Exploring practice and taking action to enable human rights and occupational justice in an Australian hospital context: An action research study

A thesis submitted for the degree of Doctor of Philosophy

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# Table of Contents

Table of Contents ............................................................................................................. ii

List of Tables and Figures .............................................................................................. vii

List of Tables .................................................................................................................... vii

List of Figures .................................................................................................................... vii

Certificate of authorship ................................................................................................. viii

Acknowledgements ........................................................................................................... ix

Ethics Approval ................................................................................................................ xii

Professional editorial assistance ...................................................................................... xiii

Abstract ........................................................................................................................... xiv

Chapter 1 ............................................................................................................................ 1

Introduction ...................................................................................................................... 1

Background to this research ............................................................................................ 1

Structure of the thesis ...................................................................................................... 8

Chapter 2 ........................................................................................................................... 11

Literature review ............................................................................................................. 11

Human rights discourse ................................................................................................. 14

Theory and philosophy of human rights ......................................................................... 14

The Australian human rights context ............................................................................. 21

Professional practice ...................................................................................................... 27

Contemporary practice theory ....................................................................................... 27

Practice wisdom and praxis ........................................................................................... 33
A critical paradigm for occupational therapy ........................................ 36

*Occupation, enablement and occupational justice.* .......................... 37

*The doing and practice of occupational justice.* .............................. 47

Chapter summary .................................................................................. 51

**Chapter 3** .......................................................................................... 53

**Methodology** .................................................................................... 53

The research questions ........................................................................ 56

Action research: Background and epistemology ................................ 57

Justification of methodology ................................................................ 61

Perspectives about how to do action research ...................................... 64

*Roles of the researchers.* .................................................................... 64

*The cycles of action research.* ............................................................ 67

Issues of positionality ........................................................................... 68

Methods .................................................................................................. 70

*Selection of site.* ................................................................................ 70

*Recruitment of co-researchers.* .......................................................... 72

*Data collection.* ................................................................................. 73

*Data analysis.* .................................................................................... 88

*Ethics.* .................................................................................................. 95

*Evaluating the quality and limitations of this research.* ................. 98

Chapter summary .................................................................................. 108

**Chapter 4** .......................................................................................... 109

**Findings: Utopian Visions, Dystopian Realities** ................................ 109

Envisioning occupational justice ......................................................... 113

*Visions for occupational justice.* ...................................................... 113

*The lucky and unlucky occupational therapist.* ............................... 118
National, cultural and professional influences .........................................124

*Occupational injustices are less visible locally.* ........................................124

*Justice not an explicit professional vision in Australia.* ..............................130

*Aspirational statements of human rights are not always pragmatic.* .........138

*An imperfect balance between rights and responsibilities.* .......................144

Chapter summary .......................................................................................148

**Chapter 5** ..............................................................................................150

**Findings: Sidelined to institutional arrangements** .................................150

Impact of medical and fiscal discourses .......................................................151

*Withdrawing services.* ...........................................................................151

*Funding body policy prevents a quality of life focus.* .................................154

Rights and governing risk discourses .........................................................157

*Advocacy for risk taking is overruled.* .....................................................157

*Defensiveness to risk-taking.* ..................................................................161

*Dual loyalties: Justice is lost.* .................................................................163

Chapter summary .......................................................................................167

**Chapter 6** ..............................................................................................169

**Findings: Taking action for human rights and occupational justice** .........169

(Re)-humanising institutional practices ......................................................170

*Re-claiming time for dialogue and stories with clients.* .........................170

*Powerful practice stories.* ........................................................................173

*A critical inquiry for supervision.* ............................................................177

Permeable, participatory spaces .................................................................181

*Home: An enabling place.* .......................................................................181

*Bringing the community inside.* ...............................................................183
Partnering with clients and families ........................................... 186
Advocating for human rights and justice ..................................... 188
Developing autonomy ................................................................. 188
Putting human rights in real, occupational terms ...................... 190
Speaking up about unfair use of professional power ..................... 193
Chapter summary ......................................................................... 196
Chapter 7 ...................................................................................... 198
Discussion: Creating spaces for human rights and
occupationally just practice ....................................................... 198
The process of creating occupationally just practice ................. 198
The first step: Understanding the context and conditions of practice .................................................. 203
The second step: Incorporating a rights culture ......................... 230
The third step: Creating participatory occupational spaces ....... 235
Chapter summary ......................................................................... 247
Chapter 8 ...................................................................................... 250
Recommendations and conclusion ............................................. 250
Recommendations for occupational therapy ............................... 251
Education .................................................................................... 251
Practice ...................................................................................... 258
Recommendations for future research and occupational science .............................................................................. 261
Conclusion .................................................................................... 266
Reference list ................................................................................ 267
Appendix A: Interview guides ..................................................... 302
Appendix B: Focus group guides .................................................. 306
Appendix C: Reading and reflection guides ............................... 316
Appendix D: Newsletters ................................................................. 329
Appendix E: Example of NVIVO Word export .............................. 385
Appendix F: Example of NVIVO Excel export - Category and theme development ................................................................. 394
Appendix G: Co-researcher Information and Consent Form... 407
Appendix H: Ideas for changing practice .................................... 419
Appendix I: My self-reflection guide ............................................ 422
List of Tables and Figures

List of Tables

Table 1: Log of site visits and actions taken during these visits ...... 76
Table 2: List of co-researchers’ plans for taking action.................. 85
Table 3: Appendices that document the audit trail...................... 107

List of Figures

Figure 1: Review and reflect – Sample questions focus group four. 81
Figure 2: Plan – Sample questions focus group six/seven .......... 82
Figure 3: Act and evaluate – Sample questions focus group
eight/nine ............................................................................. 83
Figure 4: The process of making occupationally just practice ...... 110
Certificate of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with the normal conditions established by the Executive Director, Library Services, Charles Sturt University or nominee, for the care, loan and reproduction of thesis, subject to confidentiality provisions as approved by the University.

_______________________________________
Danika Galvin                         /       /
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Abstract

It may be argued that human rights have become an increasingly important moral discourse in contemporary society and that Australian occupational therapists have a legal and ethical obligation to address matters of human rights. The emerging theory of occupational justice has potential to assist therapists to identify and address issues of occupational inequity or absence of occupational rights in practice. However, there is need for research about how occupational justice can be applied in occupational therapy practice, to overcome long-standing patterns of hegemony.

An action research study was therefore undertaken at a metropolitan hospital in Melbourne, Australia to explore the primary question: How do occupational therapists reflect upon and act to enable human rights and occupational justice in their practice? Over the course of 10 months, nine occupational therapists engaged in monthly focus groups and in three rounds of individual interviews. Data was collected through audio recording and transcribing focus groups and interviews. The transcribed data was formally analysed using thematic analysis within a framework of hermeneutic phenomenology.

A finding of this qualitative research was that initially the co-researchers tended not to see and address the full range of
occupational injustices that impacted on their clients, due to their cultural heritage as Australians and a lack of an agreed set of professional beliefs about human rights and occupational justice. The influence of medical and fiscal hegemony in the hospital precluded co-researchers from thinking about clients from an occupationally just perspective; co-researchers were initially unaware of how their loyalty to the hospital contributed to their discriminatory practices and their gate-keeping of services. Moreover, a dominant technical risk discourse contributed to a lack of occupational rights in the hospital, and to a climate of solicitousness that was a barrier to enabling occupational justice.

Through the research, the co-researchers engaged in local, contextualised discussions about people’s lived realities and experiences of injustice. This was found to be effective for cultivating a human rights culture within this group of practice scholars. Through the process of learning and critique, the co-researchers developed their sense of agency and became more likely to implement enabling, emancipatory practices.

The co-researchers made three kinds of change to enable occupational justice. They used stories as a means to highlight their clients’ humanity. They facilitated permeability between the hospital and community, thereby enriching the ward with opportunities for
people’s active participation. They used advocacy to engage their colleagues in public reasoning about matters of occupational rights.

A three-step model for the process of creating occupationally just practice was created. The first step entailed assisting the co-researchers to better understand the contextual influences that shaped and constrained their practice of human rights and occupational justice. The second step was to create a human rights culture and thus inspire the co-researchers to make a commitment to change. In the third step, the co-researchers acted for human rights and occupational justice by creating spaces for participation and partnership with clients, colleagues and community members.

This action research illustrated that applying the occupational science concept of occupational justice and using continual discursive practices may enhance occupational therapy practice and praxis. Furthermore, the co-researchers (and I) constructed new practice-based meanings about occupational justice which foreground the concepts of participatory occupational spaces. Thus, demonstrating there is potential for taking a context-specific approach to shaping of occupational science epistemology.
Chapter 1

Introduction

This thesis explores an occupational perspective of justice, which at its simplest level, I define as the right of all people to participate in occupations of their choosing. My interests, background and life experiences have sapped my understanding of occupational justice. To make my perspective as a researcher clear, and by way of introducing this study and how I came to be interested in this topic, I now briefly overview some experiences that have helped to form my interest and my viewpoint.

Background to this research

I grew up in a small rural community in inland NSW. I reflect upon this place as having well-developed forms of community engagement and a sense of connectedness based on a shared geography, interests and traditions; members of my hometown community were particularly interested in farming, sport and education. The community was predominantly Anglo-Australian, with only a few people of other, more diverse ethnic and cultural backgrounds. Of course, this description belies the complexity of people’s lives; there were sub-groups who experienced marginalisation through indirect forms of social discrimination and
stigmatising beliefs that were embedded within the thinking of the community. For example, women and people of low socio-economic status backgrounds tended to be marginalised. I found myself in a fortunate position, belonging to a middle-class family and having been afforded a range of life opportunities. Importantly, my four siblings and I were raised by parents who held strong values of social inclusion, and this perspective was formative in shaping our actions and interactions with others in the community.

Although I have not directly experienced injustice or oppression, my understanding of it has been enhanced through my undergraduate university education as an occupational therapist at Charles Sturt University (CSU) in Albury, Australia. At the time of undertaking my undergraduate studies, the occupational therapy course at CSU was newly established. The course’s early emphasis on the bonds between occupational science and occupational therapy instilled in me the need for occupational therapists to take an active role in creating just and inclusive societies. For example, in third year I designed a proposal for an occupational needs assessment for refugees and asylum-seekers in mandatory detention. This kind of curriculum and learning pedagogy reinforced the notion that occupational therapy need not be limited to practice in the fields of disability. Rather it had the potential to meet wider community needs for participation in occupation.
Notwithstanding my early grounding in alternative occupational therapy practice opportunities, I have for the past 12 years occupied what would be considered traditional (and clinical) occupational therapy roles. That is, I have practised mostly in medical practice contexts. After graduating as an occupational therapist, I took a new-graduate position at an acute metropolitan hospital in Melbourne, where I rotated through various medical specialities over a 2-year period. For the most part, I found this form of learning and practice extremely stimulating and satisfying. I was driven to learn the impairment and body-focused practices that were required for the rotations, even though they focused on medical techniques, as I firmly believed that what I did as an occupational therapist was an important aspect of enabling people’s participation in occupation.

At this early point in my career, moving from the country to a metropolitan setting enabled me to gain insights into how certain social groups in the community lacked real opportunities to make choices about, and participate in, occupation. The root causes of occupational challenges became more visible to me in the city. They included unemployment, poverty, disability, age, antisocial influences and violence, substance abuse, mental illness, dislocation from culture and so on. I felt passionate about enabling people to lead a life that was more occupationally just but I did not have a strong sense of being able to positively influence people’s social conditions.
in my occupational therapy practice. Addressing societal issues did not appear to be what I was expected or funded to do.

Nonetheless, I also found that certain features of this acute setting enabled me to practice in an ethical and just way. I recall that the occupational therapy manager and other experienced occupational therapists allowed me to be critically reflective about how to practice with clients’ needs and rights in mind. For example, in a series of panel discussions within the departmental in-service program, occupational therapy colleagues joined as a group with an ethics consultant to engage in reflective conversations about everyday moral decision-making.

In 2005, three years after I graduated, I accepted a locum position in the Central Australia Region. I was one of two occupational therapists servicing remote First Australian (Aboriginal and Torres Strait Islander Peoples) communities across an area of over 830,000 square kilometres. At the same time I commenced postgraduate studies and found myself engaging with theories of occupational justice in order to deepen my appreciation of the occupational issues of inequity and injustice that were facing this particular group of First Australians, including but not limited to a lack opportunities to participate in employment, education, sport, and other health-building occupations. My experience confirmed a
growing conviction that human rights and occupational justice ought to be at the heart of what matters to occupational therapy practice.

Since these early career experiences, I have most particularly practised in the area of inpatient rehabilitation with people who have acquired brain injury. I found the transition from the acute medical context to be surprisingly liberating. Although an impairment focus remained a feature of my practice, I also experienced freedom to practise creatively and in accordance with clients’ choices and desires for participation in occupation. I thought about clients more holistically and I considered their contexts more deeply. This work often took me to people’s homes and other places in the community, where I could see the value of what I did as an occupational therapist.

Although my practice became more occupation-focused and client-centred, I increasingly developed new insights and some discontent about the range of systemic and institutional barriers to my clients’ participation in occupation. I observed human rights problems such as inadequate privacy and lack of resources for personal care on the ward, limited opportunities for clients to participate in decision-making about their therapy, a lack of appropriate and accessible housing for clients who needed to receive residential care, and lack of support services to help people to participate in community and cultural life. Regrettably, with hindsight,
I now consider that I was on occasions complicit in maintaining the status quo and thus contributed to occupational injustice.

As I considered my actions and how they conflicted with my values, I felt unclear about how to act as an agent of change. Previously, when I have sought to implement change, I have sometimes found this process to be lonely, frustrating and burdensome. I also doubted if the changes that I had instituted, such as enhancing interdisciplinary collaboration for clients with complex needs, would be effective or sustained over time, without the broad, collective commitment of my colleagues. To this end, I formed the view that if my efforts at transforming practice were to be more ethical and just, then I required novel and fresh approaches.

Prior to taking leave from my permanent work to undertake my doctoral studies, I joined with colleagues to create a new forum in the occupational therapy department, in which occupational therapists could engage in practice scholarship around themes of occupation, participation and justice. I found it empowering to be among a group of occupational therapists from across a range of services and teams, who were similarly interested in having this kind of public discussion and developing shared understandings about occupational therapy practice.
Although I had a few discussions with my occupational therapy colleagues about new concepts and ways of practising, I was not certain about how I could discuss the idea of occupational justice with them. I became curious as to how occupational therapists in diverse geographies and practice settings around the world conceptualise and practise occupational justice in their local contexts.

My thinking about occupational justice was particularly enhanced by the path occupational therapists in South Africa have taken. In South Africa, occupational therapists have engaged individually and collectively in public discussions about human rights and occupational justice. In July 2009, after I had begun collecting data for the research described in this thesis, I used my scholarship funds to travel to the University of Cape Town, South Africa, to an Occupational Justice Symposium and Think Tank titled “Relevance of an occupational justice perspective in Africa and beyond”. A central aim of this conference was to promote “contextually relevant occupation based practice” (Firfirey et al., 2009). This experience prompted me to think further about what occupational justice means for Australia, and to an Australian way of life and peoples. In Australia, we share with South Africa, a history of injustices, such as the injustice for First Australians; a culture and peoples who experience marked socio-economic inequalities, reduced life expectancy, and family violence (Australian Human Rights
Commission, 2012). Thus, through this experience, I became even more interested to think and learn about human rights and occupational justice concepts in a developed and democratic country such as Australia.

**Structure of the thesis**

I have lightly traced the way in which my own life-world shaped an interest in this action research project and now, in order to assist the reader, I will overview the broader structure of this thesis. Following this introductory chapter, chapter two provides an appraisal of the literature relevant to the topic of this study. In particular, I review human rights discourse internationally and in an Australian context, and I also explicate ideas about the nature of professional practice. However, this research is most specifically located at a nexus of occupational science and occupational therapy, which I argue, is occupational justice. Therefore, I conclude chapter two with a review of literature about the theory, philosophy and practice of occupational justice.

Chapter three describes the methodology I employed. In this third chapter I outline the questions and action research framework selected for this study. After I detail the methods used for recruitment and data gathering, I discuss issues of power and positionality, and how analysis of interview and focus group data was conducted within
a framework of hermeneutic phenomenology. Furthermore, I evaluate the quality, and limitations, of this action research study.

The findings of the research are presented in chapters four, five and six. In chapter four, I describe the participating therapists’ individual and collective visions for human rights and occupational justice in occupational therapy practice. I discuss the disjuncture between ideals of occupational justice, and the realities of practice in this particular national, cultural and professional context.

The emphasis in chapter five is upon findings about the constraints on enablement of human rights and occupational justice in the research setting. In this chapter, I present an overarching theme of the sense of powerlessness that the participating therapists experienced when trying to implement innovative or new occupational therapy practices in the face of dominant medical, fiscal and risk discourses in their practice environment.

Chapter six reveals, in essence, the beginning steps towards transforming occupational therapy practice that the participating therapists took as a result of the action research. The therapists made practice changes that included using dialogue and stories to be more aware of their clients’ humanity, creating more permeable links between the hospital and the community, and becoming more articulate and advocating more for human and occupational rights.
In chapter seven, I discuss the overall assertion of this research, which is that the process of making occupationally just practice required the creation or opening up of particular kinds of spaces for learning and doing. First, I discuss the need for understanding aspects of the national, cultural, professional and institutional context. Second, I discuss the transformative potential of practice stories for cultivating a rights culture. Third, I discuss the kinds of actions that can enable human rights and occupational justice in practice.

The final chapter (number eight) provides recommendations for occupational therapy education, practice and research. A primary recommendation is that it is important for occupational therapists and occupational scientists to make partnerships and participation key to enabling human rights and occupational justice.
Chapter 2

Literature review

This literature review is an exploration of the literature at the nexus of human rights, occupational justice and occupational therapy practice. I accessed literature through two university libraries located near to where I lived and/or studied. I systematically searched using Primo Search at Charles Sturt University library and Super Search at the University of Melbourne library. These discovery tools searched the libraries’ collection of resources including online or print journals, e-books, books, research theses, and other physical items available in those libraries. I also conducted specific searches within journal databases. For example, I used the journal database CINAHL (Plus with Full-Text), a well-known index for allied health and nursing literature from 1937 to 2013. I also used the EBSCOnhost (Health) database to search for literature in the broader fields of medicine, sociology, health administration, and business.

I used key search words such as “occupational justice”, “human rights”, “ethics” and “action research”. I commonly added other domains, for example, “occupational therapy” or “practice” to narrow the search to references relevant to the research described in this thesis. Thus, I produced combinations of key words, such as
“action research AND occupational therapy”’ or “ethics AND practice”.

