an unspoken collective ratification of how the kitchen was used by the therapists, the people admitted to the ward and staff that enabled this to happen. Using the materiality of occupational therapy and the environment, a different power game was at play where the dominant power relations in secure forensic mental health services were able to be negotiated in ways that affected the life outcome, even if only for a short time, for the people involved.

The above practices of occupational therapists are examples of how materiality has retained historic discursive practices of the profession. The survival of these practices suggests they have a productive and useful role for the profession. The therapists were using the power relations formed by the material world to work within the silent discourse and position of subjugation a material regime of knowledge has. The significant time spent making things, tinkering and adjusting, collaborating with others outside the health and education systems and utilising the physical spaces the therapists worked within, all opened up the way they practised. They were able to negotiate the enterprising, economic, human science and legal power relations they were subjected to in ways that were productive uses of power. The minute micro-level this practice existed at positioned them as having direct impact on material outcomes for others. These micro-capillaries of action are where decisions by occupational therapists enable power to travel, providing opportunities for resistance, accommodation or re-configuration of this power. The ability to influence immediate outcomes for others is dependent on the individual therapist's judgement. The therapists could choose not to, or may not know how to, facilitate the use of certain equipment and activities, collaborate with others to solve a material problem, or work in alternate physical spaces such as sacred areas, individual homes or classrooms. Choosing not to use the material world in certain ways is just as easy, (possibly easier) as choosing to use it to alter practice. Materiality supports discourse either way. These choices are where the blurring between the extra-discursive and the discursive lies and as Hook (2001) identified, indicates a site of danger for occupational therapists.

Materiality was a strong justification for practice based decisions. Because of the strong connections these practices have with the way health, education and inpatient mental health care is delivered, at the micro-level they are a site where the material can influence discourse as much as discourse influences the material. How the therapists balance this constant interplay of power relations connects their mundane daily work with the many levels that power operates at. The power relations of their immediate workplaces are one level, how the workplace functions within industry specific power relations is another. All of these networks are part of the macro-level, supporting how the population is managed at a governmental level. The micro-level practices of the therapists are involved with all of these overlapping power relations and contribute to how they are sustained, re-configured or resisted. These layers of power relations were connected to the therapist's everyday work in often innocuous ways and by examining materiality through a lens of governmentality the way it provided another opportunity for utilising alternate discourse could be seen.

Materiality and discourse.

There were two common material elements in the occupational therapists' practices where materiality had influenced discourse rather than being an instrument of discourse. The occupational therapists productively used digital technologies and methods of documentation to support regimes of practices within their workplaces. Within the wider profession, both of these activities are sites where practices of governmentality are operating. The materiality of practice as an occupational therapist is connected with the materiality of the disciplinary technologies that govern the individual as a subject.

Digital technologies as an instrument of discourse.

Using digital technologies was a major part of all the occupational therapists' work. They spent a lot of time inputting data to online systems, editing or publishing digital photos, interacting with devices such as iPads, screens, cell-phones, scanners, printers and computers, and using the internet for research. Like the tinkering, making and modifying of the material world the use of these

technologies was another normalised material part of occupational therapy practice. At the governance level, the implementation of centralised online data collection systems had also become part of the therapists' daily practices. The way data collection had become a primary focus for all the occupational therapists was highly visible, involving many material practices. These included the array of digital objects such computers, smartphones and iPads but also complex online programmes that required daily interaction. They had become a disciplinary practice due to the often mandatory or unavoidable nature of them as well as because of the transparency digital technologies enable. The therapists were identifiable by their own name, a user name, or numerical code to multi-layers of bureaucracy. Certain aspects of their practice were visible to a large range of people due to being part of shared online systems. The use of digital technology to collect data and information in this way is deliberate to allow ease of collaboration and sharing of knowledge between services, practitioners and the funding body. Smart technologies are also one of the main foci of the most recent Health Strategy produced by the Ministry of Health.

The uptake and increased use of digital technologies is an integral objective of the recent Health Strategy (Ministry of Health, 2016b) and has been positioned as a primary way that individual healthcare users can become increasingly involved and responsible for their own healthcare. Using digital technologies is also a major method being relied on to reduce the costs of healthcare delivery as well as to increase the efficiency and quality of healthcare (Ministry of Health, 2016c). These methods are part of how the Government's strategic priority of "Delivering Better Public Services within tight financial constraints" (Ministry of Health, 2017c; State Services Commission, 2017) is being operationalised in the public health sector. The layers of disciplinary tactics within the material practices involving digital technologies linked the occupational therapists' day to day practice with the macro-level power relations of how public services were managed at the level of the population. As a by-product of the widespread use and acceptance of digital technologies in all

aspects of healthcare however, other opportunities were opened up because of the materiality of these technologies.

All the therapists used their personal cell-phones and home based computer networks for work in ways that formed a bridge between their personal life and professional life. The extensive use of digital photography by the school and wheelchair service was a good example of this. Taking a photo was normalised practice for assessments, reviews, trials of products and for supervision and consultation about intervention strategies. Photographs aided assessments and recorded progress as the visual image was able to be viewed alongside the therapists' written narratives. It was easy to upload to shared health records and provided a highly effective way to communicate and collaborate with both other health professionals and service users. Digital photography had also become part of doing occupational therapy, and photos were used to make communication aids, to record how pieces of equipment were used, to plan environmental modifications such as positioning of hand rails or ramps and for marketing on websites and publicity purposes. Using digital photography had become part of practice based policies. It was a policy of the school that student's progress was documented at least once a term with a photo accompanying a written narrative, forming an annual portfolio for the student and their support network. In the wheelchair service photos were expected for peer review, supervision and competent documentation. These normalised practices required the therapists to regularly take photos when they were working. The therapists often used their own personal cell-phone to take the photos due to the convenience of using their personal digital networks rather than the less easy to use work based technologies that involved cables, digital cameras and shared access with other staff. Having photos on their personal cell-phones required shared emailing, syncing, downloading and texting between their home and work digital networks. Managing the expected standards of privacy of health information had become part of their personal life as much as the professional one.

Using a different form of digital technology, the forensic therapists had formed a bridge between their personal and professional life in the way they provided customised music compilations for people on the ward. Due to the secure nature of the workplace CD's were considered dangerous objects so digital forms of music played from a computer or digital music player were the only form of music permitted. Hospital policies prevented accessing material from commercial internet based music sites through the organisation's computer network. To circumvent this policy the therapists (and their assistant) would transfer music at home from their own music collections onto USB sticks and bring it to work for use on an un-networked laptop. Doing this allowed the therapists to provide suitable and spontaneous collections of music without risking introducing viruses to the entire hospital network.

The combination of the materiality of digital photography and providing digitised music with the discursive practices of how digital technologies were normalised at the workplace had supported a particular subjectivity that enabled other power relations to be tapped into. The power relations involved different rules of formation that were sanctioned (in unspoken ways) because of the material possibilities created by digital technologies. The use of photography and music in occupational therapy involved decisions that were again located at the micro-level. The decisions provided a way that the therapists could productively use the power relations operating at the macro-level through the materiality of their practice. The overlapping nature of digital technologies, between personal and professional life, between micro, meso and macro levels of power relations was an active and productive site of governmentality in which lines of power were re-configured and trajectories of dominance were contested. The materiality of using digital photography and digitised music are new practices in occupational therapy that have subverted the normalisation of smart technologies in order to meet alternate ends. Another loosely connected practice was the way the therapists documented their work. Documentation is predominantly electronic and mandated in the health sector but how the

therapists responded to this changed practice of governmentality was another site where materiality was able to re-configure these power relations.

Documentation as an instrument of discourse.

As part of a much wider macro-level assemblage that involves all health practitioners⁷², documentation is a core component of healthcare provision and has substantial consequences for those writing, and those being written about. Many healthcare records are held indefinitely and have legal status and protections. They contribute to healthcare decisions about individual lives and are increasingly used for other purposes such as auditing, planning and funding services, as well as research because of the rich amount of information they contain. Individual health records are a materialisation of many heterogeneous lines of power and produce multiple subjectivities and discursive practices.

The heterogeneous properties of health records and how the skills of documentation have altered to incorporate the changing macro-level context were reflected in the Competencies for Registration iterations. The expectations for competence subtly altered in relation to documentation. Skills related to documentation were initially placed in the role titled Communication, “document occupational therapy interventions accurately and according to procedure” and also were used as a professionalising strategy by expecting therapists to “use reporting and recording practices common to occupational therapy practitioners” (New Zealand Occupational Therapy Board, 1990, 1995). In the third version this positioning was altered to a generic skill “professionally present, record and report information” (2.10), reducing the profession specific inference. In addition to this, written communications were to be “...dated and signed, and all conform to accepted standards” (4.12)(Occupational Therapy Board of New Zealand, 2000) connecting documentation to legal and enterprising assemblages rather than as a method of communication or way of

⁷² This assemblage is wide ranging and includes legislation, profession specific documents, employment related conditions and civil rights. For health practitioners these include the Privacy Act (1993), the Health Practitioners Competence Assurance Act (2003), the Code of Health and Disability Services Consumers' Rights Regulations (1996), profession specific competency frameworks and Codes of Ethics, policies and standards of institutions and organisations, human rights legislations and advocacy networks.

recording occupational therapy knowledge. In the current version of the Competencies, documentation is positioned slightly differently again, with a greater connection to enterprise and quality assurance, “you keep appropriate records of the services you provide. These records are suitable for evaluating your services, your professional performance, and your business” (1.14) (Occupational Therapy Board of New Zealand, 2015c). These examples nicely illustrate a change of practices in response to wider changes in the healthcare and public service context. Documentation has become positioned as part of data collection and enterprise and linked to the legal responsibilities of regulation rather than as a source of knowledge to inform practice. The materiality of documentation also involves alternate forms of power that impact on the power relations of these dominant discourses, however.

The therapists documented their practice in varied ways depending on their particular workplace. All of the workplaces had relatively recently converted to electronic systems of record keeping in localised ways⁷³. These varied in relation to the type of organisation. The school and wheelchair services had in-house electronic filing systems that all staff could access and contribute to in an orderly but relatively unstructured way. The hospital service had a much more layered system where staff were authorised to access only certain files and network drives and there was a much greater prescription of what was to be entered or uploaded and where this should appear. These systems have transitioned from the past practices of handwriting and contributing paper pages to individual files that were stored in central collections, either by the organisation or in the occupational therapy department itself (or both).

In the past occupational therapists who worked from an occupational therapy department or a separate service tended to write into occupational therapy only files, sending only formal typed communications to the central multi-disciplinary file. These occupational therapy files enabled a multiplicity of

⁷³ The school had just converted to an electronic system the year before, the wheelchair service had adopted a service wide electronic system gradually over the last few years but still maintained a parallel handwritten system. The hospital has used shared electronic files for several years but they were not utilised fully by all services or departments at this time.

information to be stored about a person through the ability to insert photos, small artefacts in bags, examples of art or handwriting, raw data and scores of assessments, funding applications and other forms, all alongside a chronological narrative (sometimes stretching over decades) of interventions handwritten by the therapist. These filing systems required large cabinets in accessible locations i.e. in the occupational therapy department or beside the therapist's desk. The actual files were generally loose leaf compilations of pages that were inserted as required, generally in different tabbed sections within the file, such as assessments, correspondence, progress notes, equipment, medical results etc. For the occupational therapists in the case studies the materiality of their work and the material practices of the past had combined to respond to the new expectations of electronic systems in different ways.

The new electronic documentation systems in each workplace supported ways of providing information that could easily be accessed for auditing and financial planning purposes. These systems were also part of wider policies that require greater sharing of information between providers of services, health care users and central funding bodies such as the Ministry of Health. The most recent Health Strategy states "the Ministry of Health will establish a national electronic health record that is accessed through certified systems including: patient portals, health provider portals and mobile applications" (Ministry of Health, 2016c, p. 27). The new electronic systems were designed towards meeting these macro-level strategies as well as local level contractual requirements. The type of documentation occupational therapists have traditionally carried out often includes tiny details that are not relevant for other professional or service level decisions and can be difficult to convert into a digital format. Because of this, the school therapists had already started to form a parallel physical filing system, having just converted from paper files to electronic the previous year. In these files were items like spare pieces of velcro that were a specific size or shape, an accessory for a piece of equipment (that might be suitable in the future), a sample of fabric that was the only type that worked for a person, or a particular brochure that had specific details about a service, product or experience.

The wheelchair therapists used physical files in a much more overt way. They still used paper based individual files for people as the central filing system. These files were thick, bulky and sometimes had several volumes for one person stretching back twenty years. The therapists spent considerable time reading these notes and they wrote in them constantly. The files had a physical presence in the workspace with piles of them on the therapists' desks, sometimes stretching onto the floor. They would be picked up and carried away by other therapists, wheelchair technicians and administration staff when they needed them. They were also taken into team meetings or supervision sessions to discuss clinical decisions. Although the paper file was the central form of documentation for each person, the service also had a shared electronic file for each person where more legal documents were stored such as funding applications and decisions, email correspondence from suppliers and other contract specific documents. Despite electronic records having become a normalised practice in healthcare and educational provision at the wheelchair service this had not resulted in the past practices being discarded.

In the forensic ward setting there was a less obvious holding on to the past ways of documentation. The therapists' documentation was generally in a textual form, easily uploaded or scanned into a digital format and added to the shared electronic health records. Once uploaded or entered into the formal health record, a document cannot be retrieved or altered. Despite the therapists spending considerable time documenting their practice through this shared electronic system, the therapists also maintained an informal occupational therapy electronic filing system. This existed in the occupational therapy only shared drive in the hospital computer network. It contained individual files for the people who had been in the ward and a therapist could add whatever they felt appropriate. These individual records had started to accumulate, with some having several years of entries for people who had repeated admissions to the ward.

All of these practices involving documentation were compiling a 'hidden' body of knowledge about health care users and about occupational therapy. The

occupational therapists were continuing a practice of the past where departments and services held highly specific information about the people they worked with, exclusively for their own and other occupational therapists' use. The electronic systems of documentation were configuring the occupational therapists documentation practices in certain directions. These directions had the effect of subjugating occupational therapy knowledge due to the inability of electronic systems to incorporate or have a place for the materiality of occupational therapy to be recorded. At the same time this subjugation was supporting the strong discursive practice of occupational therapists to produce and hold material records of the minute histories of individuals. The material outcome of macro-level policy requirements occurred through a combination of the discursive and extra-discursive elements involved with documentation. What continuing the practice of hiding knowledge does, is another example of where the blurring between the extra-discursive and discursive is a site of danger for occupational therapy. The choice not to input certain information or record certain actions depends on the individual and by remaining out of view is not contesting the dominant regimes of knowledge that are visible. At the same time by doing this the individual therapists were able to modify the subjectifying disciplinary tactics of digital technologies and the practices of governmentality within these.

Summary

Materiality as a productive form of power in occupational therapists' practice is a largely un-theorised or documented aspect of occupational therapy. In the case studies historical material practices were tacit and unspoken understandings rather than a consciousness of materiality as a form of power. The occupational therapy practice observed was significantly shaped by the materiality of the buildings, equipment and work tasks in different ways depending on the work setting. Materiality opened up possibilities for specialised knowledge, alternate networks and new practices to develop. These possibilities in turn offered different experiences and subjectivities that were able to re-configure the power relations the occupational therapist worked within. The interconnections

between materiality and the other lines of force that were shaping practice are where Deleuze (1991) contended power can be altered, diffracted or re-configured. New interconnections can change the trajectories and strength of the lines that form networks of power, introducing new configurations of power in the network. Giorgio Agamben (2009) has continued this theorisation more recently. He contends that in order for a subject (occupational therapy/occupational therapist) to escape being captured by a network (dispositif), it must form alternate subjectivities that can bypass the lines of force within a network. The way the occupational therapists were using materiality in predominantly unconscious ways was bypassing other forms of power. They were able to take up an alternate subjectivity that was connected to the experiences and outcomes of the material world rather than as subjects of the law, capitalism or enterprise. Doing this positioned them in ways that were part of different power relations. These power relations are not overt, and as occupational therapy has not theorised the use of materiality in terms of power and regimes of truth, they lie under the surface of practice and remain part of taken for granted ways of practising. Because of the taken for granted nature of them they also present significant danger to the profession. The way materiality is strongly connected to other people's life outcomes makes this an important power relation to understand and utilise wisely. The connection between underground practice, material outcomes and power are the focus of the discussion in chapter ten. Before this discussion occurs, chapter nine examines how the research blog functioned as part of the overall project. As a material practice itself, it crosses over many of the threads of the analysis so far and provided further insight into the underground practice of occupational therapy

Chapter 9: Critically Engaging with the Profession

One of the intentions of this research was to engage in a process of critical action with the profession of occupational therapy whilst carrying out the other strands of the research. Engagement with the profession occurred through several planned strategies as well as through some unplanned events that snowballed from these deliberate actions. The combination of these planned and unplanned acts formed the positive endeavour (Folkers, 2016) or critical action (Koopman, 2013) of the overall genealogical critique. The planned strategies were the research blog, the publication of two manuscripts in the professional association journal, five conference presentations at the professional conferences (2015 and 2017), and four in-service presentations to regional occupational therapy teams (2015, 2016, 2017). As the research became more visible and known to the profession, the snowballing effect produced other opportunities to engage in active critique of the profession. These took the form of being part of working parties to write three formal policy related submissions from the professional association⁷⁴, invitations to contribute to the monthly magazine (2017) and requests to reproduce posts or use a link to the blog. The Otago Polytechnic occupational therapy education programme uses the blog as a teaching resource⁷⁵ as part of teaching critical practice and I was invited to be part of a research project involving use of social media as a professionalising strategy by an academic at the University of Otago. The other outcome that was directly related to this project is being commissioned to carry out research by the Occupational Therapy Board of New Zealand about mandatory supervision conditions for some categories of occupational therapists⁷⁶ (2017).

⁷⁴ These were consultation documents about Health Workforce planning (2016), a submission about the use of seclusion in schools to Ministry of Education (2017) and a submission on a discussion document produced by the Ministry of Business, Innovation and Enterprise about measuring the impact of funded science projects (2017).

⁷⁵ There have been 70 views of the blog by students through the moodle online link and several new followers to the blog since this occurred.

⁷⁶ This was titled "Supervision for standard conditions on scope of practice for occupational therapists in Aotearoa New Zealand".

The research blog was the principal method that many of these unexpected events sprang from, indicating it had produced some ripples in the object of the critique through the act of critiquing. The blog was an experiment in how blogging could be used to engage in forming a critical space for the profession and it has provided useful information about using social media as well as being a practice that had other unintentional outcomes.

The Research Blog

The principal aim of the blog “Whakaora Ngangahau/Occupational Therapy in Aotearoa New Zealand – What is shaping us in 2017?” was to support the development of a discursive space where occupational therapists could speak about and think about practice issues from a perspective of critique. As described in chapter three, it was constructed using wordpress.com with the first post of the blog on 6 August 2014. The last post (for research purposes, I have continued the blog as a personal project) was on the 11th August 2016. I published a post twice a month, which resulted in forty-three posts during this period. At the time of writing, (5/10/2017) the blog has had 2474 views and 842 visitors (Silcock, 2017). It also had 101 followers at this time. Out of these, eight are my family and three are my PhD supervisors.

To promote and create interest in the content of the blog and the critical aims of it, I made a sustained effort using a variety of strategies (virtual, print and face to face) to connect with other occupational therapists about the research. These strategies continued over the first eighteen months of the two year period that the blog was used as a research method. Below is a timeline of these activities with the number of followers gained immediately after them:

Table 2: Connecting with the Profession

Date	Strategy	Followers
6/8/2014	Invited OT colleagues in personal network by email to follow blog	10
13/8/2014	Presented to regional Local Area Network occupational therapy meeting	0
25/8/2014	Mass email to all practitioners willing to be contacted about research on the OTBNZ register ⁷⁷	4
14/1/2015	Mass email by OTNZ-WNA to members	0
2/2015	Published article "The impact of taken-for-granted understandings on occupational therapy practice" (Silcock, 2015) in OTNZ-WNA monthly magazine, OT Insight	0
14/9/2015	Poster presentation at Asia-Pacific Congress of Occupational Therapists in Rotorua, New Zealand (Appendix 2) "Creating a critical space: Blogging as a reflective tool for collective agency" (Silcock, Campbell, Hocking, & Hight, 2015)).	0
29/09/2015	Mass email by OTBNZ reminding all therapists on the register about the research	0
2/3/2016	In-service for Mental Health Occupational Therapists Forum Waikato Hospital	9

Excepting the above circumstances when there was a clear link to when people chose to follow the blog the remaining number slowly grew over time. The most successful way of attracting followers was through personal invitation and face to face presentations about the research. Participating in the workplace observations was also a successful way of attracting followers, with six out of ten of the therapists and two of their managers, who were also occupational therapists, following the blog after I had carried out my observational week with them. Mass emailing, formal publishing and conference presentations did not have any direct increase in followers. Although the best daily view statistic (one hundred views) was on 29/11/2015 immediately after the OTBNZ mass email on

⁷⁷ This advertised the research project with a hyperlink to the blog site. 1,589 practitioners received the email. 33.9% of those opened the email (538), and 5.2% (82) opened the hyperlink to the blog (personal communication, IT manager, Occupational Therapy Board of New Zealand, 14/10/2014).

the same day, this resulted in no new followers. Likewise the formal articles in the monthly magazine publication OT Insight and the poster presentation at the annual conference did not result in any followers.