In addition to the journal database searches, there were particular journal titles that I directly searched, because their foci were highly compatible with my research topic. I scanned a range of international peer-reviewed journals: Journal of Occupational Science, Australian Occupational Therapy Journal, American Journal of Occupational Therapy, British Journal of Occupational Therapy, Canadian Journal of Occupational Therapy, South African Journal of Occupational Therapy and Scandinavian Journal of Occupational Therapy.

I found ideas for additional references by reading the reference lists of literature that I had obtained. This strategy helped me to locate publications by authors who were frequently cited or had produced a body of work in a particular area; for example, I found that Stephen Kemmis had written extensively about professional practice. I also sourced reports, laws, policies, position statements, and other materials published by key government and non-government institutions and bodies, such as the Australian Government, the United Nations, the Australian Human Rights Commission, and the World Federation of Occupational Therapy.
I also specifically searched the websites of different countries’ occupational therapy associations, in the United Kingdom, the United States, Canada, and in Australia, for key position papers related to human rights and occupational justice. This search achieved limited results. Further, I believe that the Occupational Therapy Association of South Africa (OTASA) released a position paper concerning human rights (Lorenzo, 2008); however I was not able to readily access this document.

All literature accessed for this review was in English and written predominantly by authors from Australia and other Western nations including New Zealand, the United Kingdom, the United States, and Canada, and to a lesser extent, by some authors from Southern nations such as South Africa. English is the official or a dominant language of these countries. Thus, despite my intentions to draw from diverse cultures and traditions, this literature review largely omits literature from Asian and Southern authors, due to cultural and language barriers that could not be readily overcome.

The broad-based nature of these searches enabled me to access a broad range of literature. In managing the large amount of literature that I discovered, I prioritised classical and foundational works cited often. I also focused on recently published literature (2003 onwards).
I commence this literature review with a discussion of philosophical, legal and political discourses about human rights. I emphasise a focus on human rights in an Australian cultural context, because the research described in this thesis occurred in Australia. Second, I explore the theory of practice and the way that knowledge conceived within the professions shapes the morality of practice. Third, I examine the extent to which issues of human rights, morality and occupational justice, have been considered in relation to occupational therapy practice.

Human rights discourse

Theory and philosophy of human rights.

Human rights ideas have been recorded in various forms in earlier ages and ancient traditions; as understood in contemporary society, however, human rights originated from Enlightenment perspectives about “natural rights” (J. Griffin, 2008). According to a natural law and natural rights viewpoint, human beings have inherent or natural rights because they are creatures with a particular capability to reason (Winston, 1989). Thus, in this view of human rights, all people are equal at birth and therefore all people naturally acquire human rights.

Towards the end of the Enlightenment, natural rights became increasingly secularised and the protection of human rights came to be understood as the responsibility of government (J. Griffin, 2008).
Nations listed rights in their key declarations or bills of rights as an expression of the political and moral values and governing principles of each society (J. Griffin, 2008). Over time, however, these liberal views about the role of the state in governing natural rights became politicised. For example, feminist philosopher Mary Wollstonecraft (1759-1797) and revolutionary Karl Marx (1813-1883) argued that listings of rights retained exclusions based upon issues of economics, gender and cultural distinctions (Winston, 1989).

It was in response to the Holocaust and other atrocities of World War Two that human rights discourse became more inclusive of all people. In reaction to a desire to prevent future violence, in 1948 the newly formed United Nations agreed upon the Universal Declaration of Human Rights (UDHR) as the moral standard that all peoples and nations should strive to respect and to observe (J. Griffin, 2008). The UDHR is a set of entitlements that are universal and that belong equally to all people as a condition of being human (Winston, 1989). Therefore, everyone is entitled to human rights without distinction; discrimination according to place, culture, gender, religion and so on ought not to occur (Winston, 1989). This recognition that all human beings are born free and equal in dignity and rights is the foundation for “freedom, justice and peace in the world” (United Nations, 1948). It is this statement of human rights that remains most well known in contemporary society.
All people are holders of human rights, and importantly, all people ought to have the freedom to “claim” human rights (Winston, 1989). An injustice is created when a claim to a fundamental human right is not respected, protected, or fulfilled by one’s fellow human beings, institutions or levels of governance (Winston, 1989). It is in the act of claiming human rights that humans experience a sense of self-respect, which in turn gives rise to the notion of human dignity (Feinberg, 2001). Thus, human rights and claims to justice are intertwined, and individuals have “entitlement to” do, be, or have something, and to “claim against” others (Feinberg, p. 185).

The UDHR was the first dedicated international commitment to conceptualise human rights in a way that accommodated different political, cultural and economic beliefs and systems (Winston, 1989). Different philosophers, who consulted to the United Nations Economic and Social Council (UNESCO) prior to the drafting of the UDHR, offered diverse cultural, philosophical and spiritual perspectives about the meaning of human rights to different peoples and cultures (Maritain, 1948). Arnold Lien (1949) proposed that human rights ought to encapsulate an individual’s all-inclusive right to self-realisation:

They are really the keystone of the dignity of man. In their quintessence they consist basically of the all-inclusive right or enabling quality of complete freedom to develop to their fullest possible extent every potential capacity and talent of the
individual for his most effective self-management, security and satisfaction. (p. 24)

The philosopher Pierre Teilhard de Chardin encouraged the drafters of the UDHR to focus on individuals in the context of society, rather than the human being as an individual (National Human Rights Consultation Committee, 2009). Teilhard de Chardin (1949) advised that governments ought to focus on enabling the societal conditions required to realise a person’s humanity, and that this action could in turn help others and society to develop collective understandings about how one ought to live.

However, the collective emphasis generated through UNESCO’s commissioning of philosophers was evidently different from the final conceptualisation of human rights in the actual UDHR, which appears to maintain an emphasis upon individual rights. Indeed, the UDHR has been criticised for its creation in a forum dominated by Western political leadership and the championing of individual rights while devaluing collective understandings of human rights prominent in other cultural, religious and philosophical traditions (Ife, 2012).

The UDHR is not legally binding, yet the document has been used as an important foundation for subsequent treaties and law (Gable, 2007). Two separate legally enforceable treaties were enacted in 1966: the International Covenant on Civil and Political
Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (United Nations, 1966a, 1966b). Due to their development at the time of the Cold War, the two international covenants have historically represented competing world-views; that is, Western nations aligned to the ICCPR, and Eastern nations with the ICESCR (Evans, 2008). That division has continued to shape understandings of human rights in contemporary society. For example, civil and political rights are emphasised in Western nations whereas social, economic and cultural rights are prominent in Eastern nations (Evans, 2008).

This historical construction of human rights in the United Nations system has shaped a conceptualisation of human rights as having developed in three generations. In this three-generation typology, human rights of the first-generation are civil and political in nature. These rights are “negative rights”, or the kinds of rights that need to be protected from human rights abuses, such as the right to vote and freedom of expression (Ife, 2012). Second-generation human rights refer to a category of “positive rights” that encompasses the right to health, employment, education and others (Ife, 2012). Second-generation rights require a proactive stance for the realisation of human potential. A third-generation of rights or “collective rights” describes those rights afforded to people as a group, such as the right to cultural participation and a healthy environment (Ife, 2012).
It is important to understand the nature of this three-generation typology, because it can be problematic for the practice of human rights, such as in health professions. In particular, classifying collective rights as “third category” separates them from the first and second generation of rights, which are therefore understood in solely individual terms. This leads to individual understandings of human rights issues and problems, as well as individualised forms of practice, rather than meeting broader social goals (Ife, 2012). A further problem is that this typology implicitly values some human rights as more important than others. The listing of civil and political human rights as “first-generation” might contribute to the perception that they are more important than social, economic and cultural rights (Ife, 2012). Thus, civil and political human rights may be given priority in practice, despite the fact that a principle of human rights is that they are interdependent and indivisible (that is, one human right ought not to be considered as any more or less important than another) (Evans, 2008). Although this critique is not exhaustive it points to some of the limitations of conventional human rights discourse.

In contemporary society, human rights discourse remains deeply grounded in its Enlightenment origins and in traditions of reason and law (Ife, 2012). The exclusive legal framing of human rights is limiting in the sense that only rights adopted by law, and that
are usually civil and political in nature, are used to protect individuals (Douzinas, 2000). According to Douzinas, this trust in governance defies the raison d’être of human rights, which is to protect people from those institutions and powers, and it precludes other professionals from engaging with and advancing ideas of human rights in their practice.

Legal procedures, political traditions, and historical contingencies may be part of their construction, but human rights retain a critical distance from law and stretch its boundaries and limits. Indeed their rhetorical nature, proclamatory enunciation and regular defiance of state law are aspects of their ability to transcend and redefine their contextual boundaries. (Douzinas, 2000, p. 344)

Nonetheless, the philosopher and leading interpreter of the Dinka people in Sudan, Francis Deng (2009) argued that thinking of human rights as particularly Western notions exacerbates divisiveness between different countries, cultures and groups. Rather, Deng considered that Western conceptualisations of human rights such as the UDHR provide a powerful starting point for dialogue about human rights, and further, that every culture has humanitarian ideals or principles to which it can add and contribute to the redefinition of universal standards of human rights.

If meaningful and lasting changes in attitudes and practices are to be achieved, the proposed reinterpretation has to be
undertaken from within the culture by those who, while promoting universal norms, are sensitive to the integrity and authenticity of the local cultures. (Deng, 2009, p. 37)

Thus, while the UDHR remains an important reference point for enacting human rights globally, the importance of the local, that is, local cultures and local circumstances, is also increasingly apparent.

**The Australian human rights context.**

Australia is a signatory to core United Nations treaties and covenants, including the UDHR, the ICCPR and the ICESCR (Australian Government, 2010). In addition, Australia is a signatory to additional conventions enacted through the United Nations to protect the rights of minority groups, such as the Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006). Citizenship is a key goal of the CRPD; this convention also sets apart articles that specifically relate to health and (re)habilitation as a human right. For example, Article 26.1 calls for signing states to:

“take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability and full inclusion and participation in all aspects of life” (United Nations, 2006, p.19).

Through the ratification of these United Nations treaties, Australia is obliged to act for human rights under international law and to protect

Even though Australia maintains international commitments to upholding human rights, as a nation it does not offer constitutional recognition or protections for human rights. Human rights protections were not embedded in the constitution that inaugurated Australia as a federated nation (Chappell, Chesterman, & Hill, 2009; Kirby, 2011). This omission may have arisen because Australian legislators were concerned that inclusion of protections would infer that Australians were not capable of acting honourably, which was a valued tradition of the British Empire that Australians wished to emulate (Chappell et al., 2009; Kirby, 2011). Another explanation is that legislators did not support the introduction of constitutional human rights protections because they were aware that this action would preclude other State legislative attempts to exclude certain minority groups from their experience of human rights (Chappell et al., 2009).

Rather than embracing liberalism and associated constitutional protections for human rights, Australian political culture is strongly imbued with egalitarian notions of social justice (Chappell et al., 2009). Thus, Australian citizens consider that legislative and democratic electoral processes will naturally work to uphold human rights in accordance with cultural values of equality and the ethics of a “fair go” (Victorian Equal Opportunity and Human Rights
A fair go reflects a widely shared and contemporary Australian view that all people are equal in worth and ought to be afforded an equal chance (Burnside, 2007).

However, interpretations of what constitutes the ethics of a fair go are far from clear, and this becomes problematic for minority or disadvantaged groups. An Australian polity governed by a utilitarian mentality has sometimes led to governments ignoring the human rights of minorities in order to achieve objectives considered to be good for the majority (Byrnes, Charlesworth, & McKinnon, 2008). Further, a reliance upon democratic and electoral processes to uphold human rights is problematic because political will and agendas shift in accordance with the party that has the support of the majority at the time of the most recent election (Chappell et al., 2009). Thus, a populist approach has potential to create conditions that produce and reproduce the marginalisation of particular groups in the Australian community.

Australia does not currently have a dedicated national system of human rights protections. Unlike other nations across Europe and the United Kingdom, and in South Africa, Canada, and New Zealand, Australia is the only liberal democracy that does not provide constitutional guarantee for human rights (Grover, 2009). Even though Australia has a strong record of ratification of United Nations covenants and treaties, a lack of constitutional protection
perpetuates inconsistencies and gaps across Australian federal, state and territory laws, and it limits citizen access to remedies for human rights breaches (Australian Human Rights Commission, 2010).

A lack of constitutional protection for human rights in Australia is compounded by the fact that the Asia-Pacific region to which Australia belongs lacks a regional human rights system like those that have been created in Europe, the Americas, and Africa (Gable, 2007). Regional human rights systems allow stronger mechanisms for oversight and enforcement of human rights, such as the creation of commissions or courts that enable individuals or groups to make a claim directly (Gable, 2007).

Attempts directed at constitutional amendment or the introduction of a human rights act in Australia have been made twice, unsuccessfully, once in the 1970s and again in the 1980s (Kirby, 2011). Furthermore, in 2009, a newly elected federal Labor government commissioned a community consultation process about the adequacy of Australia’s legal recognition and protection of human rights (National Human Rights Consultation Committee, 2009). The majority of the 30,000 submissions (made by community organisations and citizens) supported a recommendation for a national Human Rights Act for Australia (Kirby, 2011). Despite this overriding support, the Australian Government deferred consideration of a Human Rights Act until 2014 (Australian Human Rights Commission, 2010). This failure of politicians on both sides of Australia’s major political groupings to support a human rights charter is similarly attributed to such factors as a respect for the parliamentary institution and Australia’s democratic processes, as well as a failure “to grasp its need for an occasional stimulus to require it to address injustices towards unpopular and forgotten minorities” (Kirby, 2011, p. 272).

Although the Australian Government did not agree to implementation of a national charter, in 2010 it released Australia’s Human Rights Framework. This framework outlines: a government commitment to implementing education within schools, the community, and the public sector; introducing processes to enhance
legislative review; and reviewing and consolidating federal anti-discrimination laws into a single Act (Australian Government, 2010). Thus, despite the limitations that have been described, Australia has made some progress in addressing commitment to enhancing protections of human rights.

Various Australian states and territories have also strengthened human rights protections. I now briefly discuss the situation in the state of Victoria, where the research described in this thesis occurred. In 2005, the Victorian Government commissioned a community consultation process, which found majority community support for implementation of a human rights charter (Byrnes et al., 2008). Subsequently, the Victorian Charter of Human Rights and Responsibilities Act 2006 (Victorian Charter) was enacted into law, drawing upon the civil and political rights drawn from the ICCPR (Byrnes et al., 2008). Although the omission of economic, social and cultural rights limits the breadth of human rights protections, the Victorian Charter makes explicit a human rights framework for governance: all public authorities and professionals (and other entities that have a function of a public nature) in the state of Victoria are legally responsible to ensure that the human rights in the charter are upheld (Victorian Equal Opportunity and Human Rights Commission, 2012). Thus it would appear that there is an emergent human rights dialogue and culture within Victoria, and that occupational therapists, particularly those working in the public
sector, have a legal and ethical imperative to uphold human rights in their practice.

**Professional practice**

**Contemporary practice theory.**

In this section I seek to position a human rights framework as having a special moral significance for practice, however this requires an examination of practice theory. Practices are any form of “socially established cooperative human activity” (Kemmis, 2009, p. 22). In the research described in this thesis, I am interested in a particular set of practices, that is, professional practices. These practices are of utmost interest because I am specifically exploring the practices of occupational therapists.

According to practice theorist Theodore Schatzki (2002), practices are made up of “organised nexuses of actions” or sets of actions for “saying” and “doing”, that “hang together” in social life in a way that gives a sense of purpose and meaning to that practice (p. 77). This description of practice encapsulates the key features of practice that I briefly discuss: practices are meaningful activity, practices occur in a social world, practice is embedded in context, and practice is experiential.

Practices are a form of activity engaged in by people, or practitioners. A practitioner does not engage in activity for the sake of
it; rather, the activity that constitutes a practice is meaningful to that practitioner (B. Green, 2009b). Practice therefore enables a practitioner to engage in activity aimed at accomplishing particular goals or tasks. A health professional such as an occupational therapist, typically engages in activity pursuant to enabling another person’s health and well-being.

Practices are built upon people’s shared understandings and interactions about what constitutes a practice, or a “successful inculcation of shared embodied know-how” (Schatzki, 2001, p. 12). Thus, a practice is shaped through the amalgamation of different perspectives and expectations held by all the people with whom a practitioner may work. In the case of an occupational therapist, this includes the views of clients, families, managers, colleagues and other members of the community.

Practice is not only socially learned and formed, it is more broadly contextual in nature; indeed, practice cannot be thought of outside its context (B. Green, 2009a). Kemmis (2012) built upon the ideas of Schatzki, suggesting that practice is embedded in practice architectures or particular sets of cultural-discursive, material-economic and social-political arrangements, which shape how people “say”, “do” and “relate” to one another. These practice architectures give practices:
- their meaning and comprehensibility (in the cultural-discursive dimension, in semantic space, in the medium of language);
- their productiveness (in the material-economic dimension, in physical space-time, in the medium of work or activity); and
- their value in establishing solidarity among the people involved in and affected by a practice of a particular kind (in the social-political dimension, in social space, in the medium of power) (Kemmis, 2012, p. 886)

Kemmis emphasises that practices have extra-individual features. This means that practices are influenced not only by a practitioners’ action and practice knowledge, but also by external conditions and circumstances (Kemmis, 2005). A practitioner new to practice in a particular place enters a particular array of arrangements that prefigure the practitioner’s actual performance, but do not entirely enable or constrain what a practitioner may choose to do (Kemmis, 2005).

The particular set of arrangements that characterise practice in one site are inherently different from those of other sites, and also the kinds of practice arrangements characteristic of one profession are distinct from those of another (Kemmis, 2009). Through participation in the social order of practice, people learn the characteristic arrangements that constitute their particular form of
professional practice (Kemmis, 2009). Thus, occupational therapists form their professional identities through fieldwork experiences and enculturation into various practice sites and settings.

Although practice is made up of orderly arrangements that shape how it is likely to unfold, it is practitioners who make a practice through the actions that they take (Kemmis, 2012). Conceptualised in this way, practice is experiential. Practices are what particular people do, in a particular place and time. It is the practitioner who enacts a choice about what to say or do in practice, and the way that a practitioner might choose to practise, in turn shapes the unfolding of that practice.

Given that a practitioner makes decisions or choices about how to practise, it is not surprising to consider practice as a moral activity. Practices are an enactment of one’s values, and therefore they raise moral questions about what actions a practitioner takes, and the implications of these actions for others (Kemmis, 2009). From a human rights point of view, it is important that practitioners are aware of how their values or thinking about what is the right or wrong thing to do, influence their perspective on what is needed in any given practice situation (Ife, 2012)

Practices are lived and experienced in a variety of different ways. Usually, through immersion in everyday professional practice,
people develop familiarity with or become habitualised to practice (B. Green, 2009b). Practices might therefore be consciously engaged in, or they might operate below the level of self-awareness (B. Green, 2009b). Indeed, Wright-St Clair and Seedhouse (2005) viewed that the ordinary, everyday moral dimensions of practice might often be taken-for-granted.

There is a broad body of literature on the structure and organisation of power in professional practice; such discussion is beyond the scope of this review. Nonetheless, the concept of *hegemony*, as informed through the work of political theorist Antonio Gramsci, has particular importance for thinking about the way that power shapes practice (unconscious practices in particular). Hegemony refers to the phenomenon where a dominant group exerts control over less dominant groups through systematically fostering ideologies that promote their own interests; often by means of “legitimising the status quo” or the way things are already done (Gesler, 1992). In turn, people who are subordinate come to accept without question the dominant group’s ideologies and beliefs as “common sense”, even when it may not be in their best interests (Gesler, 1992, p. 740).

Indeed, a number of authors have found that occupational therapists’ decision-making may be guided by hegemonic practices. Fleming and Mattingly (1994) found that occupational therapists in
the United States adopted narrowed bio-medical goals, due to the perception that it would enhance their professional standing and secure funding. Holistic forms of practice were more readily relinquished if they interfered with medical goals, or alternatively they were taken “underground” and away from public view (Fleming & Mattingly, 1994, p. 296). Townsend’s (1998a) landmark institutional ethnography into the organisation of Canadian mental health services, found that market ideologies, insurance, laws, policy, professional dominance, all serve to overrule the “good intentions” of occupational therapists to enable occupation. Occupational therapists’ worked with a “bifurcated consciousness”, that is, they had knowledge that organisation of the mental health service limited daily practice, and yet rendered the particularities of how his occurred, to an unconscious level (Townsend, 1998a, p. 18). In an analysis of state-funded equipment schemes in Australia, Barbara and Curtin (2008) reported that occupational therapists emphasised employers’ priorities rather than advocating for more funding and consumer empowerment. In an Australian action research project with 15 occupational therapists, Wilding (2011) found that when occupational therapists engage in hegemonic practices, they enact a form of practice that is not consistent or may not be consistent with the philosophical foundations of the profession, and therefore they play an unconscious part in contributing to the subjugation of their own practice and profession. These authors have shown that occupational therapists’ moral reasoning may be unduly influenced
by hegemony. However, it is less clear in the research how occupational therapists can enhance their understanding of values and power in context to resist practice hegemony.

**Practice wisdom and praxis.**

In contemporary practice, governments and bureaucracies increasingly regulate the idea of what it means to be professional (B. Green, 2009a). The net effect of this has been professionals are pressured to adopt scientific forms of knowledge and evidence acquired through science (Macklin, 2009). In the scientific and technical paradigm it is considered necessary for a professional to have a degree of detachment from the particularities of everyday life and practice, in order to see things in a clear, objective light (Schwandt, 2005). Although technical outcomes are clearly important in practice, this level of detachment disconnects professionals from people’s actual lives and circumstances, reducing practice to standardised and instrumental forms that in themselves do not adequately meet people’s human needs (Schwandt, 2005).

Practice conditions that value scientific ways of knowing, to the exclusion of other forms of knowledge, can limit professionals’ moral agency, in turn perpetuating individual and collective professional identities that are complicit with the dominant technical paradigm (Higgs, McAllister, & Whiteford, 2009).
A technical form of decision-making is insufficient for making moral judgments (Macklin, 2009). Rather, this requires a form of rationality known as practical reasoning or practical wisdom. Practical reasoning is relevant for developing understandings of human rights; a goal of human rights is to realise people’s humanity, and this requires that a profession be inclusive of different ways of knowing and communicating (Ife, 2012). Concerning occupational therapy, Kronenberg (2013) argued practical wisdom is necessary to cultivate “occupational consciousness”. That is, an awareness of how occupational therapists’ everyday actions perpetuate hegemonies that impact upon other people’s well-being (Kronenberg, Pollard, & Ramugondo, 2011).

An Aristotelian concept that is gaining traction within this practical knowledge tradition is phronesis, a form of rationality that is different from its scientific counterpart, techne. Phronesis refers to when a practitioner might need to make particular “judgment calls” about what to do (Dunne, 2005, p. 377). Thus, reflection is implicit in phronesis. According to A. Frank (2012), in the event of competing claims upon their time, practitioners have two choices: the first is to complete routine practices with the aim of getting through the day, and the second is to stop and reflect upon which claims ought to have priority in any given practice encounter. It is Frank’s view that wise and ethical practice is not one in which a practitioner merely accepts routines that have previously been decided upon (out of
context); rather, it is one in which a practitioner engages in reflection in order to work out what should be done.

Nonetheless, it is not sufficient for a practitioner to know what to do, a change in practice requires a change in the “doing” of it (B. Green, 2009b). Phronesis is an action-oriented form of knowledge, leading to a particular form of action, referred to as praxis (Dunne, 2005). Praxis is conceptually different and “enlightened” in comparison to practice; it represents an ideal form of professional practice, as one where learning and doing occur at the same time (Reid & Green, 2009).

Two different traditions and meanings of praxis have enhanced understanding of what it means to engage in moral forms of professional practice. An Aristotelian view of praxis is understood as “action that is morally committed, and oriented and informed by traditions in a field” (Kemmis & Smith, 2008, p. 4). Thus, engaging in praxis is a way in which professionals can apply practical reasoning in order to work out what is the right or proper thing to be done in a particular practice situation. It requires “knowing what one is doing in the doing of it” (Kemmis, 2010, p. 10).

Whereas an Aristotelian tradition of praxis is derived from the epistemology or knowledge of phronesis, there is a second tradition that has shaped the concept of praxis. Building upon the work of
Hegel and Marx, Kemmis (2010, p. 9) conceptualised praxis as “history-making action”. A point of departure in this second tradition is the emphasis given to practitioners’ developing an understanding about the way in which their actions and interactions are arranged or prefigured by their practice context.

In adopting a praxis orientation, professionals constantly learn and re-formulate their practice approaches in order to best respond to the human rights concerns at hand (Ife, 2012). This requires dialogue and partnership between a professional and the people with whom they are working. Thus, they engage in praxis together:

Each learns from the other in a relationship of shared knowledge and expertise that does not privilege one above the other. And as a result of that sharing of expertise, they then act together toward the goal of achieving human rights.

(Ife, 2012, p. 231)

Conceiving of practice from a practical knowledge tradition, and more specifically as a matter of praxis, may help occupational therapists to critically consider the values and power relations that shape and govern what they do in practice.

A critical paradigm for occupational therapy

In this section I discuss how the profession of occupational therapy has entered into a new critical paradigm. That is, occupational therapists are discovering new ways of thinking that are
socio-cultural and political in nature, and in my opinion, are also coherent with developing understandings about human rights and justice. Before I discuss this critical paradigm, I will first provide an overview of how occupational therapists over time have strengthened their values and beliefs regarding occupation, and also for enabling individual and social change.

**Occupation, enablement and occupational justice.**

In the profession of occupational therapy, “occupation” is generally understood to be inclusive of all the things that people need, want, or are obliged to do (Wilcock, 2006). Although occupation might appear similar in meaning to the notion of “activity”, occupational therapists think of human occupation as more complex than activity (A. Harvey & Pentland, 2010). That is, occupation is “the occupying of place and time in a rich tapestry of experience, purpose, and attached meaning” (Christiansen & Townsend, 2010a, p. 2). Occupation includes forms of participation that people engage in to occupy their time in their lives, in school and education, at play and leisure, at work, and in home and community life.

Occupation is a central construct upon which the occupational therapy profession is based. Indeed, occupational therapists are dedicated to enabling all people to be engaged in occupation that is meaningful and to participate fully in society (Townsend & Polatajko, 2007). The profession of occupational therapy is founded upon a
central belief that people choose to engage in occupation to fulfil their physiological and subjective human needs; in turn, this participation in occupation affects people’s physical, mental and social health and well-being (Wilcock, 2006).

Although a central philosophy of the profession, occupation is not necessarily explicit in the practice of occupational therapists. Using a history of ideas approach, Hocking (2008) researched how occupational therapists from the 1930s to the early 1960s increasingly valued a scientific and technical rationality. A resultant effect during this period was that practice shifted towards meeting overly instrumental and technical goals focused on remediation of impairments, rather than engaging clients in occupation to enhance well-being (Hocking, 2008).

An ontology and epistemology centred on occupation has since re-emerged within the occupational therapy profession. In the 1960s and 1970s, in response to growing dissatisfaction with the alignment of occupational therapy with the dominant medical and scientific discourses, Reilly (1962) and colleagues argued for a renewed focus on occupation. Reilly argued that because human beings had a vital need for occupation, it was the moral responsibility of occupational therapy to generate, and make public, knowledge in support of occupation. Since that time, an occupational paradigm has
become explicit in theories and models guiding occupational therapy practice (Kielhofner, 2004).

Although occupation is what occupational therapists are concerned with, “enablement” refers to how occupational therapists practise (Whiteford & Townsend, 2011). Enablement is the way that occupational therapy’s philosophy and goals are translated into practice (Law, Polatajko, Baptiste, & Townsend, 1997). To enable occupation, occupational therapists seek to partner with people, empowering them to see and strive towards their desired futures and occupations (Townsend et al., 2007).

An enablement perspective shifts occupational therapy from the traditional use of individualised forms of practice. That is, occupational therapists not only do therapy with individuals, they might also enable social change by collaborating with a diversity of clients, including groups, communities, organisations and populations (Polatajko, 2001). Skills that are applied by occupational therapists during the course of enablement include to adapt, advocate, coach, collaborate, consult, coordinate, design/build, educate, engage and specialise (Townsend et al., 2007).

Nonetheless, contemporary leaders have questioned whether an occupational paradigm is sufficient for preparing occupational therapists conceptually and ethically to meet future societal needs.
(Duncan & Watson, 2004). Others have called for occupational therapists to develop political competencies for working in partnership with communities (Pollard, Sakellariou, & Kronenberg, 2008), as well as to espouse a global citizenship that is responsive to the diversity of humanity (Iwama, 2007) and to the human and environmental consequences of professional decisions (Thibeault, 2006).

In this twenty-first century, occupational therapy has engaged in critical rethinking about the need to take into consideration issues of power and justice that are embedded in society and practice (Whiteford, Townsend, & Hocking, 2000). This has helped to make the relationship of justice to enabling occupation more explicit. In attending to the full scope of enabling occupation, it is the role and responsibility of occupational therapists to elicit clients’ voices about their experiences of exclusion or injustice, in order to work out meaningful solutions (Pollard, Kronenberg, & Sakellariou, 2008).

Concomitantly, the development of the discipline of occupational science has opened up spaces for exploring moral and political questions in the occupational therapy profession (G. Frank, 2012). Occupational science, like occupational therapy, is inherently concerned with matters of occupation (Molineux, 2010). Historically, occupational science has been conceived as a discipline that produces knowledge that enables occupational therapy to realise its
potential in making a meaningful difference in people’s lives (Yerxa, 1993). Occupational science has contributed new knowledge in support of developing equitable, occupationally just societies (Hocking & Whiteford, 2012). In particular, “occupational justice” is a concept that is drawn from the epistemology of occupational science and occupational therapy. It encompasses the aspirational nature of occupational participation, and can be described as “a vision of society in which all populations have the opportunities, resources, privilege and rights to participate to their potential in their desired occupations” (Whiteford & Townsend, 2011, p. 66).

The idea of occupational justice is regarded as complementary to the theory of social justice, even though there are distinctions between the two (Stadnyk, Townsend, & Wilcock, 2010). Occupational justice and social justice share a common concern for equity and fairness (Durocher, Gibson, & Rappolt, 2013). Social justice frames humans as social beings with an innate need to engage in social relations and social conditions for life, whereas occupational justice addresses what people do, occupationally, in the relationships and conditions for living (Wilcock & Townsend, 2000). Furthermore, occupational justice is enacted by enabling differences between people and groups, which is distinct from the sameness approach that is particularly characteristic of distributive forms of social justice (Whiteford & Townsend, 2011). This distinction draws upon Iris Young’s critique in Politics of Difference (1990), that social
equality should be achieved through affirming group differences, not by applying principles regardless of the way in which social structures and social relations shape people’s lives (Stadnyk et al., 2010).

Occupational justice enables occupational therapists to critically consider how professional practices (including those enacted by occupational therapists) and laws, policies, regulations, funding, attitudes and so on govern opportunities for occupational participation (Whiteford & Townsend, 2011). This critical attention to context has the potential to enhance therapists’ understanding of the ways in which particular occupations become “possible, ideal and ethical” for some people, and yet are marked by various authorities as “not possible, non-ideal and unethical” for others (Rudman, 2012, p. 110).

Occupational therapists work for occupational justice so that people can participate more fully in everyday life, or by pursuing more inclusive environments (Whiteford & Townsend, 2011). Regardless of whether the intention is to enable individual or social change, the enabling of occupational justice requires therapists to focus on the different contexts in which people participate (Stadnyk et al., 2010). That is, it requires an understanding of the broader powers and structures that affect people’s occupational possibilities and rights (Watson, 2006).
In 2004, Townsend and Wilcock (2004) extended the concept of occupational justice, including through collective conversations with occupational therapists and occupational scientists at workshops on occupational justice, in Australia, Canada, Sweden and in other nations. Through the insights generated at the workshops, Townsend and Wilcock identified four kinds of occupational rights, and their corresponding occupational injustices that arise when participation in occupation is restricted:

- The right to experience occupation as meaningful and enriching. (Occupational injustice: occupational alienation).
- The right to develop through participation in occupations for health and social inclusion. (Occupational injustice: occupational deprivation).
- The right to exert individual or population autonomy through choice in occupations. (Occupational injustice: occupational marginalisation).
- The right to benefit from fair privileges for diverse participation in occupations. (Occupational injustice: occupational imbalance) (p. 71)

As the theory of occupational justice and occupational rights has gained usage and become more explicit, critical views have emerged about possible barriers to its implementation in practice. Although Townsend and Wilcock (2004) proposed four occupational
rights, Hammell (2008) argued that such framing could contribute to theoretical confusion and limit the uptake of occupational justice in practice. She proposed that there ought to be one all-inclusive occupational right for “all people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities” (p. 75).

In this thesis, when I refer to occupational rights I apply my interpretation of Hammell’s (2008) definition of occupational rights as the opportunity for all people to engage in the occupations that are meaningful to them. I find that this definition captures the meaning that occupational rights hold for me.

Hammell and Iwama (2012) argued that in contrast to concepts of justice that are concerned with what people “have” (distribution of materials and resources), the concepts of rights refers to “doing” or whether there is an “opportunity to act” (p.386). Thus, Hammell and Iwama contended that occupational therapy ought to be aligned with occupational rights, rather than occupational justice, because occupational therapy is a profession that is concerned with people’s opportunities to do occupation. Although Hammell and Iwama (2012) make this distinction between occupational rights and occupational justice, in this thesis I use the concepts of occupational rights and occupational justice interchangeably. This is because I consider that the concepts of occupational justice and occupational
rights may describe both processes and outcomes depending upon the context of how these terms are used. That is, an approach of occupational justice is necessary to achieve one’s occupational rights; and the claiming or experience of one’s occupational rights is necessary for an experience of occupational justice.

Due to my desire to maintain a connection between the idea of occupational rights and occupational justice, I also draw upon the four occupational rights as conceptualised by Townsend and Wilcock (2004). This helps me to think about the way that violations of occupational rights lead to instances of occupational alienation, occupational deprivation, occupational marginalisation, and occupational imbalance.

Meanwhile, the relationship between human rights and occupational rights has received limited consideration in the occupational science and occupational therapy literature. Only a small number of authors have offered their views. Notably, Wilcock (2006) described the UDHR as inherently occupational due to its emphasis on human rights related to participation in occupations such as work, cultural life, leisure, education, and so on. Although I agree with Wilcock that human rights in the UDHR are occupational in nature, I contend that human rights and occupational rights are also distinct ideas. I consider that statements of human rights represent a form of universal acceptance among leaders of the
world’s nations about the kinds of rights that ought to apply to all humans. In contrast, there has been no such dialogue and debate about what constitutes occupational rights; and therefore, occupational rights are not explicitly considered as important human entitlements.

In this thesis, I apply the view that ideas of human rights and occupational rights are complementary to one another. Human rights can add a level of significance and urgency to people’s claims for their right to participate in occupation, and occupational rights can bring an occupational emphasis when considering what it means to be fully human. In this thesis therefore, I differentiate between the terms of human rights and occupational rights, although I acknowledge that there are areas of congruence.

Development of a better understanding of human rights and occupational justice has the potential to reorient how occupational therapists conceptualise health, and to move away from medically-oriented and fiscally based practices (Durocher, Rappolt, & Gibson, 2013). However, a further barrier to such a practice transformation may be that the theory of occupational justice has been largely shaped through the contributions of Western occupational therapists in developed nations (Hammell & Iwama, 2012). This has meant that oppressive conditions such as poverty, discrimination and social exclusion have not traditionally been central theoretical concerns.
The doing and practice of occupational justice.

The relationship between human rights and participation in occupation was elucidated in 2006 when the World Federation of Occupational Therapists (WFOT) acknowledged in a Position Statement on Human Rights (World Federation of Occupational Therapists, 2006) that all people have the right to participate and make choices about occupation, for fulfilment of their human potential and for social inclusion. This particular position statement, as I refer to it throughout this thesis, made clear that occupational therapists had a responsibility to identify and address situations of occupational injustice in society and practice.

Concomitantly, a significant share of occupational therapy literature with an explicit focus on human rights and occupational justice has emanated from a South African context. The papers I identified provided a broad overview of topics related to human rights and rehabilitation (Lorenzo, 2010). McIntyre (2010) reported the ethics and politics of funding arrangements governing access to wheelchairs; highlighting a need for reliable statistics as a means to secure funding and the rights of participation. Van der Reyden (2008a, 2008b) completed an exposition of the concept of autonomy from a legal and bioethical perspective. She found inconsistencies in different countries’ (including Australia’s) codes of ethics in relation to
the human right principle of autonomy. Furthermore, in research exploring the rights of people to receive workers compensation, Landman and Buchanan (2010) highlighted how human rights were acknowledged when people were shown respect and care as a human being. Thus, the insights gained from other countries and contexts reinforce the need for research about human rights and occupational justice to become a collective endeavour.

Research in occupational science and occupational therapy has increasingly explored people’s lived experience of occupational injustice, with attention given to the power relations embedded in institutional contexts. The diverse topics have included: the institutional control and surveillance of young persons in residential care (Magasi & Hammel, 2009), exclusion from working life for people with rheumatism (Jakobsen, 2009), and the experience of alienation for persons attending mental health day services (Bryant, Craik, & McKay, 2004). However, it would appear that this emergent research about people’s experience of their rights (or an absence of rights) has not yet fully evolved into research about how occupational therapists respond to injustice.