Of the followers who are not family or my research supervisors, twenty-one commented in response to posts on the blog (23%). Of these twenty-one followers twelve (57%) commented more than once in the two year research period. The comments were made on twenty-three of the forty-three posts (53%). Although only 23% of the followers actively commented on the blog I had followers communicate several times with me in face to face situations and via personal emails about a post on the blog. Some people were anxious about expressing their views on a public forum so emailed their thoughts directly to me about the topic. Others introduced themselves to say they enjoyed reading it or they had passed particular posts on to their colleagues or students they taught. The connection and tensions between online and offline actions were captured on the blog itself in two of the followers' comments:

It would be interesting to know how many readers there are of your posts. I certainly know of a few who look but don't comment. To me it feels as though there is a bit of a risk in "putting yourself out there". It feels like it would be easy to say the wrong thing. To offend people, or to not have one's facts straight. Why is it we prefer to keep the peace? Can I get in trouble for being controversial? Is Big Brother watching?? Abigail (2016)

I am basically too afraid to comment because I might say something that makes me look silly...So there you have it I have spoken out and responded! I may be ostracised forever...Gerta (2016).

Creating a Critical Discursive Space

Developing a space where the critical intent of the project was overtly discussed with practitioners in order to be a form of critical action was the primary objective of the blog. The blog postings were practice oriented, involving both the people occupational therapists work with (e.g. [The Prioritisation Tool](#))

6/3/2015), the tasks and skills we are required to perform (e.g. Being an Assessor vs Therapist 28/4/2016) and how these fit into wider sociological understandings (e.g. Individualisation vs Collectivity 9/3/2016). The twenty-three posts that followers responded to are presented below in Table 3.

Table 3: Blog Posts and Comments

Date	Post Title (n=23)	Number of Comments (n=49)
6/8/2014	"In the beginning"	5
28/10/2014	"OT's do "fuck all" and other less than complimentary perceptions of us"	3
16/11/2014	"I need some help"	7
9/12/2014	"Reflective practice"	1
8/1/2015	"Being experts"	4
28/1/2015	"Have communication technologies affected our practice?"	4
13/4/2015	"Back in 1995"	1
14/5/2015	"The very first competencies"	2
13/7/2015	"Onto the 2000's"	1
24/7/2015	"One year of blogging"	3
11/8/2015	"OT and the law"	1
27/8/2015	"The introduction of the CCFR"	1
21/9/2015	"The question of ethics"	1
7/10/2015	"Bicultural competence in the 2000's"	1
5/11/2015	"My next research strand"	3
14/1/2016	"Our new competencies"	1
22/2/2016	"New alliances of knowledge"	1
12/4/2016	"Siloed practice"	2
28/4/2016	"Being an assessor vs therapist"	3
10/5/2016	"Ethical practice"	1
27/5/2016	"Research and practice"	1
6/6/2016	"Time"	1

The comments received varied from one sentence to 1300 words. Of the forty-nine comments twenty-seven were made by three followers, with the remaining twenty-two comments divided between eighteen other followers.

The Blog as a Positive Endeavour

Using a blog as the critical action component of the research was an experimental method. As part of the genealogical approach, analysing the way it functioned necessitated establishing an historical context of the way occupational therapists in Aotearoa New Zealand engage with blogging and social media. In the past there has been little uptake of social media platforms by occupational therapists. There have been formal professionalising attempts by the OTNZ-WNA and OTBNZ to use social media to engage with the profession. OTNZ-WNA had established guidelines to use online forums in 1998, and have overseen several online special interest groups for members since this time. The approximately 1000 members of the Association can access these groups for networking and support in particular interest areas. These groups have been poorly used with some having extended periods of time (months and years) where no member has posted or discussed anything. The only group (currently there are 23 active groups) that consistently has some online engagement is the Child and Young Persons occupational therapy group (personal communication, Hannah Cook, OTNZ-WNA administrator, 9 October 2017). The other main institutional structure of the profession, the OTBNZ has also attempted to engage with occupational therapists through social media.

In January 2014 an OTBNZ Facebook page was created and was promoted to all 2331 registered occupational therapists. Since then the Board has made over 50 posting to the Facebook webpage. Most messages have attracted one or two 'likes' and very occasionally there is a comment. A Facebook discussion board was established at around the same time as the Facebook page and at the time of writing has had no discussion threads since its creation (Occupational Therapy Board of New Zealand, 2016d). As well as using Facebook, the Board has more recently started using Twitter, mass texting and emails as online strategies to connect with its registrants. Although not a public social network,

the online monitoring of competency that has been carried out by the OTBNZ since 2004 (the ePortfolio) could also be considered a form of professional social networking due to its interactive element between supervisor, third party and the practitioner. The ePortfolio also has the background function that other social media platforms have where the host, the OTBNZ can access the activity and information that occurs in the network. Blogging is a different form of social media to all of these and is not used by either of the two professional structures to engage with the profession.

There are a few individual occupational therapists in Aotearoa New Zealand who have created personal blogs which are active⁷⁸ but more often occupational therapy specific blogs have started as a project (like this one) and have not been continued⁷⁹. In comparison there are many blogs from occupational therapists in other countries which are forming a substantial online community network⁸⁰. These networks have various objectives such as education and sharing knowledge, sharing resources, as part of a business, or as a site of activism - much like any other use of blogging. As part of wider social science studies of culture, the use of social media and blogging has become a burgeoning research speciality due to its increasing prominence in social life and political activities⁸¹. Using a blog to engage occupational therapists in critical discussion utilised the prominence and use of social media in everyday life activities. However, the nature of the blog positioned it in a political space that required occupational therapists to contest the highly stable line of force of underground practice in the profession and the subjectivities that this offers. The blog is a form of political participation due to it forming a public record, which a collective

⁷⁸ Such as <https://healthskills.wordpress.com/about/> and <http://otdaninnewzealand.blogspot.co.nz/>

⁷⁹ Such as <https://oteducation.wordpress.com/>, <https://lrobertson.wordpress.com/>, <https://occupationaltherapyotago.wordpress.com/>

⁸⁰ For example the USA based blog <https://otpotential.com/blog/best-ot-blogs> provides links to a myriad of other blogs by occupational therapists for occupational therapists

⁸¹ For example, there is research about how effective the use of social media is as a method to develop offline political action or activism. So far this has not been conclusive with the influence of blogging on offline actions found to be unpredictable (Lilleker & Koc-Michalaska, 2017; Oser, Hooghe & Marien, 2013; Zuniga, Bachman, Hsu, & Bundidge, 2013).

collegial group of occupational therapists reads along with anybody else with access to the internet. The current social norm of occupational therapists in Aotearoa New Zealand as a collective professional group is one of limited online participation, whatever the social media platform. Although the participation in the blog was relatively low, it did have offline impacts that indicated the blog had made ripples that have altered the profession in some way, if only to prompt therapists to “question over and over again what is postulated as self-evident, to disturb people's mental habits, the way they do and think things...” (Foucault, 1981/1988, p. 265). The most common comment that I received about the blog was that it made people think.

One therapist instigated deliberate action from reading the blog and contacted me to ask if I would be willing to offer some formal supervision to assist her in becoming more critical in her practice (which we did for a 6 month period). The other ways it impacted on offline behaviour was one of the occupational therapy schools lecturers using it as a resource for her students, team leaders distributing relevant posts to their occupational therapy teams and by posts being shared via twitter and re-publication in the occupational therapy magazine. The blog was being used by the collective profession in ways that had the potential to disturb what occupational therapists think. These offline impacts suggest that the blog did provide some form of positive endeavour of the genealogical critique, though there is no way to measure the strength or scope of this. There was also an unexpected outcome of the blog that occurred that involved my own role as an insider researcher.

Unpredicted Outcomes of the Blog

Through the process of blogging twice a month an unexpected ethical axis of the research was formed. The tension created by being a critical researcher while at the same time an active member of the profession, both locally and with the national bodies the OTBNZ and the OTNZ-WNA was acute at times. These tensions were present when I attended the two monthly Board meetings. While being part of regulating the profession I was at the same time critiquing the way the Board carried out this regulation. I was also acutely aware of problematising

issues of sovereignty through a post-colonial lens while assisting to enact the HPCA Act (2003), a colonially based legal assemblage. A further complication involved critically blogging about impacts of capitalism and the commodification of healthcare services while at the same time benefitting from this economic model as a paid Board member. In relation to OTNZ-WNA, the ethical tension created by the blog was less personal as these professional relationships are generally not maintained face to face. However I was very aware of creating a public stance that was relatively new for the Association and the membership, one that I had to stand by when I was part of OTNZ-WNA activities. Balancing my role at the OTBNZ with supporting the profession through OTNZ-WNA activities (such as conference presentations, publishing in the magazine and journal and contributing to online forums) intersected in the blog and how I wrote the posts. This tension had been anticipated and I had indicated what my research was about to the OTBNZ before being appointed as a Board member. The OTNZ-WNA were also cognisant of the topic of my research from the outset as the Association had a policy of requiring in-house ethical approval before any recruitment to its members. I had noted both these sites of ethical tension in my ethical approval application to the University of Waikato Faculty of Arts ethics committee. What was not anticipated was the way the blog facilitated the formation of an ethical axis to the research that created transparency of the nature of the research, making it an open critique rather than from the safety of academia.

The transparency occurred because I deliberately invited prominent figures in the profession, the CEO and the Chair of the OTBNZ, the CEO and President of OTNZ-WNA, academic staff from the two Occupational Therapy schools and representatives of the Māori occupational therapists network to follow the blog. These people all accepted my invitations and commented online and offline to me about the content. Each blog posting was a political act and by publically stating my position about aspects of how the profession practiced it forced me to carefully reflect on the ethical stance I was taking. I was publically discussing aspects of my research that raised ethical conflicts between my roles

as researcher, occupational therapist, OTBNZ Board member and OTNZ-WNA member. As referred to in the description of the research blog as a method (chapter three), the main ethical consideration was in relation to my position as an OTBNZ Board member while undertaking the research which eventually culminated in choosing not to remain on the Board. The ethical discomfort of publically critiquing how the profession was structured and functioned had more personal implications also.

Many of the occupational therapists who were involved with my research as participants, their managers, and other therapists who live in the same region as I do, followed the blog. Being part of the same community as these people posed more local and personal ethical concerns. I would see these therapists in person, they were my peers and colleagues, possible future employers, and part of my professional network. This made the political nature of the blog very real. When I had to present to the local occupational therapy groups I knew some of them had possibly read many of my blog posts. Knowing this shaped my offline behaviour and conduct as I was very aware of my actions being interpreted through this critical lens. These unintended outcomes of blogging influenced how the blog evolved and assisted me in understanding ethical practice in relation to research, social media and writing as a political act. In particular the importance of informed consent, managing conflicts of interest and confidentiality were constant ethical considerations when I was writing each post. The blog enabled me to provide some transparency in my conduct and assumed a mediating function. In this respect, the blog assumed a different function than as a source of data. It provided an ongoing ethical axis to the research and had a grounding effect, keeping the research focussed on the practice of occupational therapy and how my doing through blogging impacted on offline reality.

The Blog as a Discursive Practice

As argued in the preceding chapters, occupational therapy knowledge has been historically subjugated and the profession subordinated by the hierarchical nature of the human sciences. Occupational therapy has responded to this by

utilising its delegated sovereign power and co-opting the material world to bypass these power games and engage with other discourses and alternate pathways of healthcare provision. These engagements often require the individual occupational therapist to undertake ethico-political negotiations in regard to their position within accepted regimes of knowledge and underlying regimes of truth. One of the successful strategies for the profession to play this different power game is to remain underground and out of public consciousness. The outcome of this game has enabled it to exist and carve out a niche for occupational therapy in a relatively undefined space.

The blog was in direct opposition to this strongly held underground subjectivity. Speaking publically about the tensions and troubling aspects of everyday practice is not a social norm for the profession. The blog was an opportunity to take up other subjectivities for occupational therapists and as a critical practice was introducing a new line into the dispositif of occupational therapy. If the profession was less underground, different arrangements of power relations would be at play. The lack of participation on the blog by most of the followers perhaps indicates a resistance to disturbing the underground subjectivities and power relations this produces. The reluctance to alter the existing balance of power, suggests that there is productivity and stability to the power that occupational therapists currently have. What is important to understand about this productivity and stability is who is benefitting from occupational therapy practising in this way and what this practice is doing. These questions are the focus of the discussion in the next chapter.

Chapter 10: Discussion

The analysis in the preceding chapters has offered a problematisation of occupational therapy practice through the examination of localised and shared profession-wide occupational therapy practices. In the analysis the close connection occupational therapy has with medico-legal assemblages and the underlying assumptions of sovereignty this assemblage is based on, was in constant flux with economic-governmental practices. In particular the enterprising up and commodification of healthcare, including publically funded services such as those provided by the therapists in the case studies had become a normalised practice that required day to day negotiation by the therapists. Added to this dipolar relation is the central role that materiality had in how the therapists practised occupational therapy. Through the genealogical tracing of how materiality has remained a strong extra-discursive practice in the profession, it is contended that material regimes of knowledge are supporting the profession in carving out a role that offers opportunities to bypass other dominant regimes of knowledge. It is also contended that the power relations involved with the material regime of knowledge create other subject positions for occupational therapists that have the ability to modify how sovereign and economic-governmental power are played out at the level of material life outcomes.

Occupational therapy is positioned at the hard edge of where these three forms of power are exercised at the street-level. As seen in all the case studies working at this hard edge has become a normalised position for occupational therapy. All three workplaces were providing services for people where the law, economic constraints and material resources were applied at times to the greatest degree. Due to the close connection occupational therapy has to life outcomes for other people, the normalisation of this position is both a danger and an opportunity for the profession. The doing of occupational therapists is a danger because of the close alignment the profession has with regimes of knowledge and practices that support ongoing processes of colonisation and the growth of social and economic disparities. The way occupational therapy is

done does, however, present opportunities because of the strong discursive practices of the profession that have formed legitimate, alternate paths of escape from these regimes. These two perspectives are how this research has come to offer a problematisation of occupational therapy as both dangerous and full of possibilities. In this final chapter the discussion seeks to expand on this problematisation in order to contribute to a greater understanding of how these power relations affect what our doing as occupational therapists does.

Danger at the Hard Edge of Material Outcomes

The hard edge of sovereign power.

As a regulated health profession occupational therapy has been delegated sovereign power by the law. Laws such as the HPCA Act (2003), the Mental Health Act (1992) and the Education Act (1989) delegate legal authority to registered health professionals. The discursive practices that form from the delegation of power by the law are where sovereign power is enacted. For occupational therapy these practices are often at the micro-level of material life. As seen in the case studies, the roles occupational therapists have as assessors, as a means to operationalise policy, as contracted service providers and as gatekeepers to access funding for essential services, there are a wide variety of places where occupational therapists exercise their sovereign power⁸². As well as these more obvious roles, the occupational therapists were able to affect material life in day to day decision making such as whom to see, what they will offer, where they will work and how they will conduct themselves. These subjective decisions also are intimately connected with material life, at the level of day to day living. Occupational therapists along with police officers, the military, customs officials and other health professions are some of many street-level bureaucrats who have a position that enables them to make judgements of what is provided to whom at this level.

⁸² These quasi-legal processes can involve applications for funding, assessments for home help or personal care, approval to drive a vehicle or recommendations about work related adaptations or re-entry to work.

The way sovereign power is delegated occurs through the vestment of legal authority through local level legal frameworks that have developed in order to uphold the law that the English language version of the Treaty of Waitangi has sanctioned. Viewed from a post-colonial perspective these chosen professions are one of the ways that the code of imperialism that Smith (2012) refers to is enacted through the legal frameworks that guide the policies, processes and institutional structures that these professions follow and uphold. In relation to occupational therapy, occupational therapists are positioned as a micro-capillary of a much bigger structure of sovereignty and how sovereign power is exercised. In turn, this bigger structure has become increasingly inseparable from the way economic-governmental practices also support the application of sovereignty.

The increasing normalisation of market forces determining how to provide material public services has produced a situation where the way some people live in highly compromised material circumstances has become accepted as unavoidable. Several strands of the analysis demonstrated this normalisation, for example, if a vital piece of equipment (such as a part for a wheelchair or a hoist to lift a wheelchair into a vehicle) required importing, the person who is waiting for it must survive in any way they are able. The process to get this piece of equipment may take weeks or even months. Similarly if there is no way a commercial company can transport someone safely to school, they cannot attend school. Other examples are if an appropriate community based service cannot be found to support a person in the forensic service they must live where the law decides, such as in a rest home, secure institution or shared residential accommodation. In these examples the limits of the market have become acceptable justifications in the exercise of sovereign power. They are how economic-governmental practices retain the position of assumed sovereignty and sovereign power as the foundational judge over legal subjects.

The sovereign decision to give responsibility to individuals, the community and/or the market to provide for material life outcomes for people who are otherwise unable to provide for themselves is seldom spoken about. There is an unspoken assumption that collective needs will be served by

providing economic pathways to provide services. The connection of sovereignty that has enabled these economic-governmental practices to flourish is not visible at this level. What is visible is the dominance of regimes of knowledge that regard life outcomes as the responsibility of the individual and if certain life paths are not taken these outcomes can be subjected to those with delegated sovereign power. The way these taken for granted understandings have consolidated over time is where the links to the code of British imperialism becomes connected to the micro-level of material outcomes. The way occupational therapy and occupational therapists have become subjectified by this political and economic ordering in the same way as the people they work with demonstrates how the imperial code travels through the social body.

Conducting the conductors.

A chain of sovereign power that travels from the law, to the Occupational Therapy Board of New Zealand, to occupational therapists, and finally to the people therapists work with, has become a taken-for-granted, natural order of things in occupational therapy practice. Subjects (the OTBNZ, occupational therapists and the people they work with) are expected to comply with higher delegated authority due to the foundational understandings of sovereignty and the legal assemblages that support the practices of sovereign power. Occupational therapy and occupational therapists are subjectified directly through delegations of sovereign power specified in the legal networks that govern the conduct of health practitioners. For occupational therapists, this legal assemblage is directly formed by a network between the Health and Disability Commissioner (1994), the Code of Health and Disability Services Consumers' Rights (1996), the Health Practitioners Competence Assurance Act (2003) and the Occupational Therapy Board of New Zealand (OTBNZ). The network is operationalised through the Competencies for Registration and Code of Ethics documents, the online ongoing monitoring of competency, the ePortfolio, and the procedures the OTBNZ uses to enforce the above Acts (such as annual declarations of fitness to practice, police checks, warning letters, placing conditions on scopes of practice or requesting medical opinions on competence to practice). The occupational therapy Code of Ethics also closely connects

occupational therapy practice to the HPCA Act (2003) and the Code of Health and Disability Services Consumers' Rights and Regulations (1996), incorporating ethical conduct into this legal framework. As a local level legal structure it is part of a chain of legal hierarchies that support English common law as the founding framework used to govern the country. The occupational therapy specific legal network is in turn governed by other forms of sovereign power at the level of central government and parliamentary processes. At the macro-level occupational therapy is part of the wider methods of political governance of healthcare and the economic management of the population.

The legal practices outlined above are how sovereign power is used to shape the conduct of those who have the ability to influence the conduct and action of others. The way occupational therapists are governed becomes connected to how occupational therapists are able to govern others. The connection is played out in the materiality of everyday practice, making it the visible hard edge of this form of governmentality. As Dean (2013) argued, examining the material-immanent practices of sovereignty provides important answers to 'how' sovereign power filters through the social body. The micro-level nature of occupational therapy makes these material-immanent practices minute capillaries of sovereign power. What is decided by the OTBNZ and occupational therapists is shaped by the privileged place of the law, where it is considered the natural foundation for these decisions. The way the law is privileged silences the sovereignty that enables these legal assemblages to form. What is also silenced is how these sovereign decisions choose who does the deciding, how resources will be allocated and what is considered acceptable for the market or self-managing consumers to provide.

Sovereignty at the micro-level.

The therapists in the research spent hours making custom made communication boards for individual students, preparing individual cooking sessions for those in the highest level of forensic security and planning and organising to ensure people had the right wheelchair for their environments. The therapists made deliberate decisions about who, what and how they were going to provide,

support or facilitate material life outcomes for others. They also could choose who they would spend the most time with, where and for what purpose. The delegated authority they have made these everyday decisions an individual choice. Although there are many accountability safeguards for these decisions (such as application forms requiring declarations of truth, audits of clinical decision making and professional practice standards) due to the underground nature of occupational therapy often these decisions are out of view of others and rely on personal judgement.