To assist occupational therapists and other professionals advance occupational justice in practice, Whiteford and Townsend (2011) revised and re-released the Participatory Occupational Justice Framework (POJF) as a conceptual tool for doing justice.
This framework was intended for use by occupational therapists and other professionals practising with individuals, families, groups, communities, organisations or populations (Whiteford and Townsend, 2011). It profiles six enablement skills for occupational justice: to raise consciousness, engage collaboratively, mediate, strategise, support and inspire advocacy (Whiteford & Townsend, 2011). However, although this framework attempts to apply the concept of occupational justice to practice, as yet little is known about its clinical utility or its uptake by the profession.

Significantly, with the exception of research in community development, to be discussed in the methodology chapter, there is limited evidence that concepts of occupational justice have been substantively engaged with or explicitly applied in occupational therapy practice (Durocher, Rappolt, et al., 2013). A net effect of this gap in knowledge about how to practice in just and equitable ways is that the concept of occupational justice remains elusive for many occupational therapists. Despite its theoretical development, occupational therapists have difficulty implementing occupational justice in everyday practice (Riegel & Eglceder, 2009).

In particular, there is little published research exploring how understandings of human rights and occupational justice inform and guide everyday occupational therapy practice in medical practice contexts. In one of the few articles I found, Riegel and Eglceder
(2009) reported on a quality improvement activity with eight occupational therapists providing rehabilitation to people with spinal cord injury in the United States. The authors found that participation in one focus group dedicated to exploring the relationship of occupational justice to practice, enhanced occupational therapists’ thinking about ways of making occupational therapy more inclusive (Riegel & Eglseder, 2009). Thus, it would appear that occupational therapists’ engagement in local, contextualised dialogue about occupational justice may generate new knowledge and understandings for practice; however this assertion requires testing. Moreover, it is not clear in the research whether new knowledge gained by occupational therapists about occupational justice, translates to actual changes or action for practice.

There is some research that demonstrates it may be difficult for occupational therapists to enable human rights and occupational justice due to the dominant philosophies of medical practice contexts. In action research in the United Kingdom, Atwal and Caldwell (2003) found that occupational therapists might engage in thinking about the organisation as opposed to the needs and rights of the people with whom they were working. For example, they responded to fiscal pressures by cutting corners in discharge planning (Atwal & Caldwell, 2003). Dominant institutional ideologies and hegemonic practices compromised the reform of a South African metropolitan rehabilitation service towards a rights-based approach.
(Dayal, 2010). In interviews and focus groups with rehabilitation managers and senior staff (including occupational therapists), Dayal (2010) found that national health service policy reforms with a rights-based framework were in conflict with institutional imperatives. At a practice level, therefore, it was difficult to shift practitioners away from individualised, biomedical approaches (Dayal).

**Chapter summary**

Human rights have become an increasingly important moral and legal discourse in contemporary society and practice. Despite a historical lack of local human rights protections, Australian occupational therapists have a legal and ethical obligation to address matters of human rights. This may, however, prove difficult given the conditions of practice, which reduce the space for professionals to be reflective and deliberate about their actions. Just as human rights have the potential to shape occupational therapists’ knowledge and values about how to practise, praxis provides a way to assist occupational therapists’ to determine how they ought to act.

The emergence of a critical paradigm within occupational therapy coincides with the development of the discipline of occupational science, and the production of knowledge in support of building occupationally just societies. The theory of occupational justice has potential to assist therapists to identify and address
issues of occupational inequity or absence of occupational rights in practice. Yet there is still need for research about how occupational justice can be used to engage occupational therapists in praxis as is necessary to overcome practice hegemony.
Chapter 3

Methodology

As discussed in the literature review, human rights ideals occupy a central position in international political discourse, and they maintain an emergent influence on forms of governance in the Australian context. Further, conditions of contemporary practice place pressure on professionals to adopt scientific ways of knowing. To this end, human rights provide an alternative moral reference point for those professionals who seek to know what to do with their clients, while upholding shared human values.

The profession of occupational therapy has entered into a critical paradigm, and occupational therapists from different countries and cultures (Kronenberg, Pollard, & Sakellariou, 2011; Townsend & Polatajko, 2007; Watson & Swartz, 2004; Wilcock, 2006) have called for a practice coherent with ideas about human rights and occupational justice. However there are some significant gaps in understanding about how these concepts are applied in occupational therapy practice, which stem from a lack of theoretical clarity about the concepts of occupational justice (and occupational rights) (Durocher, Gibson, et al., 2013; Hammell, 2008), and a lack of research that explores how to “do” occupational justice. Furthermore, there may be some barriers to addressing occupational justice
because of long-standing patterns of hegemony in occupational therapy (Kronenberg, Pollard, & Ramugondo, 2011; Wilding, 2011). Therefore, this research focused on exploring how occupational therapists can allow human rights and occupational justice concepts to influence their practice.

Although discussion and debate about human rights and occupational justice could be informed by a range of sources, it was from the work of Australian social worker and academic, Jim Ife, that I created a framework for implementation of this research. In his text *Human Rights and Social Work*, Ife (2008, 2012) argued that there is a need to broaden dialogue about the practice of human rights beyond a legal voice and human rights law, to include, for example, the voices of citizens and health professionals. I considered that the use of Ife’s work as a key-informing source could offer a depth of ideas that was different and yet complementary to the emergent focus on human rights in occupational therapy. This is consistent with the view of G. Frank (2012), that there is a need to incorporate a range of disciplinary perspectives to better understand what possible relationship the profession of occupational therapy could have to human rights. Even though Ife (2012) stated that the material in his text is relevant to a broad range of human service and health professions, the focus of his work remains on social work practice. Thus, the theoretical concepts and practices raised by Ife (2012) are not specific to occupational therapy, and require further deep
consideration in terms of their relevance and application to occupational therapy practice.

Rather than understanding human rights as a static and unproblematic concept, Ife (2012) advocated a discursive approach, where different people in different contexts shape human rights, by talking about what human rights mean to them. Put another way, this approach requires a focus on what it might mean to be human, rather than a direct focus on statements of rights per se (Ife, 2012). A discursive approach has the potential to create an understanding of human rights so that they are relevant and responsive to the everyday lived realities and experiences of people who are oppressed and disadvantaged. This claim can be made because the knowledge arises from the use of an inductive approach to theory development; practitioners ground their discussions in their stories from practice with real people.

The benefit of a discursive approach for this research is that it facilitates a practice-based view of human rights to emerge. Both theoretical and practice perspectives are necessary to foster the creation of a society in which human rights are protected and enabled; a purely academic emphasis might fail to attend to practice realities, yet if practitioners are too immersed in the world of practice they might engage in hegemonic practice that fails to benefit from the advances in knowledge produced in academia (Ife, 2012). Thus I set
about discursively exploring if and how a group of Australian occupational therapists considered human rights and occupational injustices in their daily practice.

**The research questions**

Three main research questions drove the study described in this thesis:

1. How do occupational therapists understand and enact human rights and occupational justice issues in everyday practice?
2. What personal, historical, social, material, economic, discursive, and political conditions constrain or support occupational therapists in enabling occupational justice?
3. What actions can occupational therapists take to practice human rights and occupational justice?

A qualitative approach was important to answer these questions, because the questions seek to explore and generate new knowledge and insights about occupational therapists' experiences of enabling occupational justice in practice. The research described in this thesis sought to find new ways of improving practice, and due to this action orientation, an action research framework was selected. Action research is a form of inquiry well suited to the research questions, by virtue of its emphasis on enabling people to discover,
and to enact solutions to, problems they experience in their everyday lives and practice (Stringer, 2007).

**Action research: Background and epistemology**

John Collier and particularly, Kurt Lewin, are credited as having pioneered action research in the 1940s in the Western world (Pasmore, 2006). However, action research ideas and methods may be found in various cultures and social movements worldwide (Reason & Bradbury, 2006). Action research has drawn from a range of theoretical perspectives, such as pragmatic philosophy, humanistic philosophy and phenomenology (Reason & Bradbury, 2006). This diversity of sources may be understood as an expression of the postmodernist values that underpin action research, which give emphasis to matters of practice and to producing practical knowledge that is useful for people in the course of their everyday lives (Reason & Bradbury, 2006).

The kind of knowledge pursued in action research influences the particular approach an action researcher might take. Action research that is positivist in nature is oriented to developing technical outcomes of practices; interpretive action research is concerned with developing a person’s practical knowledge and decision-making; and critical action research seeks to emancipate people through enlightenment about their practice arrangements (Kemmis, 2006). Although similar to interpretive research, it is only using the critical
paradigm that a researcher has an intention of transforming new knowledge into action within the research itself (Titchen & Higgs, 2007). The research described in this thesis is situated within the critical paradigm.

Action researchers engage in a critically self-reflective process (McNiff, 2013). The aim is for people to engage in “planning a change, acting and observing the processes and consequences of the change, reflecting on these processes and consequences, re-planning, acting and observing, and so on” (Kemmis & McTaggart, 2005, p. 563). Through this process of critical questioning, action researchers become more aware of how their conceptions of a situation trap them in certain ways of being, thinking and doing (Gaventa & Cornwall, 2006).

Learning is an important objective of action research (Ludema, Cooperrider, & Barrett, 2006). By framing an issue as a problem, researchers can reflect, explore and critically question the situations in which they live and practise (Stringer, 2007). Learning is achieved not only through problem-focused inquiry, but also through appreciative forms of inquiry. Ludema, Cooperrider, and Barrett (2006) advocated that when people share satisfying practice stories or aspirations they create space for hopeful and energising conversations about how to transform a practice in a better way. Thus, inquiry and change are not separate processes; rather,
emancipation may be implicit in the very first questions that a person asks (Ludema et al., 2006).

Further, the nature of the learning in action research is that the people involved become conscious of how reflection can lead to transformative action (Ludema et al., 2006). This is important, as it empowers action researchers to apply their learning and doing to improve and change other aspects of their lives and practice. Thus, the possibilities are enhanced for people to sustain the changes made.

To experience emancipation through action research, people engage in the processes of reflection and action (McNiff, 2013). Freire (2000) stated that acting and reflecting together allows people to develop a growing “consciousness” or insight into an oppressive situation, and to learn about their capacities to transform those unfair power arrangements in society. Put another way, it is important to enable people to have access to knowledge, and to participate in its production with others, so that they can change the nature of power relationships and oppressive conditions (Gaventa & Cornwall, 2006).

Due to its emancipatory nature, action research also aspires to be socially just (Kemmis, 2006). People engaging in action research assume responsibility for their own emancipation from “the dictates of irrationality, injustice, alienation, and unfulfillment” (Carr &
Kemmis, 1986, p. 204). Therefore, action research is best enacted with people who have started to form a critical view about how their taken-for-granted practices contributed to injustice, or who are already committed to taking action to overcome injustices (Kemmis, 2006).

Gustavsen (2006) argued that action research creates spaces for democratic forms of dialogue. Such dialogue is important, because critical knowledge about tensions, dilemmas or uncertainties does not automatically translate to people knowing what to do to improve their situation (Kemmis, 2006). It is through formation of a public “communicative space”, or bringing of people together to discuss shared concerns and ideas, that mutual understanding and consensus about what to do can be developed (Kemmis & McTaggart, 2005, p. 578).

Collaborating in action research allows groups of people to take joint responsibility for understanding and changing their practice (Kemmis & McTaggart, 2005). The group members become co-researchers and support one another to develop a critical perspective about their practice, which includes questioning and challenging the normative assumptions underlying everyday practice (McNiff & Whitehead, 2010). A collaborative approach that builds new ideas and a supportive network of relationships can help to maintain research activity over time (Stringer, 2007).
Justification of methodology

Action research is ideally suited to exploring and changing practice (Stringer, 2007). Action research can be a tool that enables practitioners to work through the complex issues and problems they face, to make their work more meaningful and fulfilling (Stringer, 2007). By learning about the conditions that produce particular practices and problems, and are reproduced in everyday social interaction, practitioners become alert to clues about how to make and re-make other, more desired circumstances and practices (Kemmis & McTaggart, 2005).

The profession of occupational therapy is highly compatible with the inclusive and participatory principles of action research (Richardson & MacRae, 2011). Cockburn and Trentham (2002) argued that the participatory nature of action research is philosophically congruent with the occupational therapy values of client-centred enablement, partnering with, learning and change through doing, and enabling participation. The potential of action research to empower clients, families and the community, is viewed as a way that occupational therapists can more effectively target changes in the social determinants and causes of occupational issues and injustice (Taylor, Braveman, & Hammel, 2004).

Action research may be helpful in overcoming disjuncture
between occupational therapy theory, philosophy and practice (Wilding, 2008). Boniface et al. (2008) found that the use of action research with an active steering group of 16-20 occupational therapists over a 4-year period, enhanced the therapists’ clinical reasoning and helped to make occupation-focused and client-centred philosophies explicit in practice. Wimpenny, Forsyth, Jones, Matheson, and Colley (2010) reported that the use of action research enabled a group of 15 occupational therapists in the United Kingdom to rethink their identities and roles and affirmed the importance of occupation-focused practice. Thus, action research can be an important methodology for supporting change and the alignment of occupational therapy practice with occupational theory and philosophy.

Action research is evidently helpful in helping occupational therapists to become conscious of and to challenge dominant practices and hegemonies that are often generated in hospital practice settings. For example, Mattingly and Gillette (1991) used a combined ethnographic and action research design to examine the clinical reasoning of occupational therapists practising in a United States hospital. Participation in Mattingly and Gillette’s research enabled occupational therapists to make their knowledge more explicit and enhanced their confidence to present an alternative view to the dominant medical perspective. Similarly, in an Australian action research project with 15 occupational therapists, Wilding
(2011) found that participation in action research helped occupational therapists to recognise their unconscious adoption of hegemonies and to commit to an occupation-focused practice that aligned better with their philosophies and values.

Several occupational therapists have applied a particular form of critical action research, called participatory action research (PAR), in community development with marginalised peoples and communities. F. Adams and Galvaan (2010) used PAR with South African women who were carers for children with disabilities in order to identify barriers to a self-help group’s functioning. PAR was used by Van Niekerk, Lorenzo, and Mdlokolo (2006) to promote shared learning and build social and economic capital in a community entrepreneurship project with persons with disabilities. In Australia, Copley, Turpin, Gordon, and McLaren (2011) applied PAR to develop an occupational therapy program to facilitate school participation with adolescents from refugee backgrounds. The process of engagement through PAR enabled the program to more effectively target students' occupational needs for social competence (Copley et al., 2011). Thus action research has been used to develop knowledge in support of building equitable and occupationally just societies and practices. However, even though action research has clearly been of benefit in community contexts, its potential for enhancing the practice of human rights and occupational justice in hospital settings is less clear.
Perspectives about how to do action research

Roles of the researchers.

When I commenced this research, I initially selected PAR as a framework and methodology for the research. Indeed, I referred to the study as PAR in my initial correspondence with co-researchers. Upon further reflection, I decided that PAR was not the best way to frame this research. This is because the nature of my research leadership role meant that I had greater power and control over the action research processes than my co-researchers. Therefore I consider this study to be “action research” and I agree with the view of Reason and Bradbury (2006) that all action research is participatory in nature.

In action research, different members of the research group may assume different roles and contribute different knowledge and expertise that can serve the purpose of the group (Kemmis, 2006). In acknowledgement that it is not possible to entirely eliminate power asymmetries in participatory forms of action research, it is nonetheless important that these differences in roles are elucidated and made clear (Kemmis & McTaggart, 2005). Throughout this thesis, I refer to the occupational therapists who joined with me in this research as “co-researchers”.

64
The co-researchers actively participated in this research by giving an account of their experiences of enabling human rights and occupational justice in practice. Their stories formed the major data set for the study. Co-researchers made decisions about what aspects of their practice to publically share (or not share), and about how to tell their stories in a way that made sense to them. In this way, co-researchers were able to present their particular views about their particular practice situations. In addition, co-researchers questioned and challenged each other’s stories, and they put forward other possibilities and perspectives about human rights and occupational justice. Thus, co-researchers’ contributions to group discussion and debate were pivotal in shaping the progress of the inquiry, and the kind of information produced through this action research.

In this research, I assumed a research leadership role because I initiated the study as part of my doctoral studies. I recruited occupational therapists who shared an interest with me in exploring how rights and justice concepts could be applied to occupational therapy practice. I took additional responsibilities for coordinating research meetings, collecting and analysing data, and reporting on the research. The co-researchers agreed to reflect, plan and implement actions of their choosing. Although I encouraged co-researchers to actively participate, they did not determine the research questions or the methods used, and they had limited input
into the analysis of findings or the development of publications about the study.

The aim of action research is not to change others, but instead for each person to take responsibility for making changes to his or her own situation (McNiff & Whitehead, 2010). Thus, in adopting a research leadership role, I had a responsibility to enable co-researchers to “think for themselves and mobilise themselves for action” (McNiff, 2013, p. 10). For example, I encouraged co-researchers to share their reflections, comments and critiques with other co-researchers in preference to me making lots of contributions to the discussions.

I took care for my perspective to not dominate or impose unduly on the perspectives of co-researchers. For example, although I maintained greater control over the interviews through setting the agenda and interview guide, I asked questions in a flexible way and in accordance with the natural flow of conversation. If a co-researcher appeared to have something new or important to say, I paused to allow the person the opportunity to speak about his or her issue. Thus, the interview guide acted as a reminder of the questions I wanted to ask; however, I did not strictly follow the order of questioning or exact wording on the guide.
The cycles of action research.

Action research is typically enacted as an action research spiral, or as cycles of reflection and action (McNiff, 2013). Action researchers engage diligently in the steps of initial review and reflection, planning, enacting the plan, and reflection (McNiff, 2013). The cycles of reflection and action do not occur in a linear or neat, orderly way; people might find themselves rethinking, repeating, or revising steps in the process (Ladkin, 2007; Stringer, 2007).

The cycles of reflection and action represent a dialectical relationship between retrospective understanding and prospective action (Carr & Kemmis, 1986). That is, the cycles require that action researchers at each moment “look back” as a basis for reflection and “look forward” for realisation of the plan in action. Through this weaving of the past and the future, the “action researchers thus become aware of themselves as both products and producers of history” (Carr & Kemmis, 1986, p. 187).

It is generally considered that two action-reflection cycles represent the minimum level of engagement necessary for useful and meaningful change to occur (Kemmis & McTaggart, 1988). Carr and Kemmis (1986) explained that a single loop of reflection and action is only a beginning; if it stops after one cycle it should not be regarded as action research. Furthermore, a shorter-loop cycle, such as one of a month or less, is favourable in maintaining commitment,
particularly for co-researchers who are newly engaging in action research processes (Kemmis & McTaggart, 1988).

**Issues of positionality**

It is important to consider how issues of power and positionality may have influenced the research process because, as viewed by Gramsci, power shapes decision-making in professional practice, even at an unconscious level (cited in Gesler, 1992, p. 740). In particular, I note aspects of my positionality related to my cultural and professional background, which impacted across the design, analysis, interpretation, and reporting of the research.

First, I am Australian occupational therapist. I therefore have a particularly Australian way of viewing the world and occupational therapy practice. Further, I have situated this research in an Australian context as I am interested in learning about how Australian occupational therapists can better enable human rights and occupational justice. However, I do not consider that this aspect of my positionality greatly affected the status and power within my relationships with co-researchers because these therapists shared similar backgrounds as predominantly white, middle-class Australians. Nonetheless, I acknowledge that I was mostly influenced by occupational theories and concepts that are reflective of dominant Western perspectives. Thus, I may have unconsciously applied and perpetuated Western assumptions about occupational justice when
engaging in dialogue and reflection with co-researchers and in the
writing of this thesis. As Kronenberg, Pollard and Ramugondo (2011)
observed, occupational therapists serve a minority of the global
population in countries that are politically and economically powerful,
such as Australia. Thus, the very Australian-ness of this position
directly influences the kind of knowledge produced about
occupational justice. Indeed, understandings gained through this
research may not be accessible (or relevant) to the majority of the
global population or even to people in my own local community
whose conditions and circumstances are different to my own.

Another aspect of my position was as a dual “insider” and
“outsider”. At the time of commencing the research I had acquired 7
years’ experience working in metropolitan Melbourne as an
occupational therapist in similar practice settings to the research site,
and therefore I brought with me knowledge and assumptions about
the practice issues that co-researchers faced. However, even though
I am an occupational therapist with insider knowledge, I had not
worked with the co-researchers, and I did not share their well-
entrenched routines and patterns of working. This assisted me to
cultivate, as Percy (2007, p.99) described, “a deliberate naiveté” of
“knowing” and “not knowing” at the same moment (Percy, 2007, p.
99). Nonetheless, the impact of this dual positionality is not
straightforward. Indeed as an outsider, my desire not to lose co-
researchers’ cooperation and commitment to the research may have
lessened my interrogation of their taken-for-granted routines and practices. Further, as an insider, I may not always have been conscious of co-researchers’ hegemonic decision-making and practices, because of the power relations and internalised oppression I experienced in my own relations as an occupational therapist.

Methods

Selection of site.

This action research study was situated at the Austin Hospital and the Heidelberg Repatriation Hospitals that form part of the Austin Health network in Melbourne, Australia. One occupational therapy manager administered the practice of occupational therapy at the two hospitals, and therefore to an extent, each site shared similar structures and processes. For the sake of simplicity, I henceforth refer to the Austin Hospital and the Heidelberg Repatriation Hospital as one site, one hospital, and/or one department, unless it is necessary to distinguish between them.

I used purposive sampling to identify potential co-researchers for the study. Purposive sampling is used for in-depth qualitative research in order to access a sample that has a full and rich understanding of a particular phenomenon or experience (Liamputtong & Ezzy, 2005). I selected this particular site because I learned from my supervisor, Dr Clare Wilding, that occupational
therapists from the Austin Hospital were interested in developing academic-practitioner collaborations. Being interested and ready to investigate a situation or practice is an important indicator that a group of people may be ready to make changes to their practice through action research (Kemmis, 2006).

Dr Wilding had been asked to facilitate three professional development sessions about theory, evidence and occupation-focused practice, which were delivered at the Austin Hospital in June, July and August 2008. I received permission to attend these sessions with Dr Wilding, as an observer of the process. After the first session, I wrote in my reflective diary: “I saw glimpses of my topic today... a therapist talked about how poverty restricted her teenage client from accessing the gym” (28 June, 2008). Thus, this opportunity enabled me to confirm the suitability of the Austin Hospital for exploring the particular concepts of human rights and occupational justice in occupational therapy practice.

A second key reason for selecting this site was that I secured the support of the occupational therapy manager. Recruitment of people in positions of influence and authority is a strategy recommended by Stringer (2007). The support of the manager was necessary to achieve ethics approval at this site, and this collaboration was critical to shaping the research inquiry, for example, in securing the support of other senior occupational
therapists for the research. This hospital was convenient to me because it was near where I lived, and therefore I could access it over the duration of the research.

**Recruitment of co-researchers.**

I aimed to recruit 6-12 occupational therapists to participate in the study. A small group is recommended for focus group enquiry (Liamputtong & Ezzy, 2005), which was my selected methodology for the research. A total of nine occupational therapists agreed to participate in the research. Eight occupational therapists commenced their participation in the research in February 2009, and one other occupational therapist, who was new to the organisation, joined in August 2009. The co-researchers were assigned pseudonyms to help mask their identities. The pseudonyms are: Joshua, Matthew, Harry, Kate, Eve, Olivia, Sophie, Liz, and Audrey. Joshua withdrew from the research in August 2009, and Olivia withdrew from the research in October 2009, both due to their resignation from the organisation.

The co-researchers were three male and six female occupational therapists. Compared with the ratio of men to women in the occupational therapy department, the number of male participants was high. I do not know why the male occupational therapists employed by the hospital were particularly willing to participate in the study.
I recruited occupational therapists from diverse practice contexts, across both sites and specialty streams. Five co-researchers practised in acute services (and one of these therapists also practised in a community capacity); one co-researcher worked in subacute inpatient services; and three co-researchers practised in sub-acute outpatient and community services. In terms of specialty area, two co-researchers worked in mental health services and seven were in physical health services (including in hand therapy, aged care, oncology, respiratory, neurology, and transplantation services).

The co-researchers had various levels of occupational therapy practice experience: three co-researchers were new graduates; four had 3 to 10 years of experience; and two had more than 10 years of experience. Levels of tertiary education were similarly varied: five co-researchers had completed entry level occupational therapy courses, and four co-researchers had pursued postgraduate study through enrolment in or completion of a postgraduate certificate or Masters program.

**Data collection.**

I selected interviews and focus groups as the methods of collecting data. As I was aiming to facilitate change through a process of collaborative and self-reflective critique, I considered that
both interviews and focus groups would facilitate the deep reflections of co-researchers. A focus group is described by St John (2004) as a kind of discussion group (naturally occurring or specifically formed) that allows for researchers to collect data about a particular phenomenon or experience.

I initiated and formed the focus groups for the purposes of data collection and to capture interactivity between co-researchers. Focus groups are distinct from individual interviews because they yield interactive data (St John, 2004). Thus, I considered that group discussion could prompt co-researchers to talk and share their different points of view in ways that might not have occurred in a one-on-one interview. Through this combination of individual interviews and focus group methods, I was able to learn about the variations and consensus in co-researchers’ ideas and opinions about human rights and occupational justice.

Over the course of 10 months, each co-researcher was invited to engage in three semi-structured interviews. I needed to be able to direct the conversation to meet my needs for data collection. Most of the interviews were conducted in a private room in the occupational therapy department at Heidelberg Repatriation Hospital. I provided all co-researchers with an opportunity to nominate an alternative space if they wished because it is important that co-researchers can access a private and comfortable space that is “theirs” (J. Green &
Thorogood, 2009). On four occasions, co-researchers chose to use spaces available in their clinical practice areas or elsewhere on site, such as in a private area of the hospital gardens.

In this research, co-researchers took part in three individual interviews with me (at the beginning, middle, and end of the study). Each interview lasted between 30–60 minutes. The three interviews collected data about co-researchers’ thinking at three different points in time. By interviewing at three distinct times, I aimed to capture co-researchers’ changing understandings about human rights and occupational justice issues, and to detect if co-researchers had any different or new ways of looking at their particular practice situations.

In addition, this strategy of incorporating three interviews over the duration of the research assisted me to become more aware of co-researchers’ changing feelings about the research itself, as it progressed. For example, in interview two Kate described that she was feeling overwhelmed about “having to find some big thing (improvement) to work on”. Through utilising this type of feedback, I was able to better accommodate people’s needs for the research, including allowing co-researchers to have more time to think about and plan for future action.

I also completed two extra, “exit” interviews; one was with Joshua in August 2009 and one with Olivia in October 2009. The exit
interviews enabled me to understand Joshua and Olivia’s overall experiences of the action research process, and what they learned about the meaning of human rights and occupational justice concepts and practices. In September 2009, I completed another additional interview, with new co-researcher, Audrey. This new member interview enabled me to ask questions about Audrey’s background and experiences, and to prepare Audrey with information about the kind of past discussion and debate raised within the research group. Appendix A provides copies of the interview guides. Table 1 documents my site visits prior to, during and after data collection.

Table 1: Log of site visits and actions taken during these visits

<table>
<thead>
<tr>
<th>Visit</th>
<th>Dates</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6 June 2008</td>
<td>Pre-research visit to site with Dr Wilding</td>
</tr>
<tr>
<td>2</td>
<td>7 July 2008</td>
<td>Pre-research visit to site with Dr Wilding</td>
</tr>
<tr>
<td>3</td>
<td>8 August 2008</td>
<td>Pre-research visit to site with Dr Wilding</td>
</tr>
<tr>
<td>4</td>
<td>January 2009</td>
<td>Presentation to HREC, Austin Health</td>
</tr>
<tr>
<td>5</td>
<td>20 February 2009</td>
<td>1st recruitment meeting; special</td>
</tr>
<tr>
<td>6</td>
<td>25 February 2009</td>
<td>2nd recruitment meeting; departmental</td>
</tr>
<tr>
<td></td>
<td>Date</td>
<td>Event Description</td>
</tr>
<tr>
<td>---</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>February 2009</td>
<td>3rd recruitment meeting; stream-based</td>
</tr>
<tr>
<td>8</td>
<td>27 February 2009</td>
<td>E-mail reminder</td>
</tr>
<tr>
<td>9</td>
<td>23, 25, 27 March 2009</td>
<td>1st round of individual interviews (I1)</td>
</tr>
<tr>
<td>10</td>
<td>31 March 2009</td>
<td>Focus group one (FG1)</td>
</tr>
<tr>
<td>11</td>
<td>24 April 2009</td>
<td>Focus group two (FG2)</td>
</tr>
<tr>
<td>12</td>
<td>26 May 2009</td>
<td>Focus group three (FG3)</td>
</tr>
<tr>
<td>13</td>
<td>3 June 2009</td>
<td>Focus group four (FG4)</td>
</tr>
<tr>
<td>14</td>
<td>28 July 2009</td>
<td>Focus group five (FG5)</td>
</tr>
<tr>
<td>15</td>
<td>10 August 2009</td>
<td>Exit interview one (EI1)</td>
</tr>
<tr>
<td>16</td>
<td>25 August 2009</td>
<td>Focus group six (FG6)</td>
</tr>
<tr>
<td>17</td>
<td>2, 4 September 2009</td>
<td>2nd round of individual interviews (I2)</td>
</tr>
<tr>
<td>18</td>
<td>2 September 2009</td>
<td>New member interview (NMI)</td>
</tr>
<tr>
<td>19</td>
<td>22 September 2009</td>
<td>Focus group seven (FG7)</td>
</tr>
<tr>
<td>20</td>
<td>5 October 2009</td>
<td>Exit interview two (EI2)</td>
</tr>
<tr>
<td>21</td>
<td>October 2009</td>
<td>Presentation at Austin Health OT week</td>
</tr>
<tr>
<td>22</td>
<td>27 October 2009</td>
<td>Focus group eight (FG8)</td>
</tr>
<tr>
<td>23</td>
<td>24 November 2009</td>
<td>Focus group nine (FG9)</td>
</tr>
<tr>
<td>24</td>
<td>15 December 2009</td>
<td>Focus group ten (FG10)</td>
</tr>
<tr>
<td>25</td>
<td>17 December 2009</td>
<td>Final round of interviews (I3)</td>
</tr>
<tr>
<td>26</td>
<td>8 July 2010</td>
<td>Workshop post data-collection</td>
</tr>
</tbody>
</table>
The interviews and focus groups were audio-recorded and transcribed, and these transcripts formed the major data set for this research. I employed two experienced research assistants from Charles Sturt University to transcribe the data from interview rounds two and three. Aside from these rounds of interviews, I completed transcriptions for the other remaining interviews and the focus groups. I reviewed and edited all transcriptions for accuracy.

The co-researchers joined together in a series of 10 monthly focus groups that occurred over the period from March to December 2009. The purpose of these group meetings was to provide an opportunity for co-researchers to engage in dialogue and interaction about the meaning of human rights and occupational justice to their occupational therapy practice. The creation of a space for collaboration is a key feature of action research (Kemmis & McTaggart, 2005).

Each focus group lasted 90 minutes. Liamputtong and Ezzy (2005) recommended that focus groups should not exceed more than 2 hours’ duration, so that discussion does not become too tiring or boring for co-researchers. The focus groups were held in the occupational therapy department at the Heidelberg Repatriation Hospital in a room that was routinely used for large departmental gatherings. Co-researchers agreed upon this as the most suitable venue. Appendix B details the focus group guides.
I created a reading and reflection guide (Appendix C) to help the co-researchers prepare for each round of focus groups. I encouraged the co-researchers to complete the readings and use the specific month’s guide to reflect on the reading prior to attending the focus group. I often used readings from the text, *Enabling Occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation* (Townsend & Polatajko, 2007). This text is the Canadian Association of Occupational Therapists’ (CAOT) eighth national guidelines for client-centred practice, and it emphasises enabling occupational justice both at an individual level and through reducing systemic barriers to participation. The use of *Enabling Occupation II* (Townsend & Polatajko, 2008) also had potential to link this research to other action research studies that explored the clinical utility of the concepts and theories discussed in *Enabling Occupation II*, such as Wilding, Curtin and Whiteford’s (2012) study. I also selected literature from a range of national and international occupational science and occupational therapy publications for co-researchers to read, reflect upon, and discuss.

I developed my own guide because I wanted to gradually introduce new concepts to challenge co-researchers’ thinking about occupational therapy practice. For example, I considered it important for co-researchers to think deeply about matters of occupation and
enablement, to help develop their confidence to further construct ideas about human rights and occupational justice. No other previously developed models of reflection were able to provide this same level of focus on the particular issues that I thought were important for the co-researchers to consider. This process of writing my own guide required my ongoing thinking and decision-making about how to make it relevant to co-researchers’ needs for learning and interrogating practice.

The themes of the first four focus groups were: occupation, enablement, enabling occupation, and human (and occupational) rights. I chose the initial themes because the concepts of occupation and enablement were presented in the stimulus text as central to occupational therapy theory and philosophy (Townsend & Polatajko, 2007). Thus, I considered that developing therapists’ understanding of these concepts would assist them to make occupation and enablement more explicit in their practice. I selected the theme of human rights due to its direct relevance to the research aim and questions. I believed that therapists’ engagement with the concept of human rights would be important in helping them to reorient the focus of their practice towards enabling people’s rights to participation in occupation.
I now overview how the interviews and focus groups were interwoven in relation to the steps in the action research spiral. Figures 1, 2 and 3 illustrate sample questions from focus groups.

**Step 1: Review and reflect.**

Step one was a preliminary review and reflection upon co-researchers’ practice. The first four groups were dedicated to reflecting upon theory, philosophy and practice in relation to human rights and occupational justice. I also used the first round of interviews to gather background information, and to ask co-researchers about their needs and desires for learning and practice through the research.

*Figure 1: Review and reflect – Sample questions focus group four*

- What does the WFOT Position Statement say to you about human rights? What do you like or not like about it?
- What are the rights issues in this practice story? How do you take those claims seriously?
- What duties go with those rights in the practice story? Who is responsible for meeting these rights?
- How might you work towards human rights in this practice, in terms of what you do, and/or how you do it?
**Step 2: Plan**

The second step of planning required co-researchers to consider “where to act to produce the most powerful effect compatible with sustaining the struggle of reform” (Kemmis & McTaggart, 1988, p. 65). Focus group five was dedicated to encouraging co-researchers to explicate their visions for an occupationally just society and practice. Then in focus groups six and seven, co-researchers engaged more explicitly in planning for change. I asked co-researchers to plan not only what was to be done about their practice situation, but also about what, by whom, where, when, and how, as this was suggested by Kemmis and McTaggart (1988) to enhance the effectiveness of planning to act. I asked co-researchers to commit to this plan by emailing it to me for collective sharing with the group. I used the second round of interviews to explore co-researchers’ experiences of the research process.

*Figure 2: Plan – Sample questions focus group six/seven*

- What kinds of human rights issues evoke your interest? And how will you make a difference?
- What changes will you need to make to your own knowledge, or to the systems and processes of your work?
- What supports (e.g. mentors, literature) will help you?
- Will you take this action individually or with others inside/outside the group?
- How will you monitor your actions and the effect it has?
Step 3: Act and evaluate

In the third step, acting and evaluating, co-researchers simultaneously adhered to enacting their plan while remaining open to modifying it in order to better meet the immediate circumstances and conditions of the changes they were making. In focus groups eight to ten, co-researchers focused on completing the final steps of the action research spiral (acting and evaluating), and also implementing a second cycle of action research. In this step it was important that co-researchers closely observed what was happening, as a basis for future reflection and re-planning efforts.

Figure 3: Act and evaluate – Sample questions focus group eight/nine

- What changes have you made to your practice over the past month?
- What has worked well and what could have been done differently? What effect did this have (either positive or negative) on you or upon others around you?
- For those who have not yet started to enact your plan, why has this been difficult, and what supports do you require?
- What do you plan to do next? Will you continue on, stop to revise your action plan and try again, or do something else?
In the final focus group, co-researchers were encouraged to reflect deeply on the entire action research process. I asked them to share a practice story that illustrated the significance of human rights and occupational justice to their own understandings and practices. Some co-researchers emailed their practice stories for inclusion in the data set. In the final set of individual interviews, I also asked co-researchers to evaluate whether the actions they had taken were relevant and appropriate and also what they had learned or what new learning was still required for future action.

Although the research group was structured to move through a minimum of two action-reflection cycles, implementation of the cycles was not neatly formed or consistent for each co-researcher. This is because there was variation in the degree to which co-researchers could see the possibilities for new or innovative forms of occupational therapy practice. In the final 3 months of the research, some co-researchers completed several shorter-loop cycles in line with the monthly focus groups; other co-researchers were not able to engage completely in two cycles, due to their difficulty overcoming barriers to implementing change. For example, some co-researchers considered that they could not change or exercise autonomous decision-making about their workloads, funding, and practice protocols, etcetera.
A full list of co-researchers’ plans for taking action to enable human rights and occupational justice, are included in Table 2.