The hinging of material outcomes on routine and everyday decision making by individual therapists is where the doing of occupational therapy does something. The decisions that are made are how dominant discourses and underlying regimes of truth are supported, resisted or re-configured. To help guide practice based decisions the quasi-legal Code of Ethics and Competencies for Registration and the legislated Code of Health and Disability Services Consumers' Rights and Regulations (1996) provide legal definitions of ethical and acceptable practice. Alongside this is the historical acceptance of occupational therapy as a profession that specialises in the materiality of healthcare with its own unsaid and strong discursive practices. How occupational therapists decide to affect material outcomes is largely accepted but also out of view of the medico-legal assemblage they function within. The accepted role of occupational therapy relies heavily on the status of being a registered health profession with delegated sovereign power but at the same time has not translated into the profession having a visible presence in the assemblage.

The dependence on the law and the way it privileges medico-legal structures, makes occupational therapy vulnerable to the associated power relations of sovereignty and constitutional level assumptions that go with this concept. The delegation of sovereign power to the medical profession through legal regulation was an early colonising practice. Delegating legal authority to medical doctors formed a medico-legal connection where medical expertise was a regime of knowledge that was highly privileged by the law. Through occupational therapy's close association with the medical profession (particularly

psychiatry) it has followed this medico-legal pathway, also assuming a privileged place as a human science expert. The sovereign power delegated to occupational therapists in Aotearoa New Zealand has remained based on this colonially acquired position of power and its historical connections with the law and medical regimes of knowledge. These two influences are inextricably linked to how occupational therapy has sovereign power – without the legal status of being regulated health practitioners, occupational therapists would not be considered suitable to be delegated with sovereign power. In order to have this status they must also be perceived as having specialised medical based knowledge.

The continued privileging of the medico-legal discourse maintains the political-legal order that was established when Aotearoa New Zealand was colonised and the law decided who was to be delegated sovereign power. The way that life outcomes can be decided or significantly shaped by health professionals embodies how the interplay of economic-governmental and sovereign power is actualised. The normalisation of the position of health professionals to do this is a way that sovereignty exists on the surface of practice but is largely unnoticed. The way sovereign power is exercised is silent and not spoken about. What is acceptable and normalised practice is dis-connected from the underlying premise of sovereignty and constitutional rights that this power is derived from. The hard edge of this sovereign power was visible in the occupational therapy practice examined in this research and the material outcomes that the occupational therapists were associated with.

Material outcomes at the hard edge.

The interplay between sovereign and economic-governmental power has normalised how occupational therapists can decide material outcomes for others. How delegated sovereign power is contingent on both the market and the individual (both the therapist and the person/people with whom they are working) to provide these material outcomes has also become normalised. An example of this can be seen in the way the funding for disability support services is managed. When there are blowouts in the budget for publically funded

equipment and environmental modifications, individual warnings are sent to assessors to curb the amount of money they are approving. The warnings also implicate the people receiving the funding as having responsibility for overspending the budget. The warnings contain statements such as “the level of spend cannot continue, together, we need to manage the overall spend to avoid any other changes occurring to reduce costs that may have adverse impacts on complex clients in need” followed by “therefore, you may be contacted by an Enable New Zealand EMS advisor seeking additional information and we may also contact clients receiving EMS services” (Enable New Zealand, 2016, p.1). The economic-governmental practices utilised by Enable New Zealand are involving the therapist at a personal level, targeting the way they are exercising their sovereign power. As well as this, by including the person receiving the service into these practices, a naturalised order of self-responsibility is assumed.

Another way this order has become taken for granted can be seen in instances where the sovereign can over-rule delegated power and make exceptions to the law. The lack of resources, geographic or environmental constraints and the need to adhere to other policies (such as health and safety or processes to apply for funding) were acceptable limits on what the occupational therapists could provide. The ability for sovereign power to make exceptions because of these economic-governmental practices is part of a silent discourse. In the case studies, the life outcome for others was where the therapists were situated and this position was often at the end of the ordering between sovereign and economic-governmental power. Operating at this ground level is not overtly connected to the concepts of sovereignty and sovereign power. How the therapists negotiated this order in their day to day practice is where the effects of sovereign power meet the hard edge of material outcomes.

By exerting their delegated sovereign power to assess, recommend and accommodate the material world, the occupational therapists are placed at a juncture where these two elements are directly confronted. Understanding that this is a confrontation is particularly important due to the way ongoing colonising practices and the perpetuation of economic disparities that produce poverty and

marginality are connected directly to material outcomes. At the surface of everyday decision making this confrontation is largely unspoken. The way this confrontation plays out has been normalised through the commodification and globalisation of health and other public services which has only been possible through economic practices that rely on sovereign power and the material world for success.

The hard edge of capitalism.

The commodification and globalisation of the financial sector has enabled healthcare provision to be targeted as a lucrative site for generating wealth, re-aligning healthcare into the finance rather than the public service sector⁸³. The underlay of the success and actualisation of capitalism in Aotearoa New Zealand is the country's colonial context. The success of healthcare companies and the resulting global generation of wealth are ultimately based on the acquisition of land and the subsequent removal of the right to an indigenous way of living. The application of property law after the signing of the Treaty of Waitangi was an exercise of sovereign power by the Crown that enabled the establishment of commerce, trade and an economic order of colonising practices. In latter times this has up-scaled from the local economy to international free-trade agreements. These agreements have been made with an assumption of the position of sovereignty of the government where it makes decisions on behalf of all of its citizens. This assumption is contrary to Article One of Te Tiriti o Waitangi, where only the governance of Aotearoa New Zealand is ceded, as opposed to the outright sovereignty claimed in the English version. The right to agree to global free trade agreements that position citizens of Aotearoa New Zealand as subjects of a defined sovereignty is one way that Māori (Bargh, 2007c) and non-Māori (Kelsey, 2013) scholars contend that the processes of ongoing colonisation have escalated in recent years. The macro-level interplay between sovereign and economic-governmental power are an important context

⁸³ See chapter six for in depth examples of financialisation that has occurred with Aotearoa New Zealand companies over the last 30 years.

in which occupational therapy is positioned due to the direct link it has with the material outcomes of these forces.

As argued in chapter six the commodification of healthcare through the economic reforms in the 1980s and 90s saw hospitals and regional health services becoming enterprises, regulatory boards (such as OTBNZ) becoming body corporates, and the creation of new institutional structures (such as those that emerged when Tokanui Hospital closed) to maintain funder/provider splits in service provision. The case studies in this research are examples of how services have evolved since this time. The special school was a self-managing entity highly dependent on the market of children needing high-level educational support for its survival and the wheelchair service was a for-profit business only possible because of the contracted services model of delivering public services. The forensic service provided an example of how enterprise has been applied in publically provided services to link these services to the marketplace.

The economic-governmental practices in the public service reforms introduced new elements associated with market driven and financialised economic models into occupational therapy practice. The profession responded to the market driven model of healthcare by enterprising up occupational therapy. These new elements were incorporated into occupational therapy practice from the first and subsequent Competencies for Registration documents. The Competencies introduced the skills of enterprise required to be competitive in the marketplace and enabled the needs of regulation, education and employment sectors of the market to 'swarm' to one disciplinary site. These factors facilitated an economic-governmental rationality to spread to the level of the individual practitioner by providing consistency and linkages between these sectors. The OTBNZ, under-graduate education providers, employers and funders all heavily rely on the Competencies to meet legal obligations, guide the curriculum and to provide quality assurance for health care users. The economic-governmental network that has formed encourages certain types of occupational therapy and occupational therapists and normalises the way market forces are driving what occupational therapists do.

Reflecting the way legal frameworks position occupational therapists as legal subjects who filter understandings of sovereignty to the social body, the economic-governmental framework is another form of governmentality shaping the conduct of occupational therapists. The enterprising up of the profession in the Competencies is a way that market forces have become acceptable in the decision making and practices of the profession. Although occupational therapy has historically had strong connections with community service provision, these were generally localised and often in response to parochial market forces. In the current era these economic drivers are becoming replaced by the financialisation and globalisation of the health sector. Despite all the occupational therapists in the case studies being part of localised community solutions to provide public services they were all connected to macro-level elements of global financialisation through the growing international industry of health regulation, the adoption of internationally derived health economic policies, through international provision of health infrastructure services such as information technologies and the way products and services were being provided by multi-national corporations. The therapists' work supported these structures of capitalism and the generation of wealth in direct and indirect ways through the types of organisations they worked for, the services they provided and the legal processes and systems they had to comply with. For these structures to succeed they rely on the successful enterprising up of practitioners and the commodification of healthcare as a product.

The health marketplace relies on unwell and disabled people as consumers as well as the health professionals who provide services to these consumers to create market demand. Generating profit is an objective of the investment sector that aligns with the self-responsibilisation objectives of commodifying healthcare. Personally funding healthcare opens up many more material outcomes than can be provided through public funding. Options involving where one lives, what vehicle one drives, how much personal support is available, how many hours of specialised therapy and what assistive technologies are used are all available if personal resources are available. These options all

contribute to the market demand for healthcare services and purchasing products is a clear route to getting the life one desires.

Although people who live in constrained financial situations have rights to public services such as occupational therapy, the material implications of providing services for people who have limited financial resources can make their life aspirations difficult to actualise. Along with not having disposable income, other factors such as not owning one's own home, living in a non-compliant dwelling, not having a fixed abode, choosing to live rurally or, in a small or crowded home, or requiring constant one-to-one support to enable active participation, are all material limitations that preclude eligibility or nullify the ability for effective, publically funded support to be provided. Even if people in highly marginalised social situations (such as those in the case studies) have greater needs, for those with less money their material situation can seriously limit what professions such as occupational therapy can do. The material outcomes of these limiting factors are largely unspoken as they do not fit into how the marketplace operates. There is no demand for products from the people in this situation or the professions working with them. The market becomes part of a collaboration of silencing practices that form the silent discourse of what has become an acceptable life for some people but not others. As one of the professions involved in the healthcare market place occupational therapy is involved with these collaborative practices.

The occupational therapy practices analysed had increasing associations with market driven services which support the financialisation and globalisation of health and public services. At the same time therapists are expected to address the outcomes of social inequities in their practice. In the current version of the Competencies for Registration document specific skills target health inequities, for example “you recognise your responsibility as a health professional to ensure equal health outcomes for all your clients / tangata whaiora (Māori clients)” (2.2 Occupational Therapy Board of New Zealand, 2015d). Likewise reducing economic disparity is a primary government policy focus within the overarching strategy of Better Public Services (Ministry of

Health, 2013). The paradoxical position which this places a profession like occupational therapy emerges at the hard edge of practice. On one hand they are contributing to the generation of wealth and ability of the globalised financial sector to influence how healthcare is delivered whilst on the other they are charged with addressing the disparities this creates.

The economic-governmental practices decided by and supported through the sovereign power of government have enabled the expansion and insertion of capitalism into the public services examined in this research. The increasing influence the global financial element has on how services are delivered was not visible in the day to day practice decisions of the occupational therapists. What was visible was the associated regime of truths of individualism and self-responsibility for life outcomes. These regimes are also highly present in the way occupational therapists are expected to practice in the governing documents of the OTBNZ, in their conditions of employment and through government policies. The connections between economic success, self-responsibility and material outcomes are strongly linked and have become normalised in both how the conduct of occupational therapists is governed and in how they are positioned to govern others. The dominance of individualism and self-responsibility fades what happens if an individual cannot take responsibility for their own life to an opaque place in public consciousness. This fading is a silencing practice that keeps these material outcomes part of a silent discourse that has become part of everyday life. The collaborative silencing that occurs through practices of sovereign and economic-governmental power also subjugates other knowledge and discursive practices, making these difficult to recognise and the possibilities they represent difficult to imagine. However, like the silent discourse of what is an acceptable life outcome for certain people, this subjugation was right on the surface of everyday practice. There were instances of subjugated knowledge and practices in all the occupational therapists' work in the case studies. These glimmers of alternate lines of power and subjectivities provide opportunities for the profession to contest this silent discourse and the hard edge of material outcomes.

Opportunities at the Hard Edge of Material Outcomes

Bypassing dominant knowledge regimes.

Although the conditions of emergence of occupational therapy as a profession were shared by other health professions, the way occupational therapy is done opened up other parallel power relations because of the way the profession used material regimes of knowledge. From the sources and information gathered for this research, the development of occupational therapy as a profession appeared to become closely imbricated with material regimes of knowledge from the outset. The way the profession strongly deploys this regime of knowledge could be seen in the case studies, indicating it has remained a principal support in the formation of resilient and productive practices that are not part of dominant medico-legal regimes. The influence of the material world on occupational therapy practice was evident in the frequent reminiscences about vehicles, buildings, equipment, geography and making therapeutic modalities in occupational therapists memoirs (Gordon et al., 2009; Skilton, 1981). Reference to the materiality of providing healthcare is most often the only trace of what occupational therapists do in official grey documents⁸⁴, and accommodating the material world was a significant preoccupation of all the occupational therapists observed in this research. Occupational therapy is visible where material regimes of knowledge are dominant.

The highly specialised knowledge of how to actualise healthcare has resulted in expertise about how to get things done, and what is possible to do, within institutional and social structures such as hospitals, schools and community based services. Providing a person with custom made pyjamas, a USB stick of music or a hand cut and glued wheelchair cushion are material practices that involve material regimes of knowledge specific to individual

⁸⁴ As discussed in chapter eight when Tokanui Hospital was closing the only place occupational therapy was mentioned was in an accounting firm's report in conjunction to the cost of providing wheelchairs and ongoing therapy (Ministry of Health 1993; PriceWaterhouseCooper, 1994). More recent examples can be seen in the way Ministerial level agreements between Health and Education about who should provide equipment and environmental assessments clearly specify occupational therapy (Ministry of Education & Ministry of Health, 2014) whereas other policy documents only refer to general specialist services without identifying individual professions (Ministry of Education, 2014, 2016).

situations. Likewise the provision of restraints in vehicles, ramps in homes or workplaces, and opportunities to learn and practise everyday living skills are essential material practices that underpin higher level policy and rights based objectives. The material regime of knowledge does not naturally fit in the hierarchy of medical human science knowledge as it is not easily quantifiable, is difficult to document and does not have a body of literature supporting its efficacy. As seen in the examples from the case studies, many of occupational therapy's essential understandings have become 'other' knowledge that is not able to be placed in this hierarchy⁸⁵.

Occupational therapy has held onto its status as a legitimate human science chosen to be vested with delegated sovereign power, despite the increasing emphasis by medico-legal structures on the importance of knowledge involving positivistic science such as evidence based practice, population based interventions and statistical analysis of service outcomes. The success and survival of both the profession and niche services such as those the occupational therapists in the case studies provided illustrate how this subjugated knowledge contests dominant medical practice at the micro-level. At the special school occupational therapists (along with speech therapists) were the largest profession of therapists employed. The wheelchair service had grown steadily from its inception where it employed one occupational therapist to now employing approximately twenty with over fifteen other support staff⁸⁶ assisting them in their work. The forensic ward had an extremely high ratio of therapists for its bed numbers (one therapist: six inpatients), far exceeding what would have been provided in past institutions.

The demands of accommodating the material world to assist the people the therapists were working with necessitated all of these levels of staffing. The high allocation of resourcing this staffing requires has occurred despite the

⁸⁵ Being a category considered outside of human sciences but equivalent in status is nicely illustrated in the company profile of Accessable, the largest equipment management service in the country stating "Within our team we have a number of professional specialists in health sciences and occupational therapy..."(Accessable, 2017, p.2).

⁸⁶ In 2016 the service employed 11 wheelchair technicians, 4 admin staff and several wheelchair mentors to carry out wheelchair skills training courses.

profession not fulfilling the knowledge requirements to slot into the human science hierarchy. There is little positivistic evidence that indicates occupational therapy is a scientifically proven practice in any of these areas. Its influence on other professions and health theory is negligible and the academic qualifications of most of the profession remain at the level of a Bachelor's degree. Despite these anomalies, the material world has productively co-constituted occupational therapy to be essential in delivering healthcare objectives and has enabled the profession to successfully contest the dominance of positivistic science knowledge as a requirement to be a legitimate and resourced health profession. The liminal space of underground practice that has been produced by this success would not exist without the material world being a central actant. It is also reliant on the delegated sovereign power that occupational therapists have.

The way occupational therapy has been able to maintain an underground practice where what occupational therapists do is largely unclear to others is an indicator of alternate power relations at play. The immanence of the material world is an unspoken leveller where dominant forms of power are able to be re-configured. A good example of how these dominant regimes of knowledge have been successfully contested by material regimes of knowledge is the way that occupational therapists have been able to retain access to substantial public funding pools despite the wholesale commodification of public services that has transferred responsibility for these to the market.

Productive power of materiality.

The ability of occupational therapists to access money to accommodate the material world was relatively unhindered before the 1990s. Occupational therapy departments such as the one at Tokanui Hospital were historically large, often with additional rooms and buildings, workshops, cars, and stores of therapeutic equipment. Therapists had access to the skills of the on-site trade related workforce (e.g. electricians, builders, engineers, orthotists) as part of their everyday work or were able to purchase these skills to carry out their work through hospital contracted services. After the reforms, it took until 1997

before the government established some control on how much government money occupational therapists were spending. A new system was implemented that was a centralised and contracted service arrangement rather than the past regional social welfare based system (Ministry of Health, 1997). As well as this historical position as a gatekeeper to public funding, doing occupational therapy has always required ongoing financial resourcing by the service provider. Resourcing continues to be made up of multiple budgetary capillaries from a range of sources. Examples of these are petty cash systems, cost coding between departments, expense re-imburements, departmental budgets, and centralised systems of funding. These funding pools are spread over numerous intra-organisational sources (such as maintenance, capital expenditure, discretionary budgets, therapy equipment, extra-ordinary circumstances for high and complex health needs and palliative care) as well as philanthropic or corporate sponsorship. Although the healthcare marketplace has changed dramatically in response to the economic-governmental practices that introduced globalised commodification of healthcare, a situation still remains where occupational therapy practice continues to involve high levels of ongoing public and other funding that bypass the rules of the marketplace to be profitable. It is very difficult to ascertain how much the government spends on health and disability non-human support. Estimating how much philanthropic, corporate or other charitable funds occupational therapists spend is even less possible.

Due to the competitive nature of the market the financial costing for publically funded services has become commercially sensitive, with only general figures provided in public records. For example, the Enable New Zealand equipment management service does not have detailed public financial records. Its latest annual review states only that it spent \$21.7 million on equipment in 2015-16. The report also states that 3431 housing modifications were completed but does not disclose at what cost, nor was the cost of maintaining, refurbishing and freighting equipment throughout the country stated. Enable New Zealand is a subsidiary of MidCentral District Health Board, one of the

twenty public health services. In the Board's latest annual report the entire multi-million dollar company only featured as a line of expenditure in its budget and projected plans (MidCentral District Health Board, 2016a, 2016b). Enable New Zealand competes with the other national provider of equipment services, the Auckland based company Accessable. Accessable is a for-profit company and also does not make public records of its finances available (Accessable, 2017). Both of these companies have secured large government contracts that involve distributing an allocated budget for equipment management services.

As referred to earlier in relation to how sovereign power conducts the conduct of occupational therapists, budget blowouts in the allocation of equipment funding is commonplace. At least annual warnings are sent to assessors to curb the amount of money they are spending⁸⁷. Successive governments have been unable to change this with demand outstripping the budget despite many re-structures since 1997⁸⁸. The outcome of this is that the government has had to continually use its exceptional sovereign power to control the market forces of this specialised sector. Using this practice of sovereign power has occurred repeatedly over the last fifteen years. In 2004 assessors were informed that "in the Ministry of Health regions to which Enable New Zealand delivers services, the delegation to Specialised Assessors for purchasing equipment and housing modifications up to the value of \$500 is permanently withdrawn" (Enable New Zealand, 2004). In 2012 "it is highly unlikely that any funding will be available for Priority Two Housing modifications now and into the foreseeable future" (Enable New Zealand, 2012) and more recently "currently we are picking up approximately 10 service request per

⁸⁷ Budget blowouts are a regular occurrence and occupational therapists receive letters warning that they cannot continue to prescribe equipment or that the money has been frozen for certain lengths of time. For e.g. see <http://www.accessable.co.nz/news/accessable-notice> and <https://www.disabilityfunding.co.nz/all>

⁸⁸ Accessable was contracted for services in 2000 as part of the funder/provider marketplace competition. Since then the way Enable New Zealand and Accessable are required to administer funding has been constantly tinkered with, mainly through the way what are considered common items for purchase and what is specialised and more difficult to access. In 2011 the Prioritisation Tool was piloted to provide central control over this tinkering and was rolled out nationwide in 2013-14, significantly restructuring the process that both Enable and Accessable were required to comply with.

month where the person is not eligible with Band 2/3 equipment requests under \$5000” (Enable New Zealand, 2016, p. 2). Despite twenty years of reformation and methods of governmentality being deployed, the conduct of occupational therapists has not been able to be managed in a way that has produced the desired outcome.