**Table 2: List of co-researchers’ plans for taking action.**

<table>
<thead>
<tr>
<th>Co-researcher</th>
<th>Action strategy</th>
<th>Specific outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harry</td>
<td>Engage OT colleagues in use of occupation-focused language and as therapeutic activity.</td>
<td>Listen to clients about their occupational needs; role model with colleagues; facilitate in-services to supervisees.</td>
</tr>
<tr>
<td>Sophie</td>
<td>1) Champion the broad role of OT in enabling social, leisure occupations.</td>
<td>Educate multidisciplinary colleagues, such as in-services to nursing staff; develop a list of referral indicators for occupational therapy.</td>
</tr>
<tr>
<td></td>
<td>2) Enhance opportunities for client participation in occupation in a new ward.</td>
<td>Lobby nursing management during the design and build; educate clients about opportunities to participate.</td>
</tr>
<tr>
<td>Kate</td>
<td>Promote opportunities for supervisees to group discussions; listen</td>
<td>Develop opportunities for group discussions; listen</td>
</tr>
<tr>
<td>Matthew</td>
<td>engage in critical reflection about occupational justice issues in practice.</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and mentor; invite supervisees’ contributions.</td>
<td></td>
</tr>
<tr>
<td>1)</td>
<td>Enable day leave for clients who are palliative and otherwise restricted due to lack of equipment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consult with management to use client donation for purchase of equipment; record number of clients who are enabled to take day leave.</td>
<td></td>
</tr>
<tr>
<td>2)</td>
<td>Strategise ways to increase access to occupational therapy services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduce self to 1-2 clients per week, who were not referred but may have occupational needs; educate clients and families about opportunities to participate in the hospital.</td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td>Profile positive stories about the contribution of occupational therapy to Collate positive feedback from clients, such as cards; discuss outcomes</td>
<td></td>
</tr>
<tr>
<td>Liz</td>
<td>Promote students’ understanding about how to apply theoretical models in practice.</td>
<td>Engage in self-directed reading and critical reflection about the CMOP-E; encourage students through critical questioning.</td>
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<tr>
<td>-------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Audrey</td>
<td>Create opportunities for client participation in occupation through group program.</td>
<td>Lobby nursing management for nursing resources; partner with community service providers and volunteers; engage clients in design of group program.</td>
</tr>
<tr>
<td>Eve</td>
<td>Champion use of human language and descriptors when referring to clients.</td>
<td>Empower clients through use of human language in own documentation; advocate to colleagues.</td>
</tr>
</tbody>
</table>
Data analysis.

I used thematic analysis within a framework of hermeneutic phenomenology to analyse the data. Phenomenology is a research approach that seeks to give voice to people’s everyday experience, in turn generating insights (for the person and the researcher) into a particular human experience (Finlay, 2011). I selected hermeneutic phenomenology, because I considered it to be a form of analysis that aligned with the interpretive and critical goals of this research. In hermeneutic phenomenology, researchers not only describe the meaning of an experience, they also consider the contextual influences shaping experience (Finlay, 2011). This form of analysis is enacted through a hermeneutic circle, or through an iterative process of coming to understand a phenomenon or co-researcher within context. Analysis is completed by examining and interpreting the “parts” of the data before it is reintegrated and interpreted as part of the “whole” text (Higgs, Paterson, & Kinsella, 2012, p. 5).

In my analysis, I sought to capture the meaning of the experiences of the participating occupational therapists. Therefore, I foregrounded the co-researchers’ thinking, even though I acknowledge that there may be differences between what co-researchers said they did, and what they actually did in practice. I did not gather data through direct observations of their occupational therapy practice. Researchers who employ a different methodology,
for example, critical ethnography, may produce a more robust critique of the co-researchers’ practice.

In addition, I acknowledge that my values beliefs and assumptions as an occupational scientist and occupational therapist, implicitly and unconsciously, guided my interpretations of the data. In essence, I applied an occupational perspective, which refers to a “way of looking at or thinking about human doing” (Njelesani, Tang, Jonsson, & Polatajko, 2012, p. 1).

Although an occupational perspective permeated my theoretical understandings and analytic insights, a strategy that I used to enhance the authenticity of my interpretations, was to avoid the use of theoretical frameworks and concepts in the early stages of my analysis. To this end, I coded the data by reflecting the language that was naturally used by co-researchers. For example, Matthew spoke about “working smarter not harder” and Liz branded herself as a “lucky OT”. I used these phrases as names of categories. The use of in-vivo language is strategy that enables a researcher to think about themes that are representative of the data, rather than using top-down theoretical framings in which to fit the data (Richards, 2009).

The data analysis consisted of informal, less structured analysis and also formal, structured analysis. I began my informal
analysis as the audio-recordings had been transcribed, immediately after the completion of the focus group. First, I read the focus group transcripts and reflected on what co-researchers had said and the meanings I thought it had to co-researchers. I then recorded my interpretations and impressions of what had been said in the form of a monthly newsletter, which I later shared with co-researchers. I incorporated co-researchers’ words and language, so that the analysis remained grounded in the co-researchers’ everyday realities and practices. I emailed this newsletter to co-researchers prior to the next scheduled focus group. I asked that they read, considered, and critiqued the newsletter prior to attending the next focus group. I also incorporated references to other literature in the newsletter that could extend the co-researchers’ critical learning about their practice. I hoped that these extra resources would enhance their continuing reflections. A copy of each newsletter can be found in Appendix D.

My impressions, as reported in the newsletters, shaped the future actions and data collection in the research. Co-researchers could provide feedback about things I had written in the newsletter. I specifically invited them to comment on anything they thought was not accurate. For example, after reading newsletter four, Matthew voiced his opinion that my interpretation in the newsletter did not give adequate context to the way in which the co-researchers’ comments were originally discussed. Thus, through dialogue and interaction, the co-researchers and I revised and extended our understandings of
what had been said and the meaning that it held. Wilding (2008) referred to this situation in which analysis influences ongoing data collection and analysis processes, as analyses becoming “folded back in on themselves” (p. 78).

In December 2008 I undertook formal, systematic, and structured analysis of the data after all site visits and data collection were completed. The coding of the focus groups occurred separately and sequentially. For example, focus group one was completed, then focus group two, and so on. The interviews were coded after the focus groups, and in complete rounds; for example, I coded all data from interview one, then all data from interview two, and so on.

I manually analysed the data and I also used a computer program, NVIVO, to assist me in my analysis. I chose to use a combination of approaches, because I considered that neither process alone would adequately meet my needs. In particular, I found that the NVIVO program offered a systematic approach for storing, reviewing or retrieving data, thereby reducing some of the “cutting and pasting work” that Liamputtong and Ezzy (2005) described. However, I found that NVIVO did not enable me to remain close to the meaning of the data during the coding processes, which is a criticism that is levelled at many computer software programs that tend to be built around a grounded theory approach to analysis (J. Green & Thorogood, 2009). Indeed, following my first attempt at
coding exclusively with NVIVO, I received feedback from my supervisor that the codes, such as “safety and risk” and “equality”, did not make the meanings that co-researchers had attributed to their experiences explicit. Thus, following this advice, I made changes to my data analysis processes, such as incorporating manual coding processes alongside use of NVIVO software.

In order to do the formal, structured analysis I first listened to the audio-recordings of interviews and focus groups, and I read and re-read a copy of the transcript in order to develop an enriched understanding of the dialogue. During this process of reading, I noted certain narrative passages that I found to be particularly interesting, and considered why they were interesting and what was their relevance to the research.

I began the line-by-line coding by dividing the transcript into sections. Thus, sentences or paragraphs were “chunked” together for coding (Liamputtong & Ezzy, 2005). I interrogated each passage of the data so as to better understand and make sense of it. I wrote codes that incorporated my interpretation of what had been said in the data. I recorded these codes in the margins of the transcript. I used codes commencing with an active verb and with language that was close to that used by the co-researchers.

I wrote codes onto post-it notes, and positioned the codes
onto a coding board. I then developed thematic clusters by grouping like codes into clusters and naming the cluster. I compared and contrasted the codes, looking for similarities and differences, and organising and re-organising the codes. An example of a cluster was “the free will of the client”. This cluster was comprised of a number of codes, such as “feeling uncomfortable when clients are required to engage in OT in order to get home” (2, 42), and “wondering if practice is not as effective when the client is not truly engaged” (2, 43). The numbers represent my system of tracking back to the original focus group transcript.

I entered the cluster from the manual coding process and its associated text into the computer software program, NVIVO, as a “free-node”. Once the cluster was inside NVIVO, I exported a Microsoft Word document of each free-node and the corresponding passages of narrative data, to which I attached my manually-coded interpretations. This provided a convenient record of the data that had been captured for a particular free-node and it included data from different data sets. Thus, by referring to the Word document I could identify the co-researcher who had made the comment and the broader conversation in which it had been said. Appendix E provides a de-identified copy of a free-node Word document, “the push to meet hospital goals, the hospital way”.

93
In the final phase of the formal data analysis I brought the parts into a whole through developing categories and themes. In order to develop categories, I exported a Microsoft Excel document from NVIVO, which listed all the free-nodes. I printed and physically cut these into separate free-nodes and then I arranged them on the coding board into like categories. An example of a category is “adhering to the hospital push rather than client-centred practice”, and this category incorporated a range of free-nodes. For example, the free nodes included “the push to meet hospital goals, the hospital way”; “concerns about job security and practising according to funding”; and “referral goals may not match the priorities of the client”. If a free-node did not fit with a category I moved it to a “miscellaneous” category and then considered it at a later point, which was a strategy recommended by Richards (2009) to ensure logic and consistency in category development.

Once I had developed the categories, I then developed themes by looking for relationships between the different categories. Through this combining, adding, and subtracting of categories, I developed themes that were consistent with my understanding of the co-researchers’ experiences. I used a Microsoft Excel document to electronically review and rearrange the themes. Appendix F provides examples of both the category and theme development.

In the writing of the thesis, I consider that I deepened my
understanding of the themes and that I was able to see things differently from my previous analyses. For example, in October 2010 I wrote in my reflective diary, “I am feeling like the actions section is a little blurred… old practices have been reframed as changes made”. When I experienced such a disjuncture in the research, I re-engaged with the data in order to establish a deeper sense of the meaning it held for co-researchers. I re-situated the findings in a way that appeared to be more coherent with my understanding of the research story and the co-researchers’ experiences.

Ethics.

The research described in this thesis was granted ethics approval from the School of Community Health Ethics in Human Research Committee at Charles Sturt University in August 2008 (Protocol Number 405/2008/07). Research approval was also gained from the Human Research Ethics Committee of Austin Health in January 2009 (H2009/03325).

A major ethical consideration for this research was gaining informed consent from co-researchers. I addressed this issue by providing information about the research to potential co-researchers in three briefing meetings, all held in February 2010. I presented the information in an hour-long meeting convened especially to recruit to the research. I also presented it at a routine departmental meeting, and then on a third occasion in a mental health stream meeting. At
the meetings, I explained the purpose, methods, possible outcomes, and challenges of the research. Co-researchers were also provided with an opportunity to have their questions about the research answered.

Another strategy that I used to meet the requirements of informed consent was providing a Co-researcher Information and Consent Form to interested occupational therapists at the meetings and in a subsequent email reminder sent in February 2010 to all occupational therapists within the department. This Co-researcher Information and Consent Form detailed the requirements of participation, and occupational therapists were asked to sign this form if they wished to participate. As part of the Co-researcher Information and Consent Form, I asked co-researchers to sign a statement of confidentiality that they would not disclose the identity of their fellow co-researchers. A copy of the Co-researcher Information and Consent Form can be found in Appendix G.

In addition to a priori consent, verbal consent was obtained from co-researchers at relevant times throughout the research, for example, before the three interviews. This strategy is sometimes used in action research, given the unfolding nature of the action research that means the focus of the inquiry may not be known in advance (Khanlou & Peter, 2005). Co-researchers had the right to withdraw from the research at any time without penalty.
Confidentiality was another ethical consideration in this research. As a large health network, this site offered some confidentiality to co-researchers. At the time of recruitment, more than 50 full-time equivalent occupational therapists were employed. Moreover, due to the part-time arrangements of positions, the total pool of potential co-researchers was significantly in excess of the number needed (6-12) for the study. Staff changes within the occupational therapy department, such as rotations and resignations, meant that over the period of the study there was an even larger pool of potential co-researchers, thereby offering further protection for maintaining confidentiality.

Further, the strategy of de-identifying data at the earliest possible stage is recommended (Israel & Hay, 2006). Therefore, I de-identified data prior to writing up the findings and I used pseudonyms and excluded personally identifying information in my discussions with supervisors and in published material relating to the research. Some audio-files were professionally transcribed, but other than this service, no other person had access to the raw data. To protect the confidentiality of recipients of occupational therapy services, I asked co-researchers to de-identify all practice stories about clients. According to a human rights perspective it is preferable to speak of “people” or “citizens”, rather than use the term “clients”, which denotes a commercial orientation (Ife, 2012). However, in the
research described in this thesis, I henceforth have used “client” when I found it necessary to distinguish a particular person within the whole range of people that co-researchers worked with. My use of the term “client” is consistent with the co-researchers’ use of terms in their discussions of practice stories.

**Evaluating the quality and limitations of this research.**

In contrast to the conventional forms of evaluation used for scientific and technical forms of research, Mattson and Kemmis (2007) juxtaposed features that can be used to evaluate the quality of praxis-related research. As my research sought to enhance the personal and collective praxis of occupational therapists, I used praxis-related criteria to evaluate the quality and limitations of this study. First I will highlight the limitations of the research, which centred on issues of power and participation. Next, I will describe those aspects of the study that I consider to be the strengths of the research, including an emphasis on co-researchers thinking reflectively and systematically.

**Relevance.**

The relevance of research is important for determining quality (Mattson & Kemmis, 2007). As an Australian occupational therapist, I applied a particularly Australian way of viewing the world and occupational therapy practice. This aspect of my positionality is a limitation of the study, as I may have unconsciously applied and
perpetuated Western assumptions about occupational justice in this research. Thus, understandings gained through this research may not be relevant to other occupational therapy practice contexts across the world. Although this methodology provided rich local information about the practice of human rights and occupational justice in this particular Australian geographical and practice context, the same study performed with different cohorts and in different cultures and practice settings might yield different findings.

**Contribution to the well-being of society.**

In this research, co-researchers made changes and improvements to their practice with the aim to improve people’s actual lives, and to increase participation in occupation and society. Nonetheless, it was beyond the scope of this research to explore how co-researchers’ changes impacted upon their clients, and therefore whether this research had any actual desirable effect for marginalised people. This lack of understanding clients’ perspectives is a limitation of the study described in this thesis. Lack of collaborative research with clients or consumer groups is problematic for occupational therapy (Hammell, Miller, Forwell, Forman, & Jacobsen, 2012). Indeed, in an examination of occupational therapy journals from 2003-2005, Borell, Nygard, Asaba, Gustavsson, and Hemmingsson (2012) found only a few studies that elicited clients’ views of the impact of occupational therapy on their lives.
Inquiry culture.

A criterion for quality relates to the capacity of research to involve people beyond the academic world in the action research, thereby enhancing the likelihood that the changes made are sustained or further improved in practice (Mattson & Kemmis, 2007). A limitation of this research is that only a relatively small number of occupational therapists signalled their interest to participate in the research. A strategy that I used to strengthen the inquiry culture within the broader occupational therapy department was to accept co-researchers’ invitations to participate in other social or educational activities, where I could informally profile and foster acceptance of the research. Such an occasion was a presentation about the research at Austin Health Occupational Therapy Week celebrations in October 2009.

Empowerment.

Empowerment entails the extent to which researchers are empowered and develop collective self-reliance throughout the course of the research (Mattson & Kemmis, 2007). A limitation of this research was that it was not possible to fully evaluate if all of the plans for changing practice were actioned, effectual, sustained, or revised by co-researchers in their practice. This situation was compounded by the co-researchers needing more time for the process of planning for change, which reduced their time for acting and evaluating. Thus, while I found this action research to be
transformative, the full impact that co-researchers’ participation in this research had on practice (beyond the ten month duration), is not clear. Nonetheless, it would appear that this action research empowered some co-researchers to engage in further group discussions at Austin Health. For example, in July 2010, after my data collection had been completed, co-researchers facilitated a half-day workshop about occupational justice ideas with approximately 30 of their occupational therapy colleagues.

_Life experiences._

The extent to which a researcher is able to capture the meaning of an experience is important for high quality research (Mattson & Kemmis, 2007). Triangulation of data methods may be one important tool for enabling a holistic understanding to emerge about a phenomenon or experience (Curtin & Fossey, 2007). In this study I used a triangulation of data methods for data collection (interviews and focus groups) to enhance the credibility of my interpretation of the data.

I used focus groups for their potential to incorporate naturalistic forms of dialogue, which Kemmis and McTaggart (1988) suggested can help people feel more comfortable in making their experiences or vulnerabilities public. However, an emerging focus group culture might also interfere with individual expression as one or more persons may dominate a group (Fontana & Frey, 2008). For
example, the relationship between co-researchers may be strongly influenced by their different roles and responsibilities within the organisational context. To mitigate against such potential issues, I also used interviews for data collection. A potential benefit of interviews is that people feel empowered as an expert on a topic of interest, and are therefore inclined to reflect on and speak about their reality in ways that might otherwise not become available (Miller & Glassner, 2004).

*Theory and praxis.*

High quality research enables people to incorporate new knowledge and engage in praxis, or learning and doing at the same time (Mattson & Kemmis, 2007). I have discussed how in conjunction with the recommended readings, I designed reflection questions that encouraged co-researchers to think deeply about theoretical ideas and to form their own perspectives. Such opportunities to engage with theoretical literature are important for helping action researchers to better understand their practice situation and issues they would like to explore through the research (Kemmis & McTaggart, 1988).

*Reflection and communication.*

The degree to which research stimulates critical reflection and dialogue among co-researchers is a marker of quality in research (Mattson & Kemmis, 2007). I have already discussed the use of readings and newsletters to enhance critical reflection in the
research. I also encouraged co-researchers to share and discuss their practice stories. The discussion of practice stories as examples of practice is a strategy recommended by Fish and de Cossart (2007) to enhance practitioners’ learning about the invisible aspects of practice, such as the influence of one’s professional values and ways of knowing.

**Critical approach.**

A critical approach refers to the extent to which co-researchers can take a critical stand and experience emancipation (Mattson & Kemmis, 2007). I used a number of strategies to assist the co-researchers to overcome a critically inert stance throughout the research. For example, when co-researchers had difficulty planning for action, I reviewed the discussions from previous focus groups and I wrote down co-researchers’ implicit and explicit ideas and examples about where to make improvements in their practice. I then linked their ideas to the work of Kemmis and McTaggart (1988), who outlined how changes can occur to people’s thinking, talking, relating, and/or doing of practice. Through dialogue and group brainstorming, I encouraged the co-researchers to generate other new ideas to take action and to change what they thought, said, and did in practice. The list of possible changes that I generated for the discussion can be found in Appendix H.
**Integrity.**

In high-quality research, issues of integrity and autonomy must be upheld (Mattson & Kemmis, 2007). In this study, autonomy was enabled because I was not funded to complete the research, which is significant for research into human rights (Cheek, 2010). I considered that it was important that the co-researchers had ready access to the text, *Enabling Occupation II: Advancing an occupational therapy vision for health, well-being and justice through occupation* (Townsend & Polatajko, 2007) throughout the research. To avoid any inducements for participation in the research, the department purchased nine copies of the text to be loaned to co-researchers for the duration of the research; I did not provide these books to co-researchers and they became the property of the department rather than of individual co-researchers.

**Trustworthiness.**

According to Mattson and Kemmis (2007), questions of trust and meaningfulness may be as important as questions of validity, reliability and rigour within conventional scientific research. A number of strategies were applied to enhance the trustworthiness of this research. Access to quality supervision is important for pursuit of high-quality, meaningful research (Higgs & Armstrong, 2007). My supervisors both have extensive theoretical and research knowledge and experience relevant to this research project and assisted me in learning about the paradigms, norms, expectations, and practices for
doing action research. The trustworthiness of my ideas in relation to this research was further enhanced by the critique of peer-review in publications arising from this research (Galvin, Wilding, & Whiteford, 2011; Wilding & Galvin, in press).

Furthermore, I kept a reflective diary to record my ideas and extend my thinking about human rights and occupational justice. Liamputtong and Ezzy (2005) stated that using a reflective diary or field journal is a common and useful means of promoting reflexivity. My reflective diary included notes about my research supervision; my responses to literature I had reviewed; my pre-understandings and developing understandings of human rights and occupational justice concepts and practice issues; my collection of media coverage pertaining to Austin Health; artefacts I had collected from Austin Health (e.g., patient charters); my reflections on interviews and focus groups; my reflections on field visits; and my analytic insights.

The reflections in my diary shaped my decision-making about how to best facilitate future focus groups and interviews. For example, on 21 July 2009, I wrote about my experience of traveling to South Africa as a participant in a think tank exploring ideas about occupational justice. I recorded my discomfort and the sense of challenge I felt when I was asked to articulate my own point of view about occupational justice in a group context. I also wrote about the beneficial impact when “organisers allowed time for use to take the
discussion to where we wanted and needed to”. This process of reflecting upon and writing about my experiences in my research diary helped to prepare me for ensuing focus groups six and seven, in which some co-researchers struggled to articulate a vision and plan for human rights and occupational justice. I had more understanding and empathy for their experiences having been through a similar experience myself; therefore I encouraged them to take time to think through their ideas, even if it was felt to be hard, challenging work. I adapted the original focus group schedule, to allow an additional session (focus groups six/seven) for the co-researchers to engage in the process of planning for change. As a consequence of my adapting the schedule, there was less time for co-researchers to engage in the step of acting and evaluating; thus, this may have impacted upon the nature of the data obtained for analysis.

Another strategy that I used to enhance the trustworthiness of this research was to engage in self-reflection about how each interview and focus group had gone. Higgs and Titchen (2007) considered that it was important for researchers to develop their understandings and capacities as researchers. Therefore, I developed my capacity for planning and facilitating the interviews and focus groups by thinking about, and analysing, my performance after completion of each focus group and interview. For example, I considered questions, such as: Did I dominate the discussion? Did I
probe and follow-up on significant issues? How could I improve my listening skills? Who contributed to the discussion, and who did not? What worked well and what didn’t work well? A copy of my self-reflection guide is in Appendix I.

I addressed transparency of my decision-making by keeping an audit trail (McNiff, 2013). For example, I maintained electronic records of all correspondence with co-researchers, the occupational therapy manager, ethics committees, and so on. Table 3 lists the appendices that document the audit trail.

Table 3: Appendices that document the audit trail

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>Interview guides</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Focus group guides</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Readings and reflection guides</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Newsletters</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Example of NVIVO Word export</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Examples of NVIVO Excel export Category and theme development</td>
</tr>
<tr>
<td>Appendix G</td>
<td>Co-researcher Information &amp; Consent Form</td>
</tr>
<tr>
<td>Appendix H</td>
<td>Ideas for changing practice</td>
</tr>
<tr>
<td>Appendix I</td>
<td>My self-reflection guide</td>
</tr>
</tbody>
</table>
Chapter summary

I used an action research framework in this study. Action research is action-oriented and therefore helpful for understanding experience, and it is a useful way of studying the doing of occupational science (and of occupational justice). In this project, I joined with nine occupational therapists in a metropolitan hospital in Melbourne to explore their practice and take action to enable human rights and occupational justice. Over the course of 10 months, I collected data through interviews and focus groups, and the data was analysed through a combination of informal and formal analyses within a framework of hermeneutic phenomenology.
Chapter 4

Findings: Utopian Visions, Dystopian Realities

Three findings chapters are presented. Each chapter reports findings relevant to one of my three research questions. In the first findings chapter I answer the question: How do occupational therapists understand and enact human rights and occupational justice in everyday practice? In the second findings chapter I address: What conditions, such as personal, historical, social, material, economic, discursive, and political, constrain occupational therapists in enabling human rights and occupational justice? In the third and final findings chapter, I report about: What actions can occupational therapists take in order to practice human rights and occupational justice?

In the order that they are presented, the findings chapters reflect simply the kind of journey of transformation that co-researchers took through their involvement in the research. Importantly, I do not claim that co-researchers’ practice was “poor” prior to their involvement in the research, or exemplary of “best” practice thereafter. Such a division would belie the complexity of occupational therapy practice and the research story. Rather, I found that co-researchers tended to become more proactive and self-
agentic in their practice of human rights and occupational justice as a consequence of their participation in this research.

In order to assist me to conceptualise the practice transformation that occurred in the research, I use the concept of creating a path. Figure 4 represents my thinking about this process of making occupationally just practice.

*Figure 4: The process of making occupationally just practice*

Understanding the context and conditions of practice (finding out where the new path ought to be)

Incorporating a rights culture through the research (committing to making the path)

Creating participatory occupational spaces for human rights and occupational justice (walking the new path)
In essence, co-researchers set themselves on a beginning path to better enable human rights and occupational justice in practice. I found there were three different steps in the process of making and walking a new path that enabled human rights and occupationally just practice. The first step was to reflect and understand the context and the variety of conditions and circumstances that were external to co-researchers that pre-figured and shaped their practice. Kemmis and Mutton (2012) referred to such types of conditions and circumstances as practice architectures or arrangements. This first step was the longest step; co-researchers spent a significant period of time envisioning new possibilities for their practice, while also being grounded in an often-harsh practice reality. The findings in chapters four and five illuminate this early step.

The distinctive feature about the second step is that the rights culture created through the research became incorporated into co-researchers’ practice reality. Put another way, co-researchers developed a better knowledge of human rights and occupational injustice issues acquired in the first step, and through this heightened understanding they became inspired and committed to making change. In particular, I found that the sharing of practice stories with one another was transformative; the co-researchers became more energised and positive, enabling them to see new possibilities for
their occupational therapy practice. This second step was short and creative; co-researchers moved quickly through this step. Aspects of this step are reported in chapter six.

Through the learning that the co-researchers engaged in during the research, they changed their doing of human rights and occupational justice in practice. This was the third step of the process and this step relates to the findings featured in chapter six. In essence, the co-researchers developed greater autonomy and freedom about how they practised, and they created participatory occupational spaces with their clients, colleagues and community members.

In this first findings chapter, I begin the telling of this research story. I discuss the disjuncture between utopian visions for an occupationally just society and the harsh realities of implementing these ideals into everyday practice. I then discuss co-researchers’ inability to identify and address occupational injustice due to their Australian national and cultural values and to local epistemological and professional influences. Finally, I overview the complexities and impossibilities of enabling human rights and occupational justice with vulnerable groups, in the complicated world of everyday practice.
Envisioning occupational justice

Visions for occupational justice

This section details what the co-researchers thought occupational justice is and what they envisioned it to look like in their occupational therapy practice. In preparation for focus group five, I asked the co-researchers to read a journal article in which Wilcock (2001) explored the notion of utopia. Wilcock considered that an occupational utopia is one that “permits, encourages and enables all people to reach towards realising their individual potential within communities which are healthy, self-determining, ecologically sustaining, supportive, safe, satisfying, and enjoyable” (2001, p. 5). I used Wilcock’s work to stimulate the co-researchers to think critically about what an occupationally just society and practice might look like. Briskman and Fiske (2008) suggested that utopian visions and aspirational stories are particularly helpful when thinking about human rights. For example, they can help others to value local actions and actors within the group.

In this research, co-researchers considered that an occupationally just society is one in which all people are equal and are afforded the right to participate in occupations of their own choosing, regardless of their particular human qualities or characteristics. Harry said:

Having everything available, not material things, but having everything available equal amongst everyone. There is not a
specific thing that one person can do and others can’t do.

(FG 5)

Opportunities for participation in occupation, and not material goods and resources alone, were considered important for an experience of occupational justice. This required that people had freedom to choose to participate (or not to participate) in occupation, without any external forms of oppression.

Liz: That’s another of my central beliefs as that sort of justice thing that you should have the opportunity to do things even if you don’t want to, if you decide not to, it’s the opportunity bit that’s important. (I1)

An experience of occupational rights is not just a matter of directing resources and opportunities to the occupation itself; it requires a focus on meeting the range of social, cultural, economic and material conditions that influence participation. Kate said:

It’s really about having things to do and being able to do the things that you want to do. That’s the sort of basic human right I think from an occupational perspective… But I also think it’s a really difficult thing to be able to fix; like there’s no quick fix for those issues in those big population groups. There is no easy answer because it’s built up of so many different things, I mean it’s not just about having something to do with your time really, there’s so much more to it. You need to be able to have
access to things to support it and you know if you actually
don’t have anywhere to live, that just becomes what
occupation is like rather than it necessarily being something of
your choice or that occupies your time. So sometimes you
have to think about the fundamental things and how that
impacts on it [participation in occupation] as well. (I3)
Practices centred on enabling occupation would not necessarily lead
to just occupational outcomes for marginalised people, unless other
aspects of life were safe and secure, such as adequate housing and
accommodation.

Liz considered that occupational therapists are educated to
see people in the different contexts in which they live and that this
enabled them to advocate for an individual’s human and
occupational rights when social conditions restricted participation in
occupation:

I think we are more equipped to see where the problems are,
to see that it’s not actually a health problem it’s actually a
social problem or it’s actually a housing problem or it’s actually
a problem which is centred somewhere else… I think that’s
what we should be addressing or at least viewing all of those
things and try to get a much broader picture of things. We are
well placed to stamp our feet in a positive way on somebody
else’s behalf. (I1)
In addition to this emphasis on equality and opportunity, co-researchers considered that enablement of occupational justice required them to be cognisant of the way they did practice. Harry emphasised the moral value of beneficence; that is, doing occupational therapy well so that it provided benefit to people. He considered that justice entailed “giving them the full therapy, the best therapy”, regardless of time and other pressures impacting upon practice.

Sophie thought it was important to be true to the unique occupational theory and philosophy underpinning the occupational therapy profession. That is, she thought that enacting an occupational perspective was important for occupational therapy practice to be occupationally just. However, she was also uncertain as to whether or not this was what she was doing:

I think about occupation but I probably don’t bring theory into practice as much. That was kind of my interest in you and your project, really thinking about my practice and am I doing our profession justice? Am I actually committed to completing what it was I trained in and set out to do as a therapist and as a health professional? (I1)

Co-researchers envisioned that an occupationally just practice was one in which they could enable equitable opportunities for participation in occupation; but this was not always easy to do in their
particular practice context. Co-researchers desired less focus on meeting safety and discharge requirements, and more emphasis on enabling meaningful participation and quality of life.

Sophie: My utopia would be to have more time to do not discharge but just people’s occupations, thinking more about their leisure, their interest, and activity type occupation and that real occupational balance.

Olivia: I think in relation to that, probably less emphasis on safety, which we have spoken about that before because sometimes it’s our sole purpose, is to make people safe, and we don’t really look at their occupations or enable that. (FG5)

Within the hospital system there was pressure to keep up with hospital objectives geared towards a constant and rapid cycle of admission and discharge planning. The fast pace of throughput increased the likelihood that people would be discharged before to their human and occupational needs were met. Joshua desired better funding of occupational therapy so that he could enact his vision of occupational justice:

I will speak pragmatically rather than go through the whole idealistic thing. What I would like to do more than I do now, to cut to the chase of it, is to be more involved in people’s return home. So from my point of view, being in an acute psychiatric hospital with the emphasis on admission, the pressure is
always in the ED [Emergency Department], the pressure is always in getting people through, in getting people out, which has a knock-on effect that some people have to leave perhaps before I think they are ready and before the team thinks they are ready, in order to accommodate for more sick people... So from that point of view, being in a more perfect world, more resources would be allocated towards early supports at discharge and also seeing people when they are at their homes. (EI1)

The co-researchers’ visions of utopia were of a practice not constrained by health service delineations, and rather included new ways of supporting people in their homes and local communities. For Matthew, supporting people to engage in health-promoting occupation was important for enabling occupational justice. He considered it could be achieved through building community partnerships. I now explore this tension between hospital and community work in more detail.

The lucky and unlucky occupational therapist.

Co-researchers had conflicting experiences about the extent to which they could enact their visions for occupational therapy practice. Those who were able to practise in accordance with their ideals for occupational justice were considered “lucky”. For other co-researchers, being “unlucky” was their experience. That is, engaging
in occupationally just practice remained an aspiration rather than a reality.

In the community setting, which tended to be less dominated by medical theories and practices, some co-researchers had time to focus on helping people to reach their occupational potential, rather than just meeting their physical and safety needs. Liz practised in both acute and community areas of practice:

I do feel very lucky in my job that I do the acute stuff so the discharge planning, and the very much [talking to clients] “What do you need to get home safely?” but then I am able to do the follow-up in the community setting… to try and promote them thinking about what it is they want to do now they are not in hospital any more, and to make them consider their options.

(FG1)

Although some co-researchers were able to have autonomy and others had less autonomy, they all experienced a clear dissonance between the philosophies espoused within occupational therapy, and the “real world” of hospital practice. Highly medicalised contexts were generally perceived by co-researchers to be antithetical to occupationally just practice; thus, co-researchers considered that occupational therapists who could enact their ideals, were “lucky”.

Matthew: I think if you were to be sitting around in this forum,
as therapists 15 years from now you would be getting very
different answers. They [future occupational therapists] would
be a lot more adept and a lot more open to putting themselves
out there for all of these sorts of [human rights] ideas. I think
this is definitely where it is moving. It is going to be very hard
to get, we [us] the therapists that have been born, bred and
run through the wringer of the medical model for our entire
professional career, involved in these sorts of things that do
just feel so unbelievably hard to contemplate let alone to take
action on. I am hopeful that that’s the way it’s going to be
through education.

Olivia: I hope you are right, but I think at university everything
that we talk about all of the theories and the OT [occupational
therapy/occupational therapist] stuff we do learn all about that
at uni, and then you get out into the real world and that
doesn’t happen. You know, you get put into the job that you
do and you can’t do all of those occupations and enable
people in those occupations because the model doesn’t work
like that.

Matthew: It definitely depends on what area you work in.

Olivia: And I agree with you and I think your area is one which
is the ideal kind of OT, what we [ought to] do as an OT is what
you do, where a lot of us don’t do that. You are in a good area to do that type of thing. The rest of us aren’t, I guess. (FG5)

Some co-researchers, such as Olivia, learned about client-centred and occupation-focused ideals at university, but they felt that in practice they were enculturated into particular ways of saying and doing that constrained them from enabling human rights and occupational justice. Indeed, even “lucky” co-researchers like Matthew felt pessimistic about current occupational therapy practice more broadly (but also optimistic about future practice).

The model of service and values subscribed to by the multidisciplinary team influenced co-researchers’ work for human rights and occupational justice and whether they were lucky or unlucky. Human rights and occupational justice could be implemented in acute settings, so long as the team was similarly dedicated to enabling justice.

Kate: The team that I used to work with when I was in the emergency department, that whole team was about advocating for the clients and it wasn’t a team of social workers, it was a mixed background of nurses, OTs, social workers and physios. It [enabling justice] was the core values of the team, was just something that was done. I suppose the biggest impacts that I have had on people are in working in that team because of the general team philosophy. (FG2)
Some co-researchers were resigned to a belief that it was not possible to enact a vision for occupational justice in acute settings. They thought the philosophical incompatibility with hospital-based objectives was too wide to traverse due to its philosophies not being compatible with hospital-based objectives. Historically, their efforts at transforming acute practices had proved a futile endeavour. Therefore, they felt that being unlucky was a fixed reality for many occupational therapists.

Joshua: It is an interesting dilemma. I have talked to a lot of the senior OTs about this issue. The last 10 years that I have been working anyway this issue comes up again and again and again. Some people are coming to the idea that actually maybe OTs don't really belong in acute hospitals, and that are we in a sense trying to move the Titanic when it actually can't be moved? Are we better strategically as a profession to put ourselves in situations which are more satisfying to us as clinicians and as a profession, and at the same time more beneficial to the clients who are actually out there? That is kind of the argument that some people are trying to make. Having worked or tried to work on the inside for quite a few years now, it sometimes seems more appealing at times... This is the hard part. We see what we could offer there, but other people don't want in a sense what we are offering to a degree. In some ways I think a lot of good people have tried to
turn the thing around. But how long do we try? Some people get burned out by it, they just get tired and tired of it. (FG2)

In the following exchange, co-researchers expressed opposing feelings about whether the profession of occupational therapy should continue to service highly medicalised and acute practice contexts. Their use of military metaphors illustrated their depth of feeling on the matter.

Harry: I was surprised when you said that before, and you have just said it then about moving to the community.

Joshua: Strategic retreat!

Harry: Strategic loss, I would say. Retreat, that is just silly.

Matthew: It is not black or white one way or the other. We need to be smarter and more pragmatic into channelling our energy and power into areas that we can change and all the areas we can’t. We are not going to change the medical model overnight I can guarantee that much.

Joshua: The idea of hostility comes to mind. Not hostile to OTs per se, but hostile to the kind of ideas that we bring to the hospital. The shorter length of stay here, much more acute, more complex needs; that kind of language is not really
friendly to people who want to enable people to do things that they want to, need to, or are expected to do. Is it? (FG2)

Some co-researchers lamented that a loss of occupational therapists from this area of practice would prevent occupational therapists from applying their knowledge and expertise in support of human rights and occupational justice; thereby contributing to occupational injustice. Generally, the co-researchers formed a dualistic (either/or) view in thinking about where occupational therapy ought to be positioned for future practice. That is, they considered the need for the profession either to accept being told what to do, or to move to other (community) practice settings. An understanding of practice as a matter of luck limited them from seeing other future possibilities for the profession, such as how structural changes could make it possible for all occupational therapists to be “lucky” and to engage in occupationally just practice.

National, cultural and professional influences

Occupational injustices are less visible locally.