Occupational therapists are one of the main assessors responsible for spending these funds⁸⁹. The use of their delegated sovereign power in combination with the legitimised expertise they have involving the use of the material world has produced another power relation into the dominant di-polar field of sovereign and economic-governmental power. The line of power that the materiality of occupational therapy co-opts successfully provides an ongoing contestation to the way economic management legitimises the exercise of exceptional practices of sovereignty. By continuing to apply and prescribe material solutions to health related problems despite the constant pressure to constrain and control these solutions through policy changes, occupational therapists keep the material outcomes for people visible on the economic radar. The provision of material objects and environmental solutions has necessitated constant interventions by government as enterprising practices of the market have not provided what is directed in policy and rights based legislation. The delegated sovereign power of occupational therapists continues to keep this situation alive and on the surface of political economic decision making. Continual funding injections and re-configurations of economic methods of management have occurred over the last

⁸⁹ Occupational therapy has become the primary profession credentialed to access equipment and environmental modifications, with occupational therapists able to be credentialed in 7 out of 8 assessor categories compared to 1-2 possible for other professions. This has positioned occupational therapy practice as essential in the distribution of the annual budget for this element of disability support services. Over half of all applications (46,448 in 2016) to the Equipment Management Services were for daily living supports, which is a credentialed area for occupational therapists only, with another third (30,959) of applications for mobility, positioning and beds, also predominantly domains of practice of occupational therapists (Ministry of Health, 2017a).

twenty years to try and manage this system and it remains, along with the whole of disability support services a site of ongoing governmental review⁹⁰.

Although the actions of assessors successfully draw attention to the ongoing material needs of the people they work with, the ability to actually provide these material requirements remains tenuous. The dependence on wider economic and social elements such as community service availability, product availability, technological expertise or collective good-will makes any gains made by using a material regime of knowledge fragile. Recognising the position of power the material regime of knowledge offers is a way to contest dominant power relations and is a potential outcome of this research as an action oriented critique. The occupational therapists in the case studies all used largely unspoken but recognisable material regimes of knowledge that supported alternate pathways of practice and examining these in more detail provides insight to the power relations available through utilisation of a material regime of knowledge.

Alternate Pathways of Practice

All the therapists observed in this research used material practices to bypass institutional structures and traditional pathways of healthcare provision in some manner. By doing this they were supporting discursive practices of the profession which were able to operate outside dominant knowledge-power games of the health professions as well as the economic-governmental practices of contracted service provision. The discursive practices were, however, connected to the therapist's delegated sovereign power and because of this were highly contingent on the subject position of the therapist. The different

⁹⁰ In 2017 the government is currently working on developing new Disability Support Services for: people with challenging behaviours, community-based disability therapy services; community residential services (this includes achieving better outcomes for people with high and complex needs living in residential services but not covered by the High and Complex Framework); an independent living strategy; a respite strategy and an overall New Model to support disabled people that includes the ongoing funding of services (see <http://www.health.govt.nz/our-work/disability-services/disability-projects/service-strategy-development>).

services that the therapists worked in provided different opportunities for alternate pathways to form but they all involved how the therapists utilised the material world and the normalised and accepted place occupational therapy has within healthcare to do this.

Material regimes of knowledge at the micro-level.

In the forensic ward the occupational therapists utilised the physical location of their occupational therapy buildings to overtly support Te Ao Māori approaches to healthcare. Although this alternate pathway of providing healthcare was strongly endorsed at a policy level, at the level of practice the main ward building remained dominated by the medico-legal practices associated with providing forensic mental health care. The occupational therapist's position outside the main ward building enabled them to capitalise on the physical and spiritual space their location provided. The therapists were able to work in ways that operated using different power relations. This was a tentative arrangement due to the medico-legal expectations of the therapists to also assess mental state, risk status and contribute to the medical management of symptoms. However, the material world provided opportunities to modify the overarching power of medico-legal discourse and assume a different subject position, where sovereign power could be applied differently whilst still practising in a legitimate way. The use of their sovereign power to work with people outside, for extended periods of time, and by using common everyday occupations (such as cooking, eating, gardening, art, music) utilised materiality to mediate these power relations. Time was fluid in the occupational therapy area and the therapists were able to adapt and change their plans to accommodate spontaneous opportunities. These traditional practices of occupational therapy were naturalised within the ward environment and enabled the therapists to introduce different power relations into their work for short spaces of time.

At the special school, the community based network that had organically formed between the services that provided for the material needs of people with intellectual disabilities (such as housing, schooling, environmental adaptation, transport) is another example of how occupational therapists can assume subject

positions that contest dominant medico-legal practices. The network has developed and grown since Tokanui hospital closed and has formed a community based specialised niche of knowledge that centred round how to support people in the community. The network does not rely on traditional pathways of healthcare provision such as team meetings, professional roles or what constitutes therapy. Instead it relies on skills and localised material regimes of knowledge people have of the individuals' involved, physical buildings, geographic locations and how the community can provide material requirements. The occupational therapists were part of this collective due to their knowledge about the students' school and home lives. Their delegated sovereign power was utilised to support material outcomes that were outside of education based service specifications or regimes of knowledge and traditional practices associated with the healthcare system. They were able to practice in this liminal space with relative freedom, spending significant time supporting the community collective objectives.

Finally, the wheelchair therapists had strongly carved out an alternate subject position using material regimes of knowledge in several ways. They did not call themselves occupational therapists (despite most of them being licensed occupational therapists) and the service had removed itself from overt links to traditional healthcare. The work site was physically located alongside mainstream industries rather than healthcare providers, and it had developed a hybrid network that straddled the two sectors. The network was between wheelchair users and community based organisations such as CCS Disability Action⁹¹ as well as the high level funders, the Ministry of Health and ACC. The service had few formal connections with the major hospital services, enabling the therapists to assume subject positions that were outside institutionalised and traditional healthcare practices. They used their delegated sovereign power in ways that were accepted by their collective network and this had been very productive in terms of the longevity of the service and the position it had in influencing national policy. These three examples are highly specific and localised

⁹¹ CCS Disability Action was a business partner of the service from 2002-2012.

to the city and services that the occupational therapists were operating in. There were however some commonalities in the discursive practices of all the therapists that suggested that the materiality of occupational therapy could modify the interplay of economic-governmental and sovereign power at a greater level.

Material regime of knowledge as a site of resistance.

The practices discussed above are at a micro-level and demonstrated resistance to dominant regimes of power from the bottom up. Despite the productivity at this micro-level, material regimes of knowledge still remained subjugated and largely unspoken or acknowledged, part of a silenced discourse. By remaining silent the connections between sovereign and economic-governmental power and material outcomes are not confronted. It remains accepted that the interplay between these two dominant powers defines the natural limits of how material life is for certain people. The success of occupational therapy at bypassing this dominance at a micro-level gives the profession a solid ground from which to build toward addressing higher level subjugating practices. There were opportunities for this possible path of action in both the case studies and the textual analysis of the practice based archival documents in this genealogy. The strong discursive practice of occupational therapists to record and maintain alternate filing systems to store and hold information bypassed the enterprising methods used to streamline practices into auditable and accountable forms. The practice creates a body of knowledge that marks out and records the outcomes of material practices. This archive exists where occupational therapists practice, which historically has been throughout a wide range of services provided by the social body. The material records have power because of the knowledge they hold which is legitimised through the sovereign power occupational therapists have. They are where the hard edge of sovereign and economic-governmental di-polar interplays are documented and visible.

The other glimmer of possibility in the therapists' discursive practices was the way they used materiality as a way to legitimately cross personal-professional boundaries in order to influence material outcomes. All the

therapists used digital technologies in some way that connected their personal and professional lives. They also continued more traditional practices of taking material objects home to carry out a task unable to be carried out at work (e.g. washing a cushion cover) or bringing objects from home to use at work (e.g. a piece of fabric to trial). These material practices have the ability to bypass the power relations and subjectivities created by the relationship between health professionals and healthcare user. Instead of a power imbalance where sovereign power is exercised, the material regime of knowledge and material outcomes are foregrounded as most important rather than medico-legal regimes of knowledge and dominant discursive practices of this regime. These two examples present opportunities for occupational therapy, where the material immanent practices inherent in the profession have the potential for counter-conduct and contestation of dominant regimes of knowledge. The current governing documents recently produced by the OTBNZ also provide a supporting line to this opportunity for counter-conduct.

As examined in chapter five, the privileging of Te Tiriti o Waitangi in the current governing documents supports a legal position that opens up the possibilities for how occupational therapists can legitimately practise. By coupling this option with the productivity and stability occupational therapists have acquired in the natural order of healthcare provision through the use of a material regime of knowledge, the profession has the groundwork in place to alter the trajectory of the silencing practices that keep material outcomes of sovereign and economic-governmental power a silent discourse. As well as this alternate use of the position of sovereign power that occupational therapists hold, the historical position of the profession in the community and non-government sector is also a line of potential support. Occupational therapy is well used to accommodating political change and utilising local networks in order to survive. Having this lasting adaptive capacity demonstrates another productive use of sovereign power to influence economic-governmental practices.

The changing landscape that has occurred through the recent financialisation and globalisation of the health and social service industries present a political environment that offers new challenges in contesting understandings of sovereignty. The individualism and self-responsibilisation that is supported through the dominance of these capitalistic regimes strongly support legal networks and the privileging of the law. Despite this dominance, amidst the convoluted nature and pervasiveness of these macro-level lines of power, the material world remains a constant commonality to the success of these networks. The material outcome of occupational therapy, what occupational therapy does, is where the micro-level daily reality for other people can be influenced in ways that resist this pervasiveness. Through a deliberate coalition of the productive micro-capillaries of power that occupational therapy has formed over its short existence, this resistance could be grown to contest the taken-for-granted, current order of things. To grow this form of resistance to one that can impact on policy and alternate social outcomes, Gofen (2014) suggests that street-level bureaucrats require collective action and explicit transparency in their strategic endeavours. Gofen's insights appear particularly relevant in relation to the occupational therapy practices examined in this research due to the identified lack of collectivity within the profession and the strength of the unspoken norm of underground practice. The insights gained from using the blog in this research suggest that while social media may not be useful as a central strategy to develop collective action, it could be a useful medium to assist with transparency and producing a public stance for occupational therapy. Careful attention to the collaborative silencing practices that the profession is colluding with is required. Whilst the underground subjectivity meets many of the needs of the profession it also allows occupational therapists to abdicate responsibility for the vital need to improve material outcomes for people in order for them to realise self-determination and a dignified life.

Limitations of the Research

As discussed in the introductory chapter the absence of a feminist critique in this analysis is a major limitation of the research. The intersections between subjugated knowledge, dominant power and gender are significant and extremely relevant to the predominantly female profession of occupational therapy. Adding a feminist critique to the problematising offered by this thesis would be highly productive and an essential addition to the body of knowledge it is contributing to. Along with this limitation there are other methodological considerations that are also important to acknowledge as influential to the positioning and ontological basis of the research.

My own subjectivities of being of European descent and growing up in a colonised country are a necessary consideration in the positioning of the analysis. Although Foucault contended that 'the author is dead' the object of this research makes my insider position and being the author an important overlay to acknowledge as a context to the critique. The subjectivities created by these subject positions have required a constant reflexivity about how I was conducting the research and the power relations involved. Unconscious bias and subjective interpretation is one of the criticisms of Foucauldian methodologies. Writing out the subjectivity of the author in order to produce an empirical account is what Habermas (1985/1987, p. 278) describes as an "objective illusion" as any such knowledge will always be dependent on the standpoint of the author and the presentism that goes with this (Habermas, 1985/1987). By making my standpoint clear from the beginning of the thesis, my position as a researcher, occupational therapist and person have been acknowledged to provide some transparency to the level of subjectivity involved in the analysis. However the research remains limited by the constraints of being human and the inability to separate oneself from the subjectivities that go with this.

Closely connected to the issue of where the author is placed in the research are the power relations of this positioning. Producing a PhD thesis that is also an active critique is an overt use of the position of power that academic research has. It is directly using the status of being a PhD student to support and

promote certain types of knowledge. To mitigate this, transparency about the aims of the research, the collaboration involved in the case studies, the openness of the research blog and the continued involvement at a local level as a practitioner and community member have been prioritized to try and minimize the power differential of being an 'academic' rather than a practitioner. Nonetheless the thesis is exploiting the position of having knowledge and status of a PhD student in the discipline of sociology to influence the power relations of the profession.

Along with the limitations created by choosing to use Foucauldian methodologies and an insider position, Foucault's concepts also support the research being a Euro-normative critique. Foucault's concepts of the human subject are individualising as they consider the subject to have an ethics of the self, to be in a process of self-formation, and that life is the creation of a personal aesthetic of existence (Foucault, 1983). Foucault's individualising understanding of the subject is a limitation as it underlies the concepts of subjectification and governmentality used in this research. Using these concepts subjugates other understandings of the human condition such as collective forms of existence or the absence of human/non-human binaries, reinforcing a dominant and taken-for-granted acceptance of this individualised way of understanding what it is to be human. Continuing any active critique built from this research would necessitate a careful consideration of this ontological position to ensure a congruency between its aims and philosophical base. As well as this, attention to minimising the risk of inadvertently supporting the discourse and structures that are the object of critique would be essential. The potential for this slippage is particularly significant in the deployment of a post-colonial lens in this research. While the best effort has been made to take care to not inadvertently support underlying colonising practices, the use of Foucauldian methodologies and the personal subjectivities of being a white health professional make this a strong possibility due to my own taken-for-granted assumptions.

Future Research Directions

As well as adding a feminist perspective to this critique there are many other possible lines of inquiry that could build from this research. One of these could be an overt exploration of how practices of occupational therapy are connected to colonisation and imperial codes of power. As well as this the productivity of collective power relations at the street or ground level and how these collectives operate would be a natural extension to problematising underground practice in occupational therapy. The presence of these power relations indicates possibilities for practitioners to further understand effective contestation of dominant regimes of power and what the risks of active contestation may be. Connected to this line of inquiry, a further investigation into how material regimes of knowledge function in these power relations could be a targeted site for analysis. The alternate pathways of power identified in this research require additional theorisation and interrogation in order to capitalise on the knowledge that has been generated.

Lastly, through the diverse connections that the shared understanding and respect for material regimes of knowledge provides, there are many possibilities for creative and innovative research collaborations. The overlapping nature of materiality between different worldviews and bodies of knowledge creates an opportunity to find a shared ground between people, policies, practices and disciplines that privileges material outcomes. By building on the contention in this research that materiality acts as a leveling force that can compete with other forms of power, these collaborations could have the ability for street-level bureaucrats to become policy in ways that transverse traditional forms of service provision and siloed regimes of practice.

Concluding Statement

By viewing occupational therapy as both historically contingent and dangerous, a particular problematisation of practices has been presented in this research. The objective throughout has been to contribute to an understanding of what happens at the micro-level of practice where real outcomes for real people meet the macro-level of policy and discourse. The material outcomes produced through a coalition of sovereign and economic-governmental power forms a hard edge to occupational therapy practices, indicating a significant site of danger for the profession. Everyday practice decisions are often made out of view of others and are heavily reliant on individual judgements and profession specific knowledge that are sanctioned by having delegated sovereign power. Having this position is both an opportunity and a risk, as what this underground doing does can support many different discourses and power relations. Understanding how forms of power filter through to us as occupational therapists provides the opportunity to resist the way the western episteme orders axes of power which create inequitable life outcomes. The material world is where strongly entrenched discursive practices for the profession lie and is a place where a re-ordering could occur from the bottom up, using the position of being a street-level bureaucrat. Using material networks of power is an opportunity to contest the western episteme and the way this worldview normalises the social structures that make social disparity so difficult to address. Material practices and regimes of knowledge offer alternate power relations to street-level bureaucrats, enabling their practice to follow different rules outside this episteme. With collective action, practitioners can influence policy and service delivery from the street and the critical perspective developed in this thesis is intended to be used to support this agenda. Being armed with such a critical perspective provides practitioners with another tool to cut through the surface of practice, aiding recognition of what their doing does, and more importantly, to open doors to the possibilities of what their doing could do.

References

- Abberley, P. (1995). Disabling ideology in health and welfare - the case of occupational therapy. *Disability & Society*, 10(2), 221-232. doi:10.1080/09687599550023660
- Accessible. (2017). *Company Profile*. Retrieved from <http://www.accessable.co.nz/contact-us/about-us>
- Accident Compensation Corporation. (2010). *History of ACC in New Zealand*. Retrieved from http://www.acc.co.nz/about-acc/overview-of-acc/introduction-to-acc/aba00004#P27_2937
- Accident Compensation Corporation. (2015). *Managed Rehabilitation Equipment Services (MRES). Operational Guidelines*. Retrieved from http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/guide/wpc134494.pdf.
- Adams, A. (21 March 2017). NZ's highest rate of family violence in the developed world - Amy Adams has 'had enough'. *Stuff*. Retrieved from <http://www.stuff.co.nz/national/politics/90657034/nzs-highest-rate-of-family-violence-in-the-developed-world--amy-adams-has-had-enough>
- Adams, C. (2015). Deloitte Top 200: Company of the Year - Ebos. *NZ Herald*. Retrieved from http://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=11551162
- Adams, T. L. (2010). Gender and feminization in health care professions. *Sociology Compass*, 4(7), 454-465. doi:10.1111/j.1751-9020.2010.00294.x
- Agamben, G. (2009). *What is an apparatus? And other essays* (D. Kishik & S. Pedatella, Trans.). Stanford, CA: Stanford University Press.
- Anderson, P. (2015). OTNZ Whakaora Ngangahau Aotearoa news. *OT Insight*, 36(7), 4. Retrieved from <http://www.otnz.co.nz>
- Armstrong, J. (2009). *Under one roof. A history of Waikato Hospital*. Hamilton, New Zealand: Half Court Press Ltd.
- Auckland University of Technology. (2017). *Occupational therapy: Bachelor of Health Science*. Retrieved from <http://www.aut.ac.nz/study-at-aut/study-areas/health-sciences/undergraduate-courses/bachelor-of-health-science-overview/?a=56314>

- Baby, M., Glue, P., & Carlyle, D. (2014). 'Violence is not part of our job': A thematic analysis of psychiatric mental health nurses' experiences of patient assaults from a New Zealand perspective. *Issues in Mental Health Nursing, 35*(9), 647-655. doi:10.3109/01612840.2014.892552
- Bacchi, C. (2012). Why study problematizations? Making politics visible. *Open Journal of Political Science, 02*(01), 1-8. doi:10.4236/ojps.2012.21001
- Bacchi, C. (2016). Problematizations in health policy: Questioning how "problems" are constituted in policies. *SAGE Open, (April-June)*, 1–16. Retrieved from <http://journals.sagepub.com/doi/full/10.1177/2158244016653986>
- Barad, K. (2003). Posthumanist performativity: Toward an understanding of how matter comes to matter. *Signs, 28*(3), 801-831. doi:10.1086/345321
- Bargh, M. (2007a). A small issue of sovereignty. In M. Bargh (Ed.), *Resistance: An indigenous response to neoliberalism* (pp. 133-146). Wellington, New Zealand: Huia Publishers.
- Bargh, M. (2007b). Introduction. In M. Bargh (Ed.), *Resistance: An indigenous response to neoliberalism* (pp. 1-24). Wellington, New Zealand: Huia Publishers.
- Bargh, M. (Ed.). (2007c). *Resistance: An indigenous response to neoliberalism*. Wellington, New Zealand: Huia Publishers.
- Bargh, M., & Otter, J. (2009). Progressive spaces of neoliberalism in Aotearoa: A genealogy and critique. *Asia Pacific Viewpoint, 50*(2), 154-165. doi:10.1111/j.1467-8373.2009.01390.x
- Barnes, J. (2006). The continuing debate about 'plain language' legislation: A law reform conundrum. *Statute Law Review, 27*(2), 83-132. doi:10.1093/slr/hml004
- Barnes, J. (2010). When 'plain language' legislation is ambiguous - sources of doubt and lessons for the plain language movement. *Melbourne University Law Review, 34*(3), 671-707. Retrieved from <http://law.unimelb.edu.au/mulr>
- Belgrave, M. (2014). Beyond the Treaty of Waitangi: Māori tribal aspirations in an era of reform, 1984–2014. *The Journal of Pacific History, 49*(2), 193-213. doi:10.1080/00223344.2014.898232

- Boast, R. (2015). Te tango whenua – Māori land alienation In, *Te Ara - the Encyclopedia of New Zealand*. Wellington, New Zealand: New Zealand Government.
- Boyd, M. A. (1984). The 1984 NZAOT Frances Rutherford Lecture. Quality assurance in occupational therapy. *New Zealand Journal of Occupational Therapy*, 35(2), 3-11. Retrieved from <https://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Brunton, W. (2001). The case of deinstitutionalisation. In P. Davis & T. Ashton (Eds.), *Health and Public Policy in New Zealand (pp. 181-200)*. Auckland, New Zealand: Oxford University Press.
- Burgess, M. E. (1984). *Nursing in New Zealand society*. Auckland, New Zealand: Longman Paul Ltd.
- Campion, M. (2012). Mental health and legal landscapes. In Catharine Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to mental health services in the Waikato 1910-2012*. (pp. 13-26). Hamilton, New Zealand: Half Court Press Ltd.
- Cartwright, S. (1988). *The Cartwright Report*. Auckland, New Zealand: Ministry of Health Retrieved from <http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/64D0EE19BA628E4FC256E450001CC21?opendocument>.
- Clayworth, P. (2013, 29 July). *Prisons - Developing a national prison system, 1880–1949*. Retrieved from <http://www.TeAra.govt.nz/en/prisons/page-3>
- Coleborne, C., & Waikato Mental Health History Group (Eds.). (2012). *Changing times, changing places. From Tokanui hospital to mental health services in the Waikato 1910-2012*. Hamilton, New Zealand: Half Court Press Ltd.
- Community Living. (2017). *Our history*. Retrieved from <http://www.communityliving.org.nz/community-living/our-history>
- Coney, S. (2009). Exposing the experiment. In J. Manning (Ed.), *The Cartwright papers. Essays on the cervical cancer inquiry 1987-1988* (pp. 59-70). Wellington, New Zealand: Bridget Williams Books Ltd
- Council for Regulatory Excellence. (2009). *Performance review of health professional regulatory bodies 2008/09. Promoting improvement in regulation*. London, England: Author Retrieved from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/248243/0713_i.pdf.

Craig, E., Dell, R., Reddington, A., Adams, J., Oben, G., Wicken, A., & Simpson, J. (2014). *Te Ohonga Ake. The determinants of health for Māori children and young people in New Zealand*. Dunedin, New Zealand: Otago University. Retrieved from <http://dnmeds.otago.ac.nz/departments/womens/paediatrics/research/nzcyes/maori.html>

Cutchin, M. & Dickie, V. (2012). Transactional perspectives on occupation: An introduction and rationale. In M. Cutchin & V. Dickie (Eds.), *Transactional perspectives on occupation* (pp.1-10). New York, NY: Springer.

Dalgliesh, B. (2013). Critical history: Foucault after Kant and Nietzsche. *Parrhesia: A Journal of Critical Philosophy*, 18, 68-84. Retrieved from http://www.parrhesiajournal.org/parrhesia18/parrhesia18_dalgliesh.pdf

de Zuniga, H. G., Bachmann, I., Hsu, S. H., & Brundidge, J. (2013). Expressive versus consumptive blog use: Implications for interpersonal discussion and political participation. *International Journal of Communication*, 7, 22. Retrieved from <https://ijoc.org/index.php/ijoc/article/viewFile/2215/949>

Dean, M. (1994a). *Critical and effective histories. Foucault's methods and historical sociology*. London, England: Routledge.

Dean, M. (1994b). "A social structure of many souls": Moral regulation, government, and self-formation. *Canadian Journal of Sociology*, 19(2), 145-168. Retrieved from <https://ejournals.library.ualberta.ca/index.php/CJS/index>

Dean, M. (2012). The signature of power. *Journal of Political Power*, 5(1), 101-117. doi:10.1080/2158379X.2012.659864

Dean, M. (2013). *Signature of power: Sovereignty, governmentality and biopolitics*. London, England: SAGE Publications.

Deleuze, G. (1991). What is a dispositif? (T. J. Armstrong, Trans.). In T. Armstrong (Ed.), *Michel Foucault. Philosopher* (pp. 159-168). Hemel Hempstead, England: Harvester Wheatsheaf.

Denshire, S. (2011). Re-inscribing gender into the heritage of OT in Australia. "The sock knitter". In J. Higgs, A. Titchen, D. Horsfall & D. Bridges (Eds.), *Creative spaces of qualitative research: Living research* (pp. 105-114). Rotterdam, The Netherlands: Sense Publishers.

- Department of Corrections. (2017). *Prison facts and statistics - December 2016*. Retrieved from http://www.corrections.govt.nz/resources/research_and_statistics/quarterly_prison_statistics/prison_stats_december_2016.html#prison
- Department of Health. (1974). *A health service for New Zealand*. Wellington: Author Retrieved from <http://www.moh.govt.nz/notebook/nbbooks.nsf/0/05D7CBD25241DF9A4C2565D7001869DE>.
- Dey, J. K. (2012). Reflections and memories. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to Waikato mental health services, 1910-2012* (pp. 166-170). Hamilton, New Zealand: Half Court Press Ltd.
- Dreyfus, H. L., & Rabinow, P. (1982). *Michel Foucault: Beyond structuralism and hermeneutics*. Chicago, IL: The University of Chicago Press.
- du Gay, P. (2004). Against 'Enterprise' (but not against 'enterprise', for that would make no sense). *Organization*, 11(1), 37-57.
doi:10.1177/1350508404039777
- Easton, B. (2002). *The New Zealand health reforms in context*. Retrieved from http://www.eastonbh.ac.nz/2002/06/the_new_zealand_health_reforms_in_context/
- Ebos Group Ltd. (2017). *Our Company*. Retrieved from <http://www.ebosgroup.com/about-us/our-company/>
- Edens, J. (25 May 2017). NZ's bulging prison population 'unprecedented': Budget. *Stuff*. Retrieved from <http://www.stuff.co.nz/business/industries/92974224/nzs-bulging-prison-population-unprecedented-budget>
- Education Act. (1989). *New Zealand Statutes*. Wellington, New Zealand: Parliamentary Counsel Office Retrieved from <http://www.legislation.govt.nz/act/public/1989/0080/latest/DLM175959.html>.
- Education Review Office. (2016). *Early Childhood and School Reports*. Retrieved from <http://www.ero.govt.nz/review-reports/>
- Elliot, B., Baker, R., & Maniapoto-Anderson, R. (2012). Māori mental health. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to mental health services in*

the Waikato 1910-2012 (pp. 111-134). Hamilton, New Zealand: Half Court Press Ltd.

- Enable New Zealand. (2004). *Advice from the Disability Service Directorate*. Retrieved from <https://www.disabilityfunding.co.nz/all/all-archived/archived-notices2/ems-assessors-archived/additional-information-from-enable-new-zealand-and-accessable-on-advice-from-the-disability-service-directorate-of-the-ministry-of-health-dated-26th-august-2004>
- Enable New Zealand. (2012). *February 10 2012, Demand and Budget Management Update - Enable New Zealand Region*. Retrieved from <https://www.disabilityfunding.co.nz/all/all-archived/archived-notices2/ems-assessors-archived/february-10-2012>
- Enable New Zealand. (2014a). *Credentialed Categories*. Retrieved from <http://www.disabilityfunding.co.nz/ems-assessors/credentialed-categories-of-accreditation>
- Enable New Zealand. (2014b). *Eligible Health Professionals*. Retrieved from <http://www.disabilityfunding.co.nz/ems-assessors/eligible-health-professionals>
- Enable New Zealand. (2016). *Update from Enable New Zealand regarding budget, demand management and audits*. Palmerston North, New Zealand: Author Retrieved from https://www.disabilityfunding.co.nz/__data/assets/pdf_file/0005/137489/Budget-Demand-Letter.pdf.
- Enrich+. (2014). *Annual Report 2013*. Te Awamutu, New Zealand: Author Retrieved from <http://enrichplus.org.nz/wp-content/uploads/2014/06/Annual-Report-2013.pdf>.
- Fadyl, J. K., & Nicholls, D. A. (2013). Foucault, the subject and the research interview: A critique of methods. *Nursing Inquiry*, 20(1), 23-29. doi:10.1111/nin.12011
- Fadyl, J. K., Nicholls, D. A., & McPherson, K. M. (2013). Interrogating discourse: The application of Foucault's methodological discussion to specific inquiry. *Health*, 17(5), 478-494. doi:10.1177/1363459312464073
- Finlay, L. (1998). *The life world of the occupational therapist: Meaning and motive in an uncertain world* (Unpublished Doctorate of Philosophy). Open University, Great Britain.

- Fisher, M. (2015). *Balancing rangatiratanga and kawanatanga: Waikato-Tainui and Ngāi Tahu's Treaty settlement negotiations with the Crown* (Unpublished Doctorate of Philosophy). Victoria University, Wellington, New Zealand. Retrieved from <http://researcharchive.vuw.ac.nz/xmlui/bitstream/handle/10063/4642/thesis.pdf?sequence=2>
- Fitchett, E. (2012). Reflections and memories. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui Hospital to mental health services in the Waikato, 1910-2012* (pp. 161-162). Hamilton, New Zealand: Half Court Press Ltd.
- Folkers, A. (2016). Daring the truth: Foucault, parrhesia and the genealogy of critique. *Theory, Culture & Society*, 33(1), 3-28. doi:10.1177/0263276414558885
- Fortune, T. (2000). Occupational therapists: Is our therapy truly occupational or are we merely filling gaps? *British Journal of Occupational Therapy*, 63(5), 225-230. doi:10.1177/030802260006300507
- Foucault, M. (1963/1975). *The birth of the clinic: An archaeology of medical perception* (A. S. Smith, Trans.). NY, New York: Vintage.
- Foucault, M. (1966/1970). *The order of things. An archaeology of human sciences* (Tavistock Routledge Publications, Trans.). London, England: Tavistock Publications.
- Foucault, M. (1972/1984). The Politics of health in the eighteenth century. In P. Rabinow (Ed.), *The Foucault reader* (pp. 273-290). New York, NY: Pantheon.
- Foucault, M. (1975/1995). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). New York, NY: Vintage Books.
- Foucault, M. (1977/1980). Confessions of the flesh (C. Gordon, Trans.). In C. Gordon (Ed.), *Power/Knowledge. Selected interviews and other writings 1972-1977* (pp. 194-228). New York, NY: Pantheon Books.
- Foucault, M. (1977/1984). Nietzsche, genealogy, history (D. F. Bouchard & S. Simon, Trans.). In P. Rabinow (Ed.), *The Foucault reader* (pp. 76-100). New York, NY: Pantheon.
- Foucault, M. (1980/1991). Questions of method (C. Gordon, Trans.). In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault effect: Studies in*

governmentality. With two lectures by and an interview with Michel Foucault (pp. 73-86). Chicago, IL: Chicago University Press.

Foucault, M. (1981/1988). Practicing criticism (A. Sheridan, Trans.). In L. E. D. Kritzman (Ed.), *Politics, philosophy, culture. Interviews and other writings 1977-1984* (pp. 152-159). New York, NY: Routledge.

Foucault, M. (1982). The subject and power. *Critical Inquiry*, 8(4), 777-795.
Retrieved from <http://www.jstor.org/stable/1343197>

Foucault, M. (1983). On the genealogy of ethics: An overview of work in progress. In H. L. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics* (2nd ed., pp. 229-253). Chicago, IL: Chicago University Press.

Foucault, M. (1984/1985). *The use of pleasure. The history of sexuality* (R. Hurley, Trans., Vol. 2). New York, NY: Random House.

Foucault, M. (1984/1988). The concern for truth: An interview with Francois Ewald (A. Sheridan, Trans.). In L. D. Kritzman (Ed.), *Politics, philosophy, culture. Interviews and other writings 1977-1984* (pp. 255-271). New York, NY: Routledge

Foucault, M. (1997/2003). 14 January 1976 (D. Macey, Trans.). In M. Bertani & A. Fontana (Eds.), *Society must be defended. Lectures at the College de France 1975-76* (pp. 23-43). New York, NY: Picador.

Fraser, N. (1981). Foucault on modern power: Empirical insights and normative confusions. *PRAXIS International*, (3), 272-287. Retrieved from www.cceol.com

French, P. (2001). *A study of the regulation of nursing in New Zealand 1901-1997*. Wellington, New Zealand: Victoria University.

Frost, T. (2015). The dispositif between Foucault and Agamben. *Law, Culture and the Humanities*, 1-2. doi:10.1177/1743872115571697

Gale, C., Arroll, B., & Coverdale, J. (2006). Aggressive acts by patients against general practitioners in New Zealand: One-year prevalence. *The New Zealand Medical Journal*, 119(1237). Retrieved from <https://www.nzma.org.nz/journal>

Galhegio, S. M. (2010). Occupational therapy in the social field: Concepts and considerations. In F. Kronenberg, N. Pollard & D. Sakellariou (Eds.), *Occupational therapies without borders - Volume 2. Towards an ecology*

of occupation-based practices (Vol. 2, pp. 47-56). London, England: Churchill Livingstone.

Gauld, R. (2001). *Revolving doors: New Zealand's health reforms*. Wellington, New Zealand: Victoria University.

Gerlach, A. J. (2015). Sharpening our critical edge: Occupational therapy in the context of marginalized populations. *Canadian Journal of Occupational Therapy, 82*(4), 245-253. doi:10.1177/0008417415571730

Gerritson, J. (2017, 5 September). Special education wait times 'appalling'. *RNZ National*. Retrieved from <http://www.radionz.co.nz/news/national/338692/special-education-wait-times-appalling>

Gibbons, P. (1977). *Astride the river: A history of Hamilton*. Christchurch, New Zealand: Hamilton City Council.

Gilsenan, J.-A., Hopkirk, J., & Emery-Whittington, I. (2012). Kai Whakaora Ngangahau – Māori Occupational Therapists' collective reasoning. In L. Robertson (Ed.), *Clinical reasoning in Occupational Therapy. Controversies in practice* (pp. 107-128). Chichester, England: Blackwell Publishing

Gofen, A. (2014). Mind the gap: Dimensions and influence of street-level divergence. *Journal of Public Administration Research and Theory, 24*(2), 473-493. doi:10.1093/jopart/mut037

Golder, B. (Ed.). (2013). *Re-reading Foucault on law, power and rights*. Milton Park, England: Routledge.

Gordon, B. (1994). Partnerships: With aroha and integrity. *New Zealand Journal of Occupational Therapy, 45*(2), 5-10.

Gordon, B., & Creighton, N. (2009). Beyond baskets and bunnies. In B. Gordon, S. Riordan, R. Scaletti & N. Creighton (Eds.), *Legacy of occupation. Stories of occupational therapy in New Zealand 1940-1972*. (pp. 163-182). Takapuna, New Zealand: The Bush Press Ltd.

Gordon, B., Riordan, S., Scaletti, R., & Creighton, N. (2009). *Legacy of occupation. Stories of occupational therapy in New Zealand 1940-1972*. Takapuna, New Zealand: The Bush Press Ltd.

Gordon, C. (2013). Expelled questions: Foucault, the left and the law. In B. Golder (Ed.), *Re-reading Foucault on law, power and rights* (pp. 13-38). Milton Park, England: Routledge.

- Government of Canada. (2015). *Occupational Therapists*. Retrieved from http://www.servicecanada.gc.ca/eng/qc/job_futures/statistics/3143.shtml#stats
- Graham, F. (2017). New Zealand based Master's and PhD research by occupational therapists for occupational therapists 2017. *OT Insight*, 38(3), 16. Retrieved from <https://www.otnz.co.nz/members/publications/ot-insight/>
- Graham, F., Robertson, L., & Anderson, J. (2013). New Zealand occupational therapists' views on evidence based practice: A replicated survey of confidence, attitudes and behaviours. *Australian Occupational Therapy Journal*, 60, 120-128. doi:10.1111/1440-1630.12000
- Graham, L. J. (2011). The product of text and 'other' statements: Discourse analysis and the critical use of Foucault. *Educational Philosophy and Theory*, 43(6), 663-674. doi:10.1111/j.1469-5812.2010.00698.x
- Guajardo, A., Kronenberg, F., & Ramugondo, E. L. (2015). Southern occupational therapies: Emerging identities, epistemologies and practices. *South African Journal of Occupational Therapy*, 45(1), 3-10. doi:10.17159/2310-3833/2015/v45no1a2
- Habermas, J. (1985/1987). *The philosophical discourse of modernity* (F. Lawrence, Trans.). Cambridge, England: Polity Press.
- Hamilton City Council. (2011). *School days in Hamilton*. Retrieved from http://ketehamilton.peoplesnetworknz.info/hamilton_heritage/topics/show/979-school-days-in-hamilton
- Hamilton City Council. (2013). *Council partnership with Māori*. Retrieved from <http://www.hamilton.govt.nz/our-council/consultation-and-public-notice/councilpartnershipwithmaori/Pages/default.aspx>
- Hansen, M. P. (2016). Non-normative critique: Foucault and pragmatic sociology as tactical re-politicization. *European Journal of Social Theory*, 19(1), 127-145. doi:10.1177/1368431014562705
- Hardy, N. (2015). Alea capta est: Foucault's dispositif and capturing chance. *Foucault Studies*, 19, 191-216. Retrieved from <http://rauli.cbs.dk/index.php/foucault-studies/index>
- Hayes, D. N. A. (2003). Getting rid of the subject: A technique for understanding how gendered subjectivities form and function in educational discourses.

In M. Tamboukou & S. J. Ball (Eds.), *Dangerous encounters: Genealogy and ethnography* (pp. 91-110). New York: NY: Peter Lang.

Health and Safety and Employment Act. (1992). *New Zealand Statutes*. Wellington, New Zealand: Parliamentary Counsel Office. Retrieved from <http://legislation.govt.nz/act/public/1992/0096/latest/DLM278835.html>.

Health Practitioners Competence Assurance Act. (2003). *New Zealand Statutes*. Wellington, New Zealand: Parliamentary Counsel Office. Retrieved from <http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html>.

Health Quality and Safety Commission of New Zealand. (2015). *Our role*. Retrieved from <http://www.hqsc.govt.nz/about-the-commission/our-role/>

Health Workforce New Zealand. (2011). *Rehabilitation workforce service forecast*. Retrieved from <http://www.health.govt.nz/our-work/health-workforce/workforce-service-forecasts/rehabilitation-workforce-service-forecast>

Health Workforce New Zealand. (2015). *About us*. Retrieved from <http://healthworkforce.health.govt.nz/about-us>

Henare, D. (1992). Occupational therapy in Aotearoa: Part 1. The challenge. *New Zealand Journal of Occupational Therapy*, 43(2), 10-13.

Henare, D. (1993). Occupational therapy in Aotearoa: Part 2. The steps to biculturalism. *New Zealand Journal of Occupational Therapy*, 44(1), 4-9.

Hickey, B. (2014, 27 April). Bernard Hickey: Bail-out a bad safety net. *New Zealand Herald*. Retrieved from http://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=11244859

Hill, R. S. (2012). Ngā whakataunga tiriti – Treaty of Waitangi settlement process *Te Ara -the Encyclopedia of New Zealand*. Retrieved from <http://www.TeAra.govt.nz/en/nga-whakataunga-tiriti-treaty-of-waitangi-settlement-process>

Hills, D., & Joyce, C. (2013). A review of research on the prevalence, antecedents, consequences and prevention of workplace aggression in clinical medical practice. *Aggression and Violent Behavior*, 18(5), 554-569. doi:10.1016/j.avb.2013.07.014

- Hocking, C. (2000). Having and using objects in the western world. *Journal of Occupational Science*, 7(3), 148-157.
doi:10.1080/14427591.2000.9686478
- Hocking, C. (2004). *The relationship between objects and identity in occupational therapy: A dynamic balance between rationalism and romanticism* (Unpublished Doctorate of Philosophy). Auckland University of Technology, Auckland, New Zealand. Retrieved from <http://hdl.handle.net/10292/363>
- Hocking, C. (2008a). The way we were: Romantic assumptions of pioneering occupational therapists in the United Kingdom. *British Journal of Occupational Therapy*, 71(4), 146-154.
doi:10.1177/030802260807100405
- Hocking, C. (2008b). The way we were: The ascendance of rationalism. *British Journal of Occupational Therapy*, 71(6), 226-233.
doi:10.1177/030802260807100602
- Hocking, C. (2008c). The way we were: Thinking rationally. *British Journal of Occupational Therapy*, 71(5), 185-195.
doi:10.1177/030802260807100504
- Hocking, C. (2009). The challenge of occupation: Describing the things people do. *Journal of Occupational Science*, 16(3), 140-150.
doi:10.1080/14427591.2009.9686655
- Hocking, C. (2013). Occupation for public health. *New Zealand Journal of Occupational Therapy*, 60(1), 33-37. Retrieved from <https://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Hodges, B. D., & Lingard, L. (2013). Introduction. In B. D. Hodges & L. Lingard (Eds.), *The question of competence: Reconsidering medical education in the twenty-first century* (pp. 1-14). Retrieved from <http://digitalcommons.ilr.cornell.edu/books/84>
- Hook, D. (2001). Discourse, knowledge, materiality, history: Foucault and discourse analysis. *Theory & Psychology*, 11(4), 521-547.
doi:10.1177/09593543011114006
- Hope, S. (2004). The roots and reach of rangatiratanga. *Political Science*, 56(1), 23-54. doi:10.1177/003231870405600103

- Hopkirk, J. (2010). *Whitiwhitia i te ora! Culture and occupational therapy: A Māori case study* (Unpublished Masters of Philosophy). Massey University, Palmerston North. Retrieved from http://mro.massey.ac.nz/bitstream/handle/10179/2617/02_whole.pdf?sequence=1
- Hopkirk, J. H. (2013). Frances Rutherford Lecture: E rua nga ao, kotahi te taura tangata: Two worlds and one profession. *New Zealand Journal of Occupational Therapy*, 60(1), 5-15. Retrieved from <http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Hoult, A. (2012). Intellectual disability: The patient population of Tokanui 1912-1935. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to mental health services in the Waikato 1910-2012* (pp. 53-66). Hamilton, New Zealand: Half Court Press Ltd.
- Human Rights Act. (1993). *New Zealand Statutes*. Wellington, New Zealand: Parliamentary Counsel Office. Retrieved from <http://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html>.
- Hunt, A. (1992). Foucault's expulsion of the law: Toward a retrieval. *Law & Social Inquiry*, 17, 1-38.
- Hunt, A. (2013). Encounters with juridical assemblages: Reflections on Foucault, law and the juridical. In B. Golder (Ed.), *Re-reading Foucault on law, power and rights* (pp. 64-84). Milton Park, England: Routledge.
- Hunt, A., & Wickham, G. (1994). *Foucault and the law: Towards a sociology of the law as governance*. London, England: Pluto Press.
- Hunter, E. P. (2013). The Elizabeth Casson Memorial Lecture 2013: Transformational leadership in occupational therapy — delivering change through conversations. *British Journal of Occupational Therapy*, 76(8), 346-354. doi:10.4276/030802213X13757040168234
- Institute for Healthcare Improvement. (2016a). *History*. Retrieved from <http://www.ihl.org/about/Pages/History.aspx>
- Institute for Healthcare Improvement. (2016b). *Triple Aim – Concept Design*. Retrieved from <http://www.ihl.org/engage/initiatives/tripleaim/Pages/default.aspx>

- Irwin, G., & Walrond, C. (2016). *When was New Zealand first settled?* Retrieved from <http://www.teara.govt.nz/en/when-was-new-zealand-first-settled>
- Iwama, M. K. (2006). *The Kawa model: Culturally relevant occupational therapy*. London, England: Churchill Livingstone Elsevier Ltd.
- Iwama, M. K. (2007). Embracing diversity: Explaining the cultural dimensions of our occupational therapeutic selves. *New Zealand Journal of Occupational Therapy*, 54(2), 16-23. Retrieved from <https://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Jackson, M. (2007). Globalisation and the colonising state of mind. In M. Bargh (Ed.), *Resistance: An indigenous response to neoliberalism* (pp. 167-182). Wellington, New Zealand: Huia Publishers.
- Jeffery, H. (2005). Culture clash: A discussion of the provision of mental health services for Māori consumers in New Zealand. *New Zealand Journal of Occupational Therapy*, 52(2), 15-21. Retrieved from <https://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Jesson, B. (1999). *Only their purpose is mad*. Palmerston North, New Zealand: Dunmore Press Ltd.
- Johnstone, K. (27 April 2017). United Nations report slams New Zealand's use of solitary confinement. *New Zealand Herald*. Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11845544
- Jones, G. (2000). *A personal and informal perspective of events during my time as Chief Executive/Secretary/Registrar from 1986 to 2000*. Retrieved from <https://www.mcnz.org.nz/assets/Forms/MedicalCouncilofNZHistory.pdf>
- Joseph, R. (2014). Indigenous peoples' good governance, human rights and self-determination in the second decade of the new millennium – A Māori perspective. *Māori Law Review*, December 2014. Retrieved from <http://maorilawreview.co.nz/2014/12/indigenous-peoples-good-governance-human-rights-and-self-determination-in-the-second-decade-of-the-new-millennium-a-maori-perspective/>
- Jungerson, K. (1992). Culture, theory, and the practice of occupational therapy in New Zealand/Aotearoa. *American Journal of Occupational Therapy*, 46(8), 745-750. doi:10.5014/ajot.46.8.745

- Jungerson, K. (2002). Cultural safety: Kawa whakarurunau - An occupational therapy perspective. *New Zealand Journal of Occupational Therapy*, 49(1), 4-9.
- Kelsey, J. (2013). *Hidden agendas: What we need to know about the TPPA*. Retrieved from <http://bwb.co.nz/books/hidden-agendas>
- King, J. (Producer). (2014, 14 April 2016). Key Competencies Pathway. [Power Point presentation] Retrieved from <http://www.slideshare.net/FloPublications/key-competencies-pathwaykey-competencies-pathway-short-version>
- Kingi, T. K. (2007). The Treaty of Waitangi: A framework for Māori health development. *New Zealand Journal of Occupational Therapy*, 54(1), 4-10. Retrieved from <https://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Kinn, L. G., & Aas, R. W. (2009). Occupational therapists' perception of their practice: A phenomenological study. *Australian Occupational Therapy Journal*, 56(2), 112-121. doi:10.1111/j.1440-1630.2007.00714.x
- Kirkman, A. (2012, 13 July). *Health practitioners - Health-care practice*. Retrieved from <http://www.TeAra.govt.nz/en/health-practitioners/page-1>
- Knight, M. (2012). Recollections and memories. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui Hospital to mental health services in the Waikato, 1910-2012* (pp. 178-179). Hamilton, New Zealand: Half Court Press Ltd.
- Koopman, C. (2013). *Genealogy as Critique*. Bloomington, IN: Indiana University Press.
- Kristensen, H. K., Ytterberg, C., Jones, D. L., & Lund, H. (2016). Research-based evidence in stroke rehabilitation: An investigation of its implementation by physiotherapists and occupational therapists. *Disability and Rehabilitation*, 38(26), 2564-2574. doi:10.3109/09638288.2016.1138550
- Kronenberg, F., & Pollard, N. (2005). Introduction. In F. Kronenberg, S. S. Algado & N. Pollard (Eds.), *Occupational therapy without borders. Learning from the spirit of survivors* (Vol. 1, pp. 1-14). London, England: Churchill Livingstone Elsevier.
- Laliberte Rudman, D. (2014). Embracing and enacting an 'occupational imagination': Occupational science as transformative. *Journal of*

Occupational Science, 21(4), 373-388.
doi:10.1080/14427591.2014.888970

Larner, W. (1997). "A means to an end": Neoliberalism and state processes in New Zealand. *Studies in Political Economy*, 52, 7-38. Retrieved from <http://spe.library.utoronto.ca/index.php/spe/article/viewFile/6868/3849>

Lather, P., & St. Pierre, E. A. (2013). Post-qualitative research. *International Journal of Qualitative Studies in Education*, 26(6), 629-633.
doi:10.1080/09518398.2013.788752

Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*. Cambridge, MA: Harvard University Press.

Lincoln, L. (2013). Law, literature, morality: Michel Foucault and the problem of judgement. In B. Golder (Ed.), *Re-reading Foucault on law, power and rights* (pp. 85-103). Milton Park, England: Routledge.

Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. New York:NY: SAGE Publications Inc.

Lilleker, D. G., & Koc-Michalska, K. (2017). What drives political participation? Motivations and mobilization in a digital age. *Political Communication*, 34(1), 21-43. doi:10.1080/10584609.2016.1225235

Maniapoto-Anderson, R. (2012). Tokanui Te Whenua: A Tangata Whenua perspective. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui Hospital to mental health services in the Waikato, 1910-2012* (pp. 9-12). Hamilton, New Zealand: Half Court Press Ltd.

Maniapoto, D., & Maniapoto, S. T. W. (n.d). *Ngati Paretekawa WAI 2015, 2313 & 2314 Claimants' submission to the Maori Affairs Select Committee on the Raukawa Claims Settlement Bill 137-1*. Ngati Paretekawa. Wellington, New Zealand. Retrieved from www.parliament.nz/resource/.../0ab20e70b3ce0f925c963e5c57ecf83027f5581e

Marr, D. (2016). Fostering full implementation of evidence-based practice. *American Journal of Occupational Therapy*, 71(1), 1-5.
doi:10.5014/ajot.2017.019661

Mattingly, C. (1991). What is clinical reasoning? *American Journal of Occupational Therapy*, 45(11), 979-986. doi:10.5014/ajot.45.11.979

- Mattingly, C. (1994). The concept of therapeutic 'emplotment'. *Social Science and Medicine*, 38(6), 811-822. doi:10.1016/0277-9536(94)90153-8
- Mattingly, C., & Fleming, M. H. (1994). The underground practice. *Clinical reasoning: Forms of inquiry in a therapeutic practice* (pp. 295-315). Philadelphia, PA: FA Davis.
- McKee, M., & Stuckler, D. (2012). The crisis of capitalism and the marketisation of health care: The Implications for public health professionals. *Journal of Public Health Research*, 1(3), 236-239. doi:10.4081/jphr.2012.e37
- McLaren, R. (1997). *A history of Tokanui Hospital*. Te Awamutu, New Zealand: Tokanui Hospital.
- McMenamin, T. (2008). New Zealand Day-Special Schools: Changes and challenges under Special Education 2000. *New Zealand Annual Review of Education*, 18, 183-200. Retrieved from <https://ojs.victoria.ac.nz/nzaroe/article/view/1553>
- Medical Council of New Zealand. (2016). *Recertification and continuing professional development booklet*. Retrieved from <https://www.mcnz.org.nz/assets/News-and-Publications/Booklets/Continuing-Professional-Development.pdf>
- MidCentral District Health Board. (2016a). *MidCentral District Health Board Annual Plan 2015-16*. Palmerston North, New Zealand: Author Retrieved from <http://www.midcentraldhb.govt.nz/Publications/AllPublications/pages/default.aspx?query=Annual%20Report%20and%20SOI#>.
- MidCentral District Health Board. (2016b). *MidCentral District Health Board Annual Report 2015-16*. Palmerston North, New Zealand: Author Retrieved from <http://www.midcentraldhb.govt.nz/Publications/AllPublications/pages/default.aspx?query=Annual%20Report%20and%20SOI#>.
- Midland Health. (1993). *Deinstitutionalisation plan for people living with intellectual disability at Tokanui Hospital*. Hamilton, New Zealand: Midland Health Retrieved from [http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/394F0777B8DB5236C256AC60009478B/\\$file/Deinstitutionalisation%20plan.pdf](http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/394F0777B8DB5236C256AC60009478B/$file/Deinstitutionalisation%20plan.pdf).
- Midland Health. (1996). *From institution to independence*. Hamilton, New Zealand: Author.

- Miedema, B., Hamilton, R., Lambert-Lanning, A., Tatemichi, S. R., Lemire, F., Manca, D., & Ramsden, V. R. (2010). Prevalence of abusive encounters in the workplace of family physicians. A minor, major, or severe problem? *Canadian Family Physician, 56*(3), e101-e108. Retrieved from <http://www.cfp.ca/content/56/3/e101.short>
- Millar, P., & Rose, N. (2008). Governing economic life. In P. Millar & N. Rose (Eds.), *Governing the present. Administering economic, social and personal life*. (pp. 26-52). Cambridge, England: Polity Press.
- Miller, P., & Rose, N. (2008). *Governing the present. Administering economic, social and personal life*. Cambridge, England: Polity Press.
- Ministry of Education. (2012). *The Ongoing Resourcing Scheme*. Wellington, New Zealand: Ministry of Education Retrieved from <http://parents.education.govt.nz/assets/Documents/Special-Education/Ongoing-Resourcing-Scheme.pdf>.
- Ministry of Education. (2013). *Specialist Service Standards - Revised March 2013*. Unpublished Service Standards. Ministry of Education. Wellington, New Zealand.
- Ministry of Education. (2014). *Success for All. Special Education. Briefing to incoming Minister*. Wellington, New Zealand: Ministry of Education Retrieved from <http://www.education.govt.nz/assets/Documents/Ministry/Publications/Briefings-to-Incoming-Ministers/SuccessForAllSpecialEducation.pdf>.
- Ministry of Education. (2015a). *Resources for students in Ongoing Resourcing Scheme (ORS)*. Retrieved from <http://www.education.govt.nz/school/student-support/special-education/ors/resources-for-students-in-ors/>
- Ministry of Education. (2015b). *Specialist Service Standards* Retrieved from <http://www.education.govt.nz/school/student-support/special-education/ors/resources-for-students-in-ors/specialist-service-standards-for-ors/>
- Ministry of Health. (1993a). *Corporate plan 1993-94*. Wellington, New Zealand: Ministry of Health Retrieved from [http://www.moh.govt.nz/notebook/nbbooks.nsf/0/66BB0102849DFBE94C2565D7000E0D63/\\$file/Corporate%20plan%201993-94.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/66BB0102849DFBE94C2565D7000E0D63/$file/Corporate%20plan%201993-94.pdf).
- Ministry of Health. (1993b). *Planned deinstitutionalization*. Wellington, New Zealand: New Zealand Government Retrieved from

[http://www.moh.govt.nz/notebook/nbbooks.nsf/0/b0b040a4729884a14c2565d7000e4af5/\\$FILE/92618.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/b0b040a4729884a14c2565d7000e4af5/$FILE/92618.pdf).

Ministry of Health. (1997). *Developing a national framework for the provision of environmental support services for people with disabilities*. Unpublished consultation document. Ministry of Health. Wellington, New Zealand.

Ministry of Health. (2013). *Better Public Services*. Retrieved from <http://www.health.govt.nz/about-ministry/what-we-do/strategic-direction/better-public-services>

Ministry of Health. (2014a). *Care closer to home*. Wellington, New Zealand: Ministry of Health Retrieved from <http://www.health.govt.nz/publications/Care%20closer%20to%20home>.

Ministry of Health. (2014b). *The case for change*. Wellington, New Zealand: Ministry of Health Retrieved from <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/review-health-practitioners-competence-assurance-act/case-change>.

Ministry of Health. (2014c). *Equipment and modification services. Equipment manual*. Wellington, New Zealand: Author Retrieved from <http://www.health.govt.nz/system/files/documents/pages/equipment-manual-nov2014.pdf>.

Ministry of Health. (2014d). *Equipment and modifications services. Housing manual*. Wellington, New Zealand: Author Retrieved from <http://www.health.govt.nz/system/files/documents/pages/housing-modification-manual-aug2014.pdf>.

Ministry of Health. (2014e). *Health Workforce New Zealand Strategic Plan*. Wellington, New Zealand: Health Workforce New Zealand Retrieved from <http://healthworkforce.health.govt.nz/hwnz-strategic-intent-and-priorities-statement-intent-2014-2018>.

Ministry of Health. (2015a). *Disability Support Services Strategic Plan 2014-18*. Wellington, New Zealand: Ministry of Health Retrieved from <http://www.health.govt.nz/system/files/documents/publications/disability-support-services-strategic-plan-2014-to-2018-v2.pdf>.

Ministry of Health. (2015b). *Prioritisation tool resources*. Retrieved from <http://www.health.govt.nz/our-work/disability-services/contracting-and-working-disability-support-services/equipment-and-modification-services/prioritisation-tool-resources>

- Ministry of Health. (2015c). *Responsible authorities under the Act*. Retrieved from <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/responsible-authorities-under-act>
- Ministry of Health. (2016a). *Health of the Health Workforce 2015*. Wellington, New Zealand: Ministry of Health Retrieved from <http://www.health.govt.nz/system/files/documents/publications/health-of-health-workforce-2015-feb16.pdf>.
- Ministry of Health. (2016b). *New Zealand Health Strategy*. Wellington, New Zealand: Author. Retrieved from <http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf>.
- Ministry of Health. (2016c). *New Zealand Health Strategy. Roadmap of actions*. Wellington, New Zealand: Author Retrieved from <http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-roadmapofactions-2016-apr16.pdf>.
- Ministry of Health. (2016d). *Section 99 Inspection of Waikato District Health Board Mental Health and Addiction Services*. Wellington, New Zealand: Author Retrieved from <http://www.health.govt.nz/system/files/documents/publications/section-99-inspection-waikato-dhb-mental-health-addiction-services-apr16.pdf>.
- Ministry of Health. (2017a). *Demographic report on clients allocated the Ministry of Health's disability support services*. Wellington, New Zealand: Author Retrieved from <http://www.health.govt.nz/system/files/documents/publications/report-clients-allocated-dss-funding-jul17.pdf>.
- Ministry of Health. (2017b). *eHealth*. Retrieved from <http://www.health.govt.nz/our-work/ehealth>
- Ministry of Health. (2017c). *Strategic Direction*. Retrieved from <http://www.health.govt.nz/about-ministry/what-we-do/strategic-direction>
- Ministry of Justice. (2016). *Waitangi Tribunal*. Retrieved from <https://waitangitribunal.govt.nz/>
- Ministry of Social Development. (2016). *Community investment strategy. Update 2016*. Wellington, New Zealand: Author Retrieved from <https://www.msd.govt.nz/documents/about-msd-and-our-work/work->

programmes/community-investment-strategy/community-investment-strategy-update-2016.pdf.

- Mitchell, D., Morton, M., & Hornby, G. (2010). *Review of the literature on Individual Education Plans*. Christchurch, New Zealand: College of Education, University of Canterbury. Retrieved from http://www.educationcounts.govt.nz/__data/assets/pdf_file/0012/102216/Literature-Review-Use-of-the-IEP.pdf
- Mol, A. (2002). *The body multiple: Ontology in medical practice*. Durham, England: Duke University Press.
- Molke, D. K. (2011). *Authentic occupational therapy: A genealogy of normative technology in occupational therapy* (Unpublished Doctorate of Philosophy). The University of Western Ontario, London, Ontario. Retrieved from <http://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1205&context=etd>
- Neal, A. W. (2004). Cutting off the King's head: Foucault's Society Must Be Defended and the problem of sovereignty. *Alternatives: Global, local, political*, 29(4), 373-398. doi:10.1177/030437540402900401
- New Zealand Bill of Rights. (1990). *New Zealand Statutes*. Wellington, New Zealand: Parliamentary Counsel Office Retrieved from <http://www.legislation.govt.nz/act/public/1990/0109/latest/DLM224792.html>.
- New Zealand Government. (1995). *Her Majesty the Queen and Waikato-Tainui Deed of Settlement*. Wellington, New Zealand: Crown Copyright. Retrieved from <https://www.govt.nz/dmsdocument/3778.pdf>.
- New Zealand Government. (2016). *Ngāti Koroki Kahukura settlement summary*. Retrieved from <https://www.govt.nz/treaty-settlement-documents/ngati-koroki-kahukura/ngati-koroki-kahukura-deed-of-settlement-summary-20-dec-2012/>
- New Zealand Occupational Therapy Board. (1985). *Meeting Minutes 6 November 1985*. Wellington, New Zealand: Author.
- New Zealand Occupational Therapy Board. (1989). *Meeting minutes 3 October 1989*. Wellington, New Zealand: Author.
- New Zealand Occupational Therapy Board. (1990). *Competencies for registration as an occupational therapist*. Wellington, New Zealand: Author.

New Zealand Occupational Therapy Board. (1995). *Competencies for registration as an occupational therapist*. Wellington, New Zealand: Author.

Nicholls, D. (2008). *Body politics: A Foucauldian discourse analysis of physiotherapy practice* (Unpublished Doctorate of Philosophy). Auckland University of Technology, Auckland, New Zealand. Retrieved from <http://hdl.handle.net/10292/1911>

Nicholls, D. A. (2012). Foucault and physiotherapy. *Physiotherapy theory and practice*, 28(6), 447-453. doi:10.3109/09593985.2012.676937

Nicholls, D. A., Walton, J. A., & Price, K. (2009). Making breathing your business: Enterprising practices at the margins of orthodoxy. *Health*, 13(3), 337-360. doi:10.1177/1363459308101807

NSW Rural Doctors Network. (2017). *Registration Pathways - Occupational Therapists*. Retrieved from <https://www.nswrdn.com.au/site/index.cfm?display=286392>

Nursing Council of New Zealand. (2013). *Bibliographic timeline of the introduction of cultural safety into nursing education in New Zealand 1988-2012*. Wellington, New Zealand. Retrieved from <http://www.ngamanukura.co.nz/Portals/73/PDF/NCNZ%20Cultural%20Safety%20Feb%202013.pdf>

O'Farrell, C. (2005). *Michel Foucault*. London, England: Sage.

O'Sullivan, D. (2015). Power, politics and the street-level bureaucrat in Indigenous Australian health. *Journal of Sociology*, 52(4), 646-660. doi:10.1177/1440783315575170

Occupational Therapy Act. (1949). *New Zealand Statutes*. Wellington, New Zealand: New Zealand Legal Information Institute. Retrieved from http://www.nzlii.org/nz/legis/hist_act/toc-1949.html.

Occupational Therapy Amendment Act. (1999). *New Zealand Statutes*. Wellington, New Zealand: New Zealand Legal Information Institute Retrieved from http://www.nzlii.org/nz/legis/hist_act/otaa19991999n134332/.

Occupational Therapy Board of Australia. (2016). *Registrant Data*. Melbourne, Australia: Australian Health Practitioner Regulation Agency Retrieved from <http://www.occupationaltherapyboard.gov.au/About/Statistics.aspx>.

- Occupational Therapy Board of New Zealand. (1994a). *Meeting minutes 7 June 1994*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (1994b). *Meeting minutes 27 October 1994*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (1997). *Meeting minutes 13 November 1997*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (1999). *Meeting minutes 19 July 1999*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2000). *Competencies for registration as an occupational therapist*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2004a). *Code of ethics for occupational therapists*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2004b). *Continuing competence framework for recertification. Practitioner handbook*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2004c). *General scope of practice*. Wellington, New Zealand: Author Retrieved from <http://www.otboard.org.nz/documents/#general-information-2-o>.
- Occupational Therapy Board of New Zealand. (2005a). *Meeting minutes 18 November 2005*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2005b). *Meeting minutes 21 April 2005*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2006). *Meeting minutes 8 August 2006*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2008). *Annual Report*. Wellington, New Zealand: Author Retrieved from <http://www.otboard.org.nz/wp-content/uploads/2015/04/2008-Annual-Report.pdf>.
- Occupational Therapy Board of New Zealand. (2010). *Meeting minutes 20 April 2010*. Wellington, New Zealand: Author.

- Occupational Therapy Board of New Zealand. (2011). *Annual Report*. Wellington, New Zealand: Occupational Therapy Board of New Zealand. Retrieved from <http://www.otboard.org.nz/GeneralInfo/PoliciesandPublications/AnnualReportsandStrategicplans.aspx>
- Occupational Therapy Board of New Zealand. (2012a). *Meeting minutes 1 February 2012*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2012b). *Meeting minutes 4 December 2012*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2012c). *Meeting minutes 12 June 2012*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2012d). *Meeting minutes 16 October 2012*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2013a). *Meeting minutes 8 October 2013*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2013b). *Meeting minutes 11 June 2013*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2014a). *Draft Competencies for Board meeting October 2014*. Unpublished consultation document. Occupational Therapy Board of New Zealand. Wellington, New Zealand.
- Occupational Therapy Board of New Zealand. (2014b). *Meeting minutes 14 October 2014*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2015a). *Annual Report*. Wellington, New Zealand: Author Retrieved from <http://www.otboard.org.nz/wp-content/uploads/2015/10/2015-Annual-Report.pdf>.
- Occupational Therapy Board of New Zealand. (2015b). *Code of ethics for occupational therapists*. Wellington, New Zealand: Author Retrieved from <http://www.otboard.org.nz/documents>.
- Occupational Therapy Board of New Zealand. (2015c). *Competencies for registration and continuing practice*. Wellington, New Zealand: Author Retrieved from http://www.otboard.org.nz/wp-content/uploads/2015/04/Competencies_April20151.pdf.

- Occupational Therapy Board of New Zealand. (2015d). *Competencies for registration and continuing practice. Quick reference*. Wellington, New Zealand: Author Retrieved from <http://www.otboard.org.nz/>.
- Occupational Therapy Board of New Zealand. (2015e). *Meeting minutes 17 February 2015*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2016a). *Annual Report 2015-2016*. Wellington, New Zealand: Author Retrieved from <http://www.otboard.org.nz/wp-content/uploads/2016/10/OTB-AOG-16831-Annual-Report-2016-v7-WEB.pdf>.
- Occupational Therapy Board of New Zealand. (2016b). *ePortfolio handbook. A guide for practitioners*. Wellington, New Zealand: Author Retrieved from <https://www.otboard.org.nz/wp-content/uploads/2016/04/OTBNZ-ePortfolio-Handbook.pdf>.
- Occupational Therapy Board of New Zealand. (2016c). *Meeting minutes 15 April 2016*. Wellington, New Zealand: Author.
- Occupational Therapy Board of New Zealand. (2016d). *Occupational Therapy Board of New Zealand*. Retrieved from <https://www.facebook.com/OTBNZ/>
- Occupational Therapy Board of New Zealand. (2017). *Annual Report 2017*. Wellington, New Zealand: Author Retrieved from <https://www.otboard.org.nz/wp-content/uploads/2017/09/2017-Annual-Report.pdf>.
- Occupational Therapy New Zealand Whakaora Ngangahau Aotearoa. (2017). *Occupation and health*. Retrieved from <http://www.otnz.co.nz/public/>
- Oranga Tamariki. (2017). *About us*. Retrieved from <https://www.mvcot.govt.nz/about-us/who-we-are/>
- Orange, C. (2012). *Treaty of Waitangi*. Retrieved from <http://www.teara.govt.nz/en/treaty-of-waitangi>
- Orange, C. (2014). *What happened at Waitangi?* Wellington, NZ: BWB Texts.
- Oser, J., Hooghe, M., & Marien, S. (2013). Is online participation distinct from offline participation? A latent class analysis of participation types and their stratification. *Political Research Quarterly*, 66(1), 91-101. doi:10.1177/1065912912436695

- Otago Polytechnic. (2017). *Bachelor of occupational therapy*. Retrieved from <https://www.op.ac.nz/study/health-and-community/occupational-therapy/bachelor-of-occupational-therapy/>
- Papa, R., & Meredith, P. (2012). '*Kīngitanga – the Māori King movement*'. Retrieved from <http://www.TeAra.govt.nz/en/kingitanga-the-maori-king-movement>
- Paul, B. (2009). Pioneer voices. In B. Gordon, S. Riordan, R. Scaletti & N. Creighton (Eds.), *Legacy of occupation. Stories of occupational therapy in New Zealand 1940-1972*. (pp. 45-89). Takapuna, New Zealand: The Bush Press Ltd.
- Pavlich, G. (2013). Sovereignty by acquisition at the Cape: Foucault, Hobbes and de Mist. In B. Golder (Ed.), *Re-reading Foucault on law, power and rights* (pp. 107-126). Milton Park, England: Routledge.
- Penman, M. (2013). *Do we have what it takes? An investigation into New Zealand occupational therapists' readiness to be self-directed learners*. (Unpublished Doctoral Thesis). University of Otago, Dunedin, New Zealand. Retrieved from <http://hdl.handle.net/10523/4596>
- Phillips, J. (2015). *History of immigration*. Retrieved from <http://www.teara.govt.nz/en/history-of-immigration>
- Physiotherapy Board of New Zealand. (2016). *Recertification programme guidelines*. Wellington, New Zealand: Author Retrieved from <http://www.physioboard.org.nz/physiotherapy-practice-thresholds-australia-aotearoa-new-zealand>.
- Pickering, A. (1995). *The mangle of practice: Time, agency, and science*. Chicago, IL: University of Chicago Press.
- Plain English Awards. (2016). *Who's the clearest of them all?* Retrieved from <http://www.plainenglishawards.org.nz/>
- Pollock, K. (2012, 13 July). *King Country region - Overview*. Retrieved from <http://www.TeAra.govt.nz/en/king-country-region/page-1>
- Pool, I., & Kukutai, T. (2011). *Taupori Māori – Māori population change*. Retrieved from <http://www.teara.govt.nz/en/taupori-maori-maori-population-change>
- Poole, S., Wellington, E., Symonds, J., & Tapsell, R. (2012). Midland regional forensic psychiatric service 1990-2010. In C. Coleborne & Waikato Mental

Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to mental health services in the Waikato 1910-2012* (pp. 135-150). Hamilton, New Zealand: Half Court Press Ltd.

Prebble, K. (2012). Mental health nursing education in the Waikato, 1912-2010. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to mental health services in the Waikato 1910-2012* (pp. 67-85). Hamilton, New Zealand: Half Court Press Ltd.

Price Waterhouse. (1994). *Report on the funding implications for Health Waikato Limited and the Midland Regional Health Authority of future strategies for Tokanui Hospital*. Wellington, New Zealand: Ministry of Health Retrieved from [http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/C894AA96568C7E84CC256AC600093D36/\\$file/100436.pdf](http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/C894AA96568C7E84CC256AC600093D36/$file/100436.pdf).

Public Finance Act. (1989). *New Zealand Statutes*. Wellington, New Zealand Parliamentary Counsel Office Retrieved from <http://www.legislation.govt.nz/act/public/1989/0044/latest/DLM160809.html>.

Ramugondo, E. L., & Kronenberg, F. (2015). Explaining collective occupations from a human relations perspective: Bridging the individual-collective dichotomy. *Journal of Occupational Science*, 22(1), 3-16. doi:10.1080/14427591.2013.781920

Reed, K., Hocking, C., & Smythe, L. (2013). The meaning of occupation: Historical and contemporary connections between health and occupation. *New Zealand Journal of Occupational Therapy*, 60(1), 38-44. Retrieved from <https://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>

Robinson, H. (2011). *Te Taha Tinana: Māori Health and the Crown in Te Rohe Pōtae Inquiry District, 1840-1990. A report for Te Rohe Pōtae District Inquiry (WAI 898)*. Wellington, New Zealand: Waitangi Tribunal Retrieved from https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_807563/Wai%20898%2C%20A031.pdf

Rose, N., & Miller, P. (2010). Political power beyond the State: Problematics of government. *The British Journal of Sociology*, 61, 271-303. doi:10.1111/j.1468-4446.2009.01247.x

- Rose, N., O'Malley, P., & Valverde, M. (2006). Governmentality. *Annual Review of Law and Social Science*, 2(1), 83-104.
doi:10.1146/annurev.lawsocsci.2.081805.105900
- Ruru, J. (2005). Indigenous peoples and family law: Issues in Aotearoa/New Zealand. *International Journal of Law, Policy and the Family*, 19(3), 327-345. doi:10.1093/lawfam/ebi026
- Ruru, J. (2009). *The legal voice of Māori in freshwater governance. A literature review*. Retrieved from www.otago.ac.nz/law/research/otago036237.pdf
- Ryan, S., Wright St Clair, V., Preddey, G., & Grant, J. (1988). *Education. A professional issue. Report on the review of occupational therapy education*. Wellington, New Zealand: Department of Health & Department of Education.
- Satherley, D. (21 July 2017). NZ's homelessness the worst in OECD - by far. *Newshub*. Retrieved from <http://www.newshub.co.nz/home/politics/2017/07/nz-s-homelessness-the-worst-in-oecd-by-far.html>
- Savage, J. (3 October 2017). Moko inquest: 94 kids killed since Nia Glassie's horrific murder. *New Zealand Herald*. Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11929006
- Schneider, J., Weerakoon, P., & Heard, R. (1999). Inappropriate client sexual behaviour in occupational therapy. *Occupational Therapy International*, 6(3), 176-194. doi:10.1002/oti.96
- Scholar, H. (2016). The neglected paraphernalia of practice? Objects and artefacts in social work identity, practice and research. *Qualitative Social Work*, 1-18. Retrieved from <http://journals.sagepub.com/toc/qswa/0/0>
- Setchell, J., Nicholls, D. A., & Gibson, B. E. (2017). Objecting: Multiplicity and the practice of physiotherapy. *Health*, 1-20. doi:10.1177/1363459316688519
- Silcock, M. (2015). The impact of taken-for-granted understandings on occupational therapy practice. *OT Insight*, 36(1), 16. Retrieved from <https://www.otnz.co.nz/public/publications/ot-insight/>
- Silcock, M. (2017). *Stats [weblog dashboard]*. Retrieved from <https://wordpress.com/stats/insights/marysilcock3.wordpress.com>

- Silcock, M., Campbell, M., & Hocking, C. (2016). How Western structures shape our practice: An analysis of the Competencies for Registration for occupational therapists in Aotearoa New Zealand 1990-2014. *New Zealand Journal of Occupational Therapy*, 63(2), 4-12. Retrieved from <https://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Silcock, M., Campbell, M., Hocking, C., & Hight, C. (2015). *Creating a critical space: Blogging as a reflective tool for collective agency*. Paper presented at the Doing Well Together. 6th Asia Pacific Occupational Therapy Congress, 14 - 17 September, Energy Event Centre, Rotorua, New Zealand
- Silcock, M., Campbell, M., Hocking, C., & Hight, C. (2017). How has ethical practice been shaped for occupational therapists practising in Aotearoa New Zealand? A Foucauldian discourse analysis. *New Zealand Journal of Occupational Therapy* 64(2), 13-21. Retrieved from <https://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Skilton, H. (1981). *Work for your life: The story of the beginning and early years of occupational therapy in New Zealand*. Auckland, New Zealand: Author.
- Smith, L. T. (2012). *Decolonizing methodologies* (2nd ed.). London, England: Zed Books.
- St. Pierre, E. A. (2013). The posts continue: Becoming. *International Journal of Qualitative Studies in Education*, 26(6), 646-657. doi:10.1080/09518398.2013.788754
- State Sector Act. (1988). *New Zealand Statutes*. Wellington, New Zealand: Parliamentary Counsel Office Retrieved from <http://www.legislation.govt.nz/act/public/1988/0020/latest/DLM129110.html#DLM129437>.
- State Services Commission. (2017). *Better Public Services*. Retrieved from <http://www.ssc.govt.nz/better-public-services>
- Statistics New Zealand. (2013a). *2013 Census QuickStats about a place: Hamilton City*. Wellington, New Zealand: Author Retrieved from [http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-a-place.aspx?request_value=13702&tabname=.](http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-a-place.aspx?request_value=13702&tabname=)
- Statistics New Zealand. (2013b). *2013 Quickstats about national highlights*. Wellington, New Zealand: Author Retrieved from

<http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-national-highlights.aspx>.

Statistics New Zealand. (2013c). *Iwi grouping profile. Waikato-Tainui*. Retrieved from <http://m.stats.govt.nz/>

Strathern, M. (Ed.). (2000). *Audit cultures*. London, England: Routledge.

Sunderland, N., Catalano, T., & Kendall, E. (2009). Missing discourses: Concepts of joy and happiness in disability. *Disability & Society, 24*(6), 703-714. doi:10.1080/09687590903160175

Swain, N., Gale, C., & Greenwood, R. (2014). Patient aggression experienced by staff in a New Zealand public hospital setting. *The New Zealand Medical Journal 127*(1394), 10-18. Retrieved from <https://www.nzma.org.nz/publications/new-zealand-medical-journal>

Tantau, K. (9 December 2015). Patricia Avenue's major milestone. *Hamilton Press*. Retrieved from <http://www.pressreader.com/new-zealand/hamilton-press/20151209/281543699858877/TextView>

Te Aho, L. (2006). Contemporary issues in Māori law and society: Mana motuhake, mana whenua. *Waikato Law Review, 14*, 102-119. Retrieved from www.nzlii.org/nz/journals/WkoLawRw/2006/6.pdf

Te Pou o te Whakaaro Nui. (2016). *Home*. Retrieved from <http://www.tepou.co.nz/home>

Te Pou te Whakaaro Nui. (2016). *The HoNOS tool*. Retrieved from <http://www.tepou.co.nz/outcomes-and-information/the-honos-tool/61>

Te Rau Matatini. (2009). *Te Umanga Whakaora. Accelerated Māori occupational therapy workforce development*. Wellington, New Zealand: Te Rau Matatini & New Zealand Association of Occupational Therapists. Retrieved from http://matatini.co.nz/sites/default/files/resources/publications/Te_Umanga_Whakaora_final_doc111109.pdf

Tenbenschel, T., Dwyer, J., & Lavoie, J. (2013). How not to kill the Golden Goose: Reconceptualizing accountability environments of third-sector organizations. *Public Management Review, 16*(7), 925-944. doi:10.1080/14719037.2013.770054

Tenbenschel, T., Mays, N., & Cumming, J. (2011). A successful mix of hierarchy and collaboration? Interpreting the 2001 reform of the governance of the

New Zealand public health system. *Policy & Politics* 39(2), 239-255.
doi:10.1332/030557310X519678

The Treasury. (2014). *Better Public Services*. Retrieved from
<http://www.treasury.govt.nz/statesector/betterpublicservices>

The Treasury. (2017). *New Zealand Productivity Commission report on more effective social services*. Retrieved from
<http://www.treasury.govt.nz/statesector/nzpcsocser>

Tse, S., Lloyd, C., Penman, M., King, R., & Bassett, H. (2004). Evidence-based practice and rehabilitation: Occupational therapy in Australia and New Zealand experiences. *International Journal of Rehabilitation Research* 27(4), 269-274. Retrieved from
<http://journals.lww.com/intjrehabilres/toc/2004/12000>

Turkel, G. (1990). Michel Foucault: Law, power, and knowledge. *Journal of Law and Society*, 17(2), 170-193. doi:10.2307/1410084

Underhill, J. (2016, 25 August). Ebos posts 20% gain in full-year profit as sales top \$7 bln. *Scoop Independent News*. Retrieved from
<http://www.scoop.co.nz/stories/BU1608/S00842/ebos-posts-20-gain-in-full-year-profit-as-sales-top-7-bln.htm>

Upton, D., Stephens, D., Williams, B., & Scurlock-Evans, L. (2014). Occupational therapists' attitudes, knowledge, and implementation of evidence-based practice: A systematic review of published research. *British Journal of Occupational Therapy*, 77(1), 24-38.
doi:10.4276/030802214X13887685335544

Waikato District Health Board. (2015a). *Memorandum to the Health Waikato Advisory Committee*. Hamilton, New Zealand: Waikato District Health Board Retrieved from <http://www.waikatodhb.health.nz/assets/about-us/agendas/HWAC/2015/August/4.3.pdf>.

Waikato District Health Board. (2015b). *Mental Health and Addictions integrated care pathway policy, 2015-2018*. Unpublished policy, Ref.no 1703. Waikato District Health Board. Hamilton, New Zealand.

Waikato Raupatu Claims Settlement Act. (1995). *New Zealand Statutes*. Wellington, New Zealand: Retrieved from
<http://www.legislation.govt.nz/act/public/1995/0058/latest/DLM369893.html>.

- Waitangi Tribunal. (n.d). *Te Rohe Potae* Retrieved from <http://www.justice.govt.nz/tribunals/waitangi-tribunal/inquiries/district-inquiries/te-rohe-potae>
- Walters, L. (15 June 2017). Unicef releases damning child welfare report. *Stuff*. Retrieved from <https://www.stuff.co.nz/national/93705446/unicef-releases-damning-child-welfare-report>
- Whalley Hammell, K. (2007). Reflections on... a disability methodology for the client-centred practice of occupational therapy research. *Canadian Journal of Occupational Therapy*, 74(5), 365-369. doi:10.2182/cjot.07.003
- Whalley Hammell, K. (2009). Sacred texts: A sceptical exploration of the assumptions underpinning theories of occupation. *Canadian Journal of Occupational Therapy*, 76(1), 6-22. doi:10.1177/000841740907600105
- Whalley Hammell, K. (2013a). Client-centred occupational therapy in Canada: Refocusing on core values. *Canadian Journal of Occupational Therapy*, 80(3), 141-149. doi:10.1177/0008417413497906
- Whalley Hammell, K. (2013b). Occupation, well-being, and culture: Theory and cultural humility. *Canadian Journal of Occupational Therapy*, 80(4), 224-234. doi:10.1177/0008417413500465
- Whalley Hammell, K. (2014). Belonging, occupation, and human well-being: An exploration. *Canadian Journal of Occupational Therapy*, 81(1), 39-50. doi:10.1177/0008417413520489
- Whalley Hammell, K. (2015a). Participation and occupation: The need for a human rights perspective. *Canadian Journal of Occupational Therapy*, 82(1), 4-5. doi:10.1177/0008417414567636
- Whalley Hammell, K. (2015b). Quality of life, participation and occupational rights: A capabilities perspective. *Australian Occupational Therapy Journal*, 62(2), 78-85. doi:10.1111/1440-1630.12183
- Whalley Hammell, K., & Iwama, M. K. (2012). Well-being and occupational rights: An imperative for critical occupational therapy. *Scandinavian Journal of Occupational Therapy*, 19(5), 385-394. doi:10.3109/11038128.2011.611821
- Whiteford, G. (2007). Autonomy, accountability, and professional practice: Contemporary issues and challenges. *New Zealand Journal of Occupational Therapy*, 54(1), 11-14.

- Wihongi, H. (2010). *Tino Rangatiratanga in health policies and practices. A Kaupapa Māori analysis of the 1996 National Cervical Screening Programme's Policy document – the years 1990 to 2000* (Unpublished Doctorate of Philosophy). University of Waikato, Hamilton, New Zealand. Retrieved from <http://researchcommons.waikato.ac.nz/handle/10289/4819>
- Wilding, C., & Whiteford, G. (2007). Occupation and occupational therapy: Knowledge paradigms and everyday practice. *Australian Occupational Therapy Journal*, 54(3), 185-193. doi:10.1111/j.1440-1630.2006.00621.x
- Wilson, J. (2005). *History - Māori arrival and settlement*. Retrieved from <https://teara.govt.nz/en/history/page-1>
- Wilson, J. (2016). *European discovery of New Zealand*. Retrieved from <http://www.teara.govt.nz/en/european-discovery-of-new-zealand>
- Wilson, L. H. (2003). *Role differentiation in a professionalising occupation: The case of occupational therapy, New Zealand* (Unpublished Doctoral Thesis). University of Otago. Retrieved from <http://hdl.handle.net/10523/1483>
- Winance, M. (2010). Care and disability. Practices of experimenting, tinkering with, and arranging people and technical aids. In A. Mol, P. Moser & J. Pols (Eds.), *Care in practice. On tinkering in clinics, homes and farms*. Retrieved from <https://halshs.archives-ouvertes.fr/halshs-00495614/document>
- Wise Group. (2014). *More effective social services. The Wise Group's submission to the New Zealand Productivity Commission*. Hamilton, New Zealand: Author Retrieved from <http://www.productivity.govt.nz/sites/default/files/sub-social-services-41-wise-management-services-ltd-800Kb.pdf>.
- Wise Group. (2016). *What we do*. Retrieved from <http://www.wisegroup.co.nz/>
- World Federation of Occupational Therapists. (2011). *Position Statement. Occupational Science, revised*. Author Retrieved from <http://www.wfot.org/ResourceCentre.aspx>.
- World Federation of Occupational Therapists. (2016). WFOT Human Resources Project 2016. Retrieved from <http://www.wfot.org/>
- World Federation of Occupational Therapists. (n.d-a). *History*. Retrieved from <http://www.wfot.org/AboutUs/History.aspx>

- World Federation of Occupational Therapists. (n.d-b). *Member Organisations of WFOT*. Retrieved from <http://www.wfot.org/Membership/MemberOrganisationsofWFOT.aspx>
- World Federation of Occupational Therapy. (2012). *Definition of occupational therapy*. Retrieved from <http://www.wfot.org/AboutUs/AboutOccupationalTherapy/DefinitionofOccupationalTherapy.aspx>
- Writemark. (2010a). *Writemark. Plain English Standard*. Retrieved from <http://www.writemark.co.nz/>
- Writemark. (2010b). *The WriteMark: An international symbol of clarity*. Retrieved from <http://www.write.co.nz/Document+services/The+WriteMark.html>
- Yerxa, E. J. (1993). Occupational science: A new source of power for participants in occupational therapy. *Journal of Occupational Science*, 1(1), 3-9.
doi:10.1080/14427591.1993.9686373
- Yerxa, E. J. (1998). Occupation: The keystone of a curriculum for a self-defined profession. *American Journal of Occupational Therapy*, 52(5), 365-372.
doi:10.5014/ajot.52.5.365
- Young, C. (2012). Reflections and memories. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to Waikato mental health services, 1910-2012* (pp. 184-187). Hamilton, New Zealand: Half Court Press Ltd.

Appendix 1: Blog Front Pages




August 2014-August 2016 (year changed accordingly)




August 2016 - Present

Appendix 2: Poster Presentation Asia Pacific Occupational Therapy Congress



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Mary Silcock, Dr Maxine Campbell,
Associate Professor Craig Hight



Professor Clare
Hocking

Creating a Critical Space: Blogging as a Reflective Tool for Collective Agency

Objective: The blog is a social networking experiment that aims to provide a collaborative space for Occupational Therapists in NZ to engage in political and critical discussion about the profession.



Methods: Bi-monthly blogs on NZ practice, written from a critical Foucauldian analytical perspective provide material for online discussion.

I so wasn't used to reading things like that about us. We are one of the good guys in health care aren't we?
"OT's do f... all" 28/10/2014

"I graduated with a sense that no other profession could see or understand a person in the way that an OT can!"
2/11/2014

"Generously share knowledge with other professionals/ consumers" was changed in 1995 to "Responsibly share knowledge with other professionals/consumers".
"The very first competencies"
14/5/2015

"I personally see nothing wrong with 'being generous' as health workers/occupational therapists. Why not?"
18/5/2015

Whakaora
Ngangahau/
Occupational
Therapy in
Aotearoa New
Zealand – What is
shaping us
in 2015?

PhD research for and about
OTs in Aotearoa New Zealand

marysilcock3.wordpress.com

So what sort of experts are we? How does this fit into the ways of governing healthcare and the development of our communities?
"Being Experts" 8/1/2015


"I do think that conducting more heavyweight research will provide greater political leverage, but not on its own."
12/1/2015

Being a registered health profession has given us power and a position in the medical system but at some cost to our autonomy and ability to direct where our professional skills are best placed.
"In the beginning..." 6/8/2014

"It may be that occupational therapy in this part of the world is following a route that is removing itself from health and beginning to align itself with social services..."
29/8/2014

Findings: The public nature of the blog involves visible personal and professional subjectivities. Using the blog for research highlights the fluid and competing nature of these subjectivities, requiring ongoing reflexivity about the content of posts and comments. Comments on posts have been fewer than expected, with only 14 out of 63 followers commenting on posts over a 12 month period.

Blog Statistics

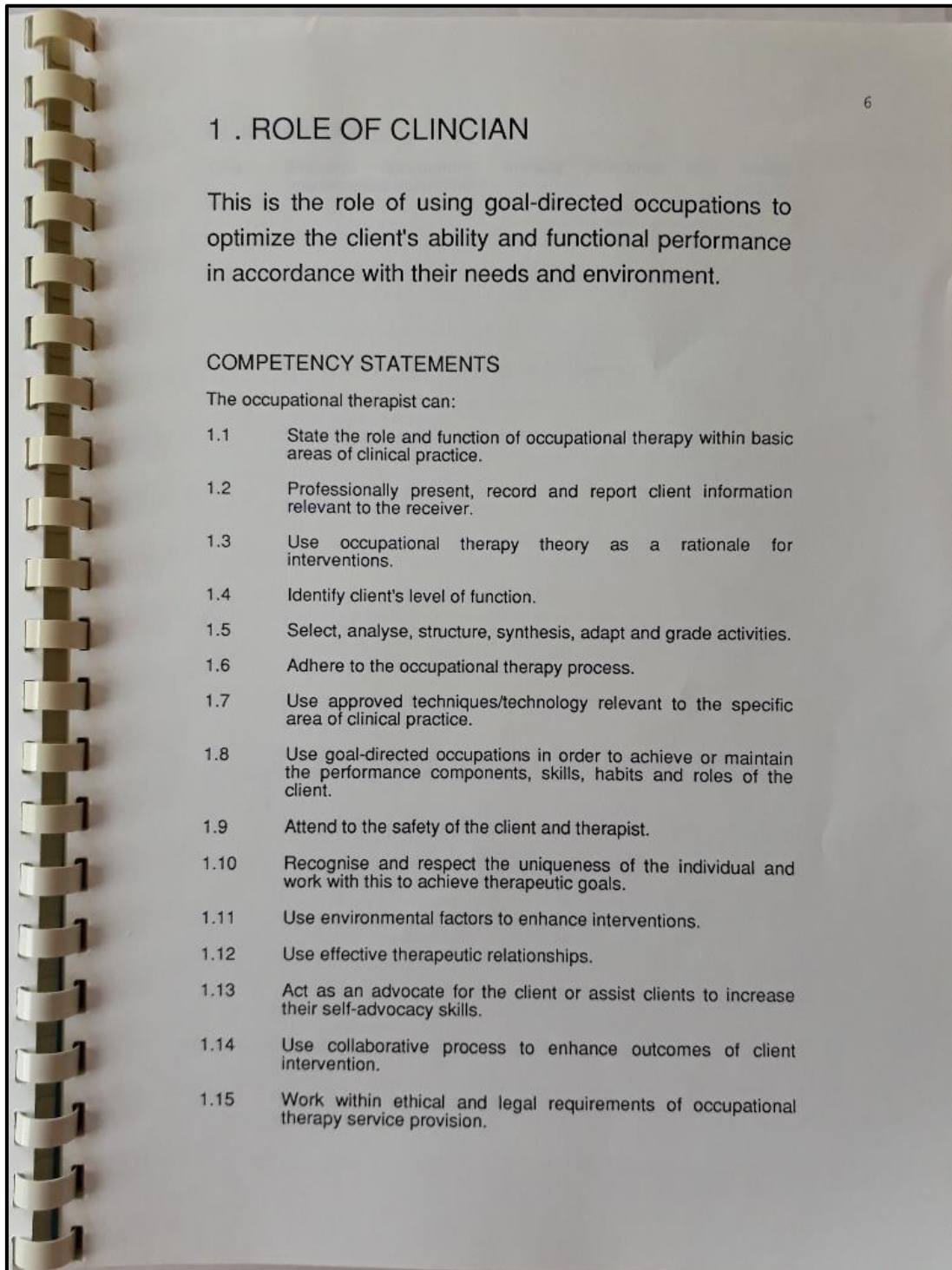


Totals, Followers & Shares		
Totals	Shares	Spam
Content		
21 Posts	1 Categories	2 Tags
Followers (Includes Follower)		
64 Followers	5 Comments	

Conclusion: The blog may be assisting in the development of personal and collective political voices. Ways to increase participation in the blog continue to be trialled and explored. How the blog is being used by Occupational Therapists is part of the ongoing project. As a research method the blog provides a grounding to the theoretical nature of the wider PhD project by enabling a frequent and informal connection to real life.

Appendix 3: Examples of the Competencies for Registration Documents

Version 1: 1990



1 Role of Clinician

In this role, the occupational therapist uses goal-directed occupations to optimise the client's ability and functional performance in accordance with his or her needs and environment.

Competency Statements

The occupational therapist can:

- 1.1 State the role and function of occupational therapy within basic areas of clinical practice.
- 1.2 Use effective therapeutic relationships.
- 1.3 Attend to the safety of the client, self and significant others.
- 1.4 Use occupational therapy theory as a rationale for interventions.
- 1.5 Adhere to the occupational therapy process.
- 1.6 Select, analyse, structure, synthesise, adapt and grade activities.
- 1.7 Identify the client's level of function.
- 1.8 Recognise and respect the uniqueness of the individual and work with this to achieve therapeutic goals.
- 1.9 Use goal-directed occupations in order to achieve or maintain the performance components, skills, habits and roles of the client.
- 1.10 Use approved techniques and technology relevant to the specific area of clinical practice.
- 1.11 Use the environment to enhance interventions.
- 1.12 Represent and support the client or assist the client to increase his or her self-advocacy skills.
- 1.13 Use collaborative processes to enhance outcomes of client intervention.
- 1.14 Professionally present, record and report client information relevant to the receiver.
- 1.15 Work within the ethical and legal requirements of occupational therapy service provision.
- 1.16 Evaluate occupational therapy outcomes and modify interventions accordingly.

COMPETENCY	1 Implementation of Occupational Therapy	2 Safe, Ethical, Legal Practice	3 Culturally Safe Practice
OUTCOME: the entry level practitioner will:	Facilitate & enable occupations for people through engaging their needs, preferences & capacities in the context of their environment to optimise ability & functional independence.	Act, & justify actions, in compliance with ethical, legal, professional & safety requirements.	Provide a service that takes into account the socio cultural values of the client/tangata whaiora, family/whanau & significant others.
PERFORMANCE CRITERIA:	<ul style="list-style-type: none"> 1.1 Establish the need for, & the role & function of, occupational therapy in partnership with the client/tangata whaiora. 1.2 Negotiate mutually agreed, prioritised goals. 1.3 Acknowledge client/tangata whaiora values, beliefs, attitudes & practices. 1.4 Use current theory, evidence, & sound clinical reasoning to inform best occupational therapy practice. 1.5 Identify contra-indications & consequences of intervention. 1.6 Demonstrate understanding of perspectives of occupation as a core modality. 1.7 Use meaningful occupations to achieve, maintain, or enhance performance components, skills, habits, & roles of the client. 1.8 Identify opportunities to use the client's/tangata whaiora actual occupation & environment to enhance occupational therapy interventions. 1.9 Identify the effect of environmental factors on the client's/tangata whaiora function & dysfunction. 1.10 Demonstrate understanding & uses of the occupational therapy process. 1.11 Select, analyse, structure, synthesise, adapt & grade activities/occupations to achieve client/tangata whaiora goals. 1.12 Demonstrate competent use of a range of appropriate assessment techniques as a base for intervention. 1.13 Safely use relevant, approved techniques & technology. 1.14 Use a systematic problem solving approach. 1.15 Identify need to change or modify occupation or environment. 1.16 Adapt & prescribe occupations, techniques & equipment relevant to client/tangata whaiora need. 1.17 Assist/enable the client/tangata whaiora to access appropriate resources. 1.18 Promote health practices, attitudes, & environments which contribute to occupational well being. 1.19 Evaluate outcomes & client/tangata whaiora satisfaction & modify interventions accordingly. 1.20 Seek feedback from clients/tangata whaiora to evaluate safe & effective practice. 1.21 Identify the appropriate end point of intervention. 	<ul style="list-style-type: none"> 2.1 Comply with the Health Practitioners Competence Assurance Act 2003. 2.2 Comply with the Code of Ethics for Occupational Therapists in NZ (2004). 2.3 Comply with all other relevant legislation, regulations, codes (eg Health & Disability Code of Rights, & Privacy Code), service standards, & professional guidelines. 2.4 Attend to safety of client/tangata whaiora, self, & others. 2.5 Respect privacy & maintain confidentiality. 2.6 Recognise when privacy & confidentiality cannot be upheld & act appropriately. 2.7 Recognise when there is a conflict of interest & refer client/tangata whaiora on to an appropriate service or support. 2.8 Provide occupational therapy services that recognise principles of social justice. 2.9 Provide occupational therapy services that enable & empower clients/tangata whaiora & enhance their participation. 2.10 Professionally present, record & report information. 2.11 Comply with basic health & safety procedures (eg First Aid, CPR) relevant to setting. 2.12 Use ethical reasoning to make & justify decisions on ethical issues in practice. 2.13 Seek appropriate guidance to resolve ethically challenging issues. 2.14 Conduct ethically sound & safe therapeutic relationships. 2.15 Participate in a continuous quality improvement approach to contribute to the safety of practice. 2.16 Demonstrate awareness of the scope & limitations of occupational therapy & own knowledge & skills. 	<ul style="list-style-type: none"> 3.1 Demonstrate understanding of the complexity of culture. 3.2 Recognise the multiple realities & identities people bring to the practice context eg, gender, ethnicity, religious belief, sexual orientation, ability, life stage. 3.3 Demonstrate understanding of power dynamics in therapeutic contexts & foster opportunities for clients/tangata whaiora to maximise self advocacy skills. 3.4 Demonstrate awareness of the cultures of occupational therapy & their potential impact on the person. 3.5 Identify personal significant cultural values, beliefs, attitudes, & prejudices & understand their potential impact. 3.6 Recognise own level of cultural safety, consult & refer on where indicated. 3.7 Identify & safely respond to client/tangata whaiora values, beliefs, attitudes & practices. 3.8 Recognise & respect the uniqueness of the individual in the context of their community. 3.9 In consultation with the client/tangata whaiora, identify & work in partnership with resources of family/whanau, community, & significant others. 3.10 Ensure intervention is guided by reflective practice. 3.11 Action Treaty of Waitangi partnership responsibilities, liaising & developing relationships with local iwi & Maori health, welfare & education workers. 3.12 Respond appropriately in situations where cultural difference may be an issue.

PERFORMANCE INDICATORS FOR COMPETENCY

1. Applying occupational therapy knowledge, skills and values

You apply what you know. You engage with people and communities to enable occupations based on rights, needs, preferences and capacities. You work within the context of each client's environment to optimise their participation and well-being.

To achieve this competency and its outcome, you must demonstrate the following abilities and actions:

- 1.1 You apply an occupational perspective to your practice.
- 1.2 You work within the scope of occupational therapy practice. You identify the boundaries of the service you can provide, and make appropriate referrals.
- 1.3 You use a range of strategies for communicating. You adapt how you communicate to each context, acknowledging and respecting the values, beliefs, attitudes and practices of your clients / tangata whaiora (Māori clients).
- 1.4 You enable and empower your clients / tangata whaiora to improve their own occupational performance and participation.
- 1.5 You collaborate with people and communities to establish priorities and goals that you all agree on.
- 1.6 You select the appropriate assessments and evaluations when planning your practice.
- 1.7 You use current theory and evidence, as well as sound clinical reasoning, to help you make decisions and use the best processes in your practice.
- 1.8 You identify the individuals, organisations or sections of the community that help, hinder or pose risks to your practice.
- 1.9 You recognise and respect that each individual is unique, and you practise in a way that respects mana (status) and wairua (spirit).
- 1.10 You help your clients live ordinary lives within their natural environments. You engage them in sustainable occupations that they find meaningful and valuable.
- 1.11 You choose and use a range of strategies, including: helping clients to adapt, modifying their environments, developing their skills, and teaching them processes for learning. You consult, advocate, and coach.
- 1.12 You evaluate your practice using appropriate measures and client feedback. You review, modify or complete your practice based on this evaluation.
- 1.13 You identify, express, document and justify the strategies you choose as appropriate for your clients, based on the results of your assessment.
- 1.14 You keep appropriate records of the services you provide. These records are suitable for evaluating your services, your professional performance, and your business.
- 1.15 You promote healthy practices, attitudes, and environments that contribute to occupational well-being.
- 1.16 You understand and recognise key Māori concepts, and you include appropriate tikanga (Māori customs) in your practice.
- 1.17 You facilitate and advocate for occupational justice.



Appendix 4: Sample of Observational Notes from each Case Study

Forensic Ward

Tuesday 3/11/15

[redacted] sick
evening shift (330-930)

7:54 Arrive at security/entrance ⇒ Security staff ring for [redacted] ask if I want dates
7:55 [redacted] lets me in. Only O.T. here yet. alarm
- On computer/logging on.

7:59 - Organising things in dpt/writing notes etc/checking emails.

8:12 - Other staff coming/going in out of kitchen/OT room.

8:16 - [redacted] arrives - logs on computer ⇒ takes til 8:24 to get on it.

8:18 - Other O.T.'s using kitchen for breakfast meal preparation.
Noise & bustle going on, keyboards, doors, keys locking/unlocking.
[redacted] & [redacted] chattering about management changes happening
in wards; laptop that has been at I.T. & 100's of viruses on it.
Need to use Iron key & all DHB computers. Problem & MP3/music files as
difficult to access unless pop
through iTunes.

8:26 - x1 phone call.
[redacted] leaves.

8:27 [redacted] leaves for ward

8:31 - [redacted] arrives - terrible traffic today.
- Logs on computer/checking emails.
- O.T.'s in kitchen have gone/finished.

8:33 - Someone in/out of O.T. area (door opening/shutting).

9:00 [redacted] goes to admin block to get more photocopy paper.

9:02 [redacted] back - back to computer.

9:05 [redacted] back.
- [redacted] & [redacted] plan/organise using kitchen so 2nd person is in
office & kitchen will be free for lunch for staff.
- Discussing people on ward/day ahead/tomorrow.

9:10 - [redacted] back - planning day/finding cupcake recipe
⇒ Discussing plans & others ⇒ when doing things & charts/using kitchen/who
might attend volleyball/when families can visit.

9:19 Looking up what mental health A&S mean on computer/chart in
preparation for meeting this afternoon. (All O.T.'s)

Wheelchair Service

Tuesday - 23-2-16	
8am	██████ here. Working on computer.
8.11	██████ here from 7.45, setting up cushion for chair downstairs. Working on computer.
8.16	██████ leaves/returns to printing. Continuing work on computer
8.23	██████ arrives
8.30	Staff meeting - all staff present, admin, techs, therapists. (weekly) ⇒ Minuted, signed speeches. ⇒ Health & Safety & cultural awareness quality projects for year. ⇒ Practiced Māori song for Powhiri next week. All therapists/staff going for powhiri in Ngongotaha (Rohine) for new building. Talking Kaumaha Man Hamilton who has = disability.
9.00	Therapists meeting. (weekly) ⇒ Peer review meeting. 5 charts discussed & photos, clinical notes for problem solving by Kam.
9.50	Return to office - ██████, ██████ All on computers - ██████ doing stats/emails
9.56	██████ writing in clinical notes. - big pile of notes.
9.58	██████ out to organise equipment to be picked up by suppliers. Coes back to ph client re. equipment trial
10.03	off ph. ↗
10.05	██████ back out to sort out equipment downstairs.
10.07	██████ on ph. re status update of walking equipment to colleague
10.17	██████ going downstairs to talk to admin
10.12	██████ off ph.
10.17	██████ back
10.19	Technician comes in to talk to ██████.
10.20	██████ leaves.
10.22	██████ back makes ph call.
10.24	██████ off ph. makes mobile call
10.29	██████ off ↗

Special School

Tuesday 5th April.

8:00 [redacted] at work. Chatting to SLT about plans for day.
On computer.

8:15 [redacted] arrived to work, unpacking stuff onto computer.

8:23 [redacted] arrives, unpacks, sorts out stuff

8:25 [redacted] rips out to talk to someone.

8:26 [redacted] organising resources from cupboards - putting rise in small cupboard.
leaves [redacted] S.L.T for just visit in Community bus duty.

8:28 [redacted]

8:30 Bell goes.

[redacted] on computer

8:31 Writing note for OTA in her job log exercise book.

8:37 [redacted] & [redacted] getting ready to go to Sallie class.
Packing up bags of resources, difficult to carry it all.

8:39 Leave office.

8:41 OTA arrives.

8:45 " "

9am Bell rings.

9:05 [redacted] back. goes onto computer to check emails.

9:12 [redacted] goes to printer/lab.

9:14 [redacted] getting organised for morning, taking adapted cutlery
looking in cupboards for ^{more} cutlery. Takes assessment kit.

9:18 [redacted] off to Cambridge.

10:30 Bell goes. - morning tea.

10:45 [redacted] & [redacted] return - job quick done. heads off

10:50 Bell goes. (one of the students rips into staffroom & grabs cutlery)

10:54 [redacted] on computer
[redacted] putting away things in cupboard.

10:55 Carelaker (?) rips in to talk to [redacted] to discuss some
plywood [redacted] has requested. IS asking maintenance
guy to make something. Discussing putting rail onto the
renovations/side stairs that will be done in holidays.

10:58 [redacted] leaves for bathpaste prep.