The particular constraints of the hospital context on enabling human rights and occupational justice are more fully explored in the second findings chapter. I now discuss other national, cultural and professional issues that contributed to co-researchers’ disconnect between their ideals for occupational justice and their practice realities.
Before the study, co-researchers sometimes did not see the full range of occupational injustices that were impacting on people within their local practice setting. Initially, when thinking about human rights abuses, the co-researchers tended to think of human suffering as arising from war and poverty. They struggled to understand the broad kinds of human rights abuses that impacted on Australian citizens.

Liz: I think it is more difficult in Western societies because you haven’t got such glaring diversities.

Matthew: It is not in your face, as it is in Sudan or wherever else.

Liz: Yeah, the injustices that are there [Sudan], they need something doing about it, and there are great structural things that need to change. If you did come across somebody who didn’t have an indoor toilet [in Australia] or you saw that there was something that needed doing, you would address that on an individual basis I think, rather than saying, “What other people haven’t got them? What is the sanitation like here? What is the drinking water like? What other things can you do?” (FG3)
A dominant perception among co-researchers was that Australian citizens are generally afforded basic human rights for their safety and survival. In Australia, the co-researchers considered that they would usually address a claim to human rights through individual intervention, rather than by applying a population-based approach in their practice.

Co-researchers understood that human rights abuses and injustices in Australia were a problem for particular marginal groups. For example, they talked about the obvious social and economic disadvantage affecting Indigenous Australians, persons with mental illness, and persons experiencing homelessness. However, they felt that overall and in general, other countries had more pressing human rights problems than Australia.

Joshua: I agree with Matthew, it is less obvious in the Western countries. I use Maslow’s hierarchy of needs as a framework in that there are less people who are homeless; they have shelter, safety and food. Most people have access to those things in our country, most, not all, but most. So it is less obvious than when people are in war-torn countries; these documents [The WFOT Position Statement] on that background and that context, look a lot darker.
Eve: Although if you worked in the NT [Northern Territory] and parts of northern Queensland you would probably think quite differently.

Joshua: Absolutely, that’s true. There are certain pockets; people with mental illness too are quite similar, and parts of the city where the homeless shelters are everywhere. [However] in local Melbourne, the general population people have a right to participate in a range of occupations. Not all [people], but a lot. (FG4)

The co-researchers tended to notice pressing injustices that occurred internationally and to not notice injustices that occurred in Australia. Although co-researchers were cognisant of some of the injustices experienced by their clients, the group did not automatically consider the full range of societal injustices, such as poverty, legislative injustices, racial prejudice and social discrimination. By not seeing diversity in their clients’ life circumstances, it is likely that co-researchers may have perpetuated occupational injustice because, according to Townsend (2007), in order for practice to be occupationally just, it is important to see diversity in human experience.

Thinking about human rights issues as confined to particular groups or pockets of society made it difficult for co-researchers to
see how human rights abuses could impact on the people they worked with on a daily basis. For example, Kate perceived she had limited exposure to working with vulnerable or minority populations in the hospital:

I think it is an exposure sort of thing. If you don’t come across vulnerable populations regularly enough, then really you don’t have any idea what to do when that happens. I just think that the population that you work with within the hospital setting here is, well, to a degree you are limited by what is presented here. (FG9)

On the wards, the clinical environment appeared to render people less distinctive from each other. Hospital gowns created an illusion that all people shared the same characteristics. Liz described this fusing of the person with the hospital environment as “a white person in a white bed”; the person appeared to be almost indistinguishable from the hospital context. The hospital wards were stark and cleared of most personal belongings; this de-personalisation appeared to conceal the true identities of clients and also masked their vulnerabilities and needs.

Kate: It does very much depend on the population you are working with. I think from my ED [Emergency Department] days where you see a lot more people on the fringe.

Joshua: It is quite obvious isn’t it?
Kate: Whereas the kind of people we are getting on the wards, and I suppose if they suffer that sort of injustice, deprivation or whatever it is, it may not be as obvious to us on the wards because we do not necessarily see where they are at home. (FG3)

The lack of contrast between client and background made it difficult to see either person or context clearly in the hospital wards.

In contrast to these instances in which occupational justice issues were camouflaged and therefore ignored, in other areas of practice, occupational justice issues could be so pronounced so as to be unavoidable. In the emergency department and in case coordination roles the visibility of occupational injustices was heightened, and responsibility could not merely be abdicated as belonging to social work.

Kate: When I was doing care coordination you look at everything on a much bigger picture scale. I don’t know I am just sort of thinking about what we might consider more typically of social work things to think about. You know, how they are going to pay for something or what they have in the way of finance or what they have in the way of supports, to enable them to do whatever; those sorts of things, which we may not always think about but in some in cases you can’t not [think about it]. (FG1)
Justice not an explicit professional vision in Australia.

In the previous section I discussed that the co-researchers tended not to see occupational injustices in their practice because of their preconceived ideas that injustice tended only to be something that happened to particular marginalised groups of Australians. Instances of injustice in the co-researchers’ practice also appeared to be camouflaged by the clinical conventions of the hospital, which appeared to conceal the true identities, needs and injustices of clients.

In this section I will consider how co-researchers thought that enabling human rights and occupational justice was not characteristic of occupational therapy education and practice in Australia. This issue was raised when I asked the co-researchers to read *Enabling Occupation II: Advancing an occupational therapy vision for health, well-being and justice through occupation* (Townsend & Polatajko, 2007). The co-researchers considered that some of the concepts in the text, such as “enablement”, encapsulated what they did in everyday practice. After reading the Canadian Model of Client-Centred Enablement, a newly developed model published in the text, Kate said, “It was like, yeah, that is what we do! It is nice to see it out there in a list. I think that is what I do, all the time” (FG3).
Although co-researchers felt that the concept of enablement captured the essence of how occupational therapists practise, they did not consider that justice was a clear reason why Australian occupational therapists practised occupational therapy. This perception became more marked after reading a paper by Canadian occupational therapist, Thibeault (2006), in preparation for focus group three. Thibeault asserted that justice was a feature of her occupational therapy practice; however, some co-researchers could not see justice as characteristic of their occupational therapy practice:

Kate: I love that this is what she [Thibeault] has written about and what she is passionate about. Maybe it is much more in Canada, I don’t know I don’t get a strong feeling of that here; [the idea of justice is] certainly not overt…I mean of course well-being, client-centredness, meaning and that sort of stuff. I suppose it is the social justice thing that she keeps bringing up.

Liz: I suppose it is the logical extension of what we are trying to do. When we have been taught occupational therapy and all that stuff around that, those longer lines haven’t been drawn for us, that sort of longer range view hasn’t been made. (FG3)
The co-researchers considered that concepts and theories of justice were not explicit in their practice due to a lack of focus in their university education. This was not only the case for experienced occupational therapists, but also for Audrey, who was in her first year of practice as a new graduate occupational therapist:

It [occupational justice] is not a phrase that is automatically familiar to me. Enabling occupation is more familiar, occupational justice not as much. It doesn’t automatically ring bells. I would probably just make up my own definition of that… that people have the right to be engaging in the occupations that they need to be doing, and that often social, financial, and educational factors do limit that, but there is still that right and they should be enabled to do that. Yeah, there is probably a lot of occupational injustice in the work that I do.

(NMI)

Audrey was not readily conscious of how the philosophies of justice underpinned her everyday practice, despite her recent university education. However, the fact that she so readily articulated her own unique view of occupational justice demonstrated her tacit understanding of this concept. Thus, it would appear that prior to this research, the co-researchers had not had an opportunity to consciously engage with the idea of occupational justice.

On the one hand, Liz considered that “the pointing out of the failings of society is a human duty, not just the province of the OT or
the campaigner!” Yet, despite her natural interest in enabling occupational justice, political action did not necessarily feature in Liz’s occupational therapy practice, even though it was part of her personal life:

Yeah, because all that social justice stuff is the stuff that I used to do. You know I went home and did that! Going on marches, writing letters and sending emails. That was somebody else... but I never really saw it as part of occupational therapy. (FG3)

This disjunct between co-researchers’ personal and professional activism for occupational justice points towards a potential lack of opportunity for occupational therapists to engage with human rights and occupational justice ideas through the undergraduate and postgraduate curricula, as well as in their continuing professional development activities.

Overall, the co-researchers thought that practice of occupational justice seemed more relevant and accepted in Canada than in Australia. Indeed, Canadian advances in broadening the professional objectives of occupational therapy contributed to co-researchers’ feeling that the local emphasis on competency-based education and practice was irrelevant, even redundant.

Kate: The one thing that really came out for me for reading this [Enabling Occupation II text], was that, man, those Canadians seem to have it a lot more together than anyone
else does! Oh my God, they are actually setting out all this stuff! I don’t know. I feel that some of our OT competencies might be a little irrelevant… They [the Canadians] have done it all in the last couple of years, it’s current and it seems relevant to me. (FG2)

The co-researchers’ practice emphasised an overly instrumental focus (such as goals for improving individual body function, using technical supports). Their competency-based practices did not seem to capture or match the visionary and justice-emphasis that appeared in a range of texts from Canada.

Co-researchers did not know what vision Occupational Therapy Australia (OTA) had of occupational therapy practice, nor what role human rights and occupational justice might play in such a vision. Kate questioned why the idea of human rights, as put forward in the position statement, had not been commented upon, or contextualised locally by, OTA:

WFOT have done it and obviously put out the challenge to OTs and OT associations to make it more relevant at a local level. I am not yet convinced that has perhaps happened. I have never seen an OT Australia Association response to it. I don’t know if it exists? (FG4)

The co-researchers perceived that a lack of leadership by their national association limited their uptake of human rights and occupational justice concepts in their practice; it lessened the
imperative to make human rights and occupational justice a focus of continuing professional development.

Some co-researchers also considered that occupational therapists had themselves not taken adequate responsibility to contextualise ideas about rights and justice. Matthew, in responding to Harry’s view that something held occupational therapists back from engaging with ideas about occupational justice, reflected that the majority of occupational therapists at the hospital opted not to participate in the research:

Matthew: Do you think that this is the case for all of the OT profession though? For instance, [for] this focus group there would have been 60 or 70 OTs that were invited yet there are only eight of us here. Do you know what I mean? I think it is definitely the case in this room, but do you think it is the case for the majority of the OT world?

As a corollary of this lack of collective engagement, co-researchers did not feel adequately supported by their occupational therapy colleagues in enabling human rights and occupational justice. For some co-researchers, the most support and encouragement they experienced was not having barriers put up against them. Others, however, were directly discouraged in their efforts to enable occupational justice.

Matthew: Have you been supported in your team?
Harry: I wouldn’t say supported so much, but not hampered. Like I can do whatever I want to do as long as I just give them some feedback so that’s fine. But I wouldn’t say they are chomping at the bit to do what I do.

Matthew: I am probably digressing a little but, probably the reason I brought it up is because I was talking to my supervisor the other day and I started mentioning our focus group and what it is all about and occupational justice, and I was pretty amazed with the comment that she made. I can’t remember exactly word for word what the quote was but she said “Oh yeah I think all that sort of stuff is good in theory but I don’t think it will work on an acute ward where we are here for discharge planning”. (FG10)

Lack of active support and encouragement from occupational therapy colleagues was very discouraging for the co-researchers, and in all likelihood made the task of implementing occupational justice significantly more challenging. For example, co-researchers expressed their reluctance to publicly share their ideas about how occupational justice was and could be a part of practice.

The position statement filled a void for the co-researchers about the connection between human rights and participation in occupation. For example, prior to reading the position statement Kate
had difficulty explaining the link between human rights and occupation. This became evident to her when drafting a community submission for the National Human Rights Consultation Committee in support of a human rights charter.

Kate: All these policy people who were going to write some document and I thought what am I doing here? ... Anyway, one of the girls said to me “what do you think human rights are?” and I was sort of thinking about social needs, human needs, whereas they are thinking freedom of speech, at a political level. I think housing though, food, shelter… but I was trying to be all “occupational” and trying to convince them that that should be a human right. They couldn’t quite see where I was coming from, but I was trying! (FG3)

However, after the co-researchers read and discussed the relevance of the position statement to their local practice, Kate found a resonance between the position statement and the occupational view of human rights that she had difficulty advocating for while preparing the submission for the National Human Rights Consultation:

I wish I had of seen this [position statement] when I did what I was talking about last time about the human rights thing. This is what I was probably trying to say to them but couldn’t quite get those words out. No not quite like that! (FG4)

Thus, it would seem that when co-researchers were provided with opportunities to engage in reflection and dialogue around human rights and occupational justice theories and concepts, and to see
their practice as part of a broader professional vision for justice, they could better understand what their unique occupational perspective offered in matters of rights and justice.

**Aspirational statements of human rights are not always pragmatic.**

I have discussed how the co-researchers’ ability to see occupational injustice was further impaired by their view that addressing issues of injustice was not a typical part of Australian occupational therapy practice. It was not explicit in their university preparation for practice, and there is no official position statement about occupational injustice that has been published by Occupational Therapy Australia.

In this section, I discuss that even though the position statement enabled co-researchers to better understand how to enable people’s human and occupational rights, the co-researchers considered that it was not possible to readily apply such ideals to their practice reality. After considering the position statement some co-researchers had difficulty reconciling the aspirations of the position statement with the practice realities of working with particular groups of people, such as those who did not have the capabilities for participation in some occupations. Matthew doubted that an actual place where human rights ideals are fully respected, protected and realised could ever exist:
Matthew: I just read it [the position statement] and thought, could you take me to a place in the world where you can tick off all these boxes, and we are all happy and dandy? Because I just couldn’t imagine a place where you can literally tick off every one of these things. I know it’s not designed to be a concrete guide, but … [trails off]

Liz: It’s aspirational, isn’t it?

Matthew: Very aspirational

Harry: But don’t you need some realism, or a realistic part of it? For example, the very first part about being able to participate in a range of occupations… there are some things that some people may not be able to do or have the capabilities to do… Sometimes when you set goals so high they are so far out of reach that it makes them not worthwhile.

Liz: But it doesn’t say that you can do whatever you dream you want to do, it just says that you have the right to participate in a range of occupations.

Harry: But then it also says that you have a right to be supported to participate in occupations. (FG4)
Even though co-researchers articulated their personal visions of an occupationally just society and practice, reading the position statement engendered frustration. The co-researchers thought that the position statement had limited consideration of the contextual pressures that affected their ability to enable occupational justice, such as how to practise with particular vulnerable groups. Thus, co-researchers experienced a mismatch between what is aspired to and what they believed they could actually achieve in the course of their everyday practice.

In particular, co-researchers had continuing concerns about how to implement the ideals of human rights and occupational justice when a person’s judgment is impaired. The position statement did not account for occupational therapists particular responsibilities for enabling occupational justice, given the tricky and grey situations in occupational therapy practice, such as how occupational therapists are required at times to restrict occupational participation in order to prevent harm occurring.

As co-researchers struggled to make the position statement more achievable, it was suggested that it might be better if the position statement qualified the right to make choices about participation in occupation, such as by the inclusion of a phrase to include a phrase such as “so long as persons were of sound mind and body”. After further consideration and discussion, however, co-
researchers recognised that this proposed change would imply that persons with disabilities ought to be treated in an unequal manner to other human beings.

Matthew: I was particularly talking about the sound mind; I don’t know why the sound body part was included. I think that was the thing I had with the interpretation [in the newsletter], was trying to apply those human rights in our everyday practice and those were some of the examples that we came up with where that buffer in-between promoting those rights to that person but them maybe not being in a psychological or cognitive head space to realise that is what we are doing for them.

Eve: It is hard. It is that mental health status and cognitive issues where it is grey, because if you can’t get up the stairs because you have got a broken hip, well then, that is a bit more concrete than if you can’t manage the cooking tasks because you can’t do the planning. (FG5)

Co-researchers were uncertain as to how the ideals of human rights practice could be incorporated in the messy world of everyday practice, when there was uncertainty about people’s capacity to make reasoned decisions about their life. Kate shared a practice story in which she had initially considered she had acted ethically and in her client’s best interests. However, with the passage of time
Kate had come to question whether her actions had an oppressive impact upon her client:

I am going to put myself out there, because my story is the opposite. I don’t feel like it was enabling, it was very much more against human rights in some ways. I was not actually working as an occupational therapist at the time; it was as a care coordinator in the emergency department, where we did some long-term case management. I worked with this guy who was probably only in his 70s. I think he was Croatian. He didn’t speak a great deal of English, and he lived in a rooming house in Fitzroy. As far as we knew he had no contacts whatsoever. He had a number of [emergency department] presentations over a short period of time, and eventually got admitted into the hospital. We took him to VCAT [Victorian Civil and Administrative Tribunal] and got him a guardian, and put him in a hostel and all the rest of it. It is one of those things, I probably didn’t struggle with it at the time, but I have struggled with it a lot since. I feel like I did that to him. (FG4)

Co-researchers aspired to be knowledgeable about their clients, although it could be difficult to acquire a good understanding of a situation in order to work out what should be done. For example, in the previous practice story there was much that Kate did not know about her client’s context and life circumstances, and therefore she
experienced discomfort that her professional actions could be highly influential upon legal outcomes.

Kate: He lived in an absolute dump of a boarding house, people who knew the area said that this was a horrible boarding house, that with the other people that lived there he was at risk from living in an environment like that. You know, the front doors were boarded up. We never got in there, we couldn’t get in there, it was a disaster, the place… It’s just that he had chosen to live in that environment and at which point do you step in and stop? [people living like that]… there was so much to him that you couldn’t really know. (FG4)

The aspirational nature of the position statement did not appear to take into account the complexities when occupational therapists were required to act with people who might be considered vulnerable. Kate experienced a tension because her actions to prevent harm from befalling her client conflicted with her occupational therapy values and beliefs that people ought to be supported in their right to live in places and participate in occupations of their choosing.

Although some co-researchers lost motivation after reading the position statement because they felt that it was unachievable, others found it inspiring, something that they could strive to achieve in practice. Liz considered that the position statement was “a
document to move towards, it gives you a place to go rather than a place you have to be, a kind of subtle distinction” (I2).

The opportunity to participate in a dialogic space centred upon human rights and occupational justice exposed the co-researchers to new and different ways of thinking about occupational therapy practice. After further discussion, Harry also came to acknowledge that the position statement could stimulate his thinking about the possibilities for enabling occupational justice:

I thought back to that WFOT proposal of the human rights, and how that is the goal to achieve and that might be difficult, but at least it is something to aim for. If the academic side are setting out fairly high goals or high bars than at least it is something to aim for. (I2)

Rather than seeing a dissonance or divide between academic and practice views, the position statement offered Harry a framework and language about what it is that occupational therapists might aspire to do.

**An imperfect balance between rights and responsibilities.**

Previously, I discussed how the co-researchers thought that the position statement had limited consideration of the contextual pressures that shaped their practice. In particular, co-researchers had continuing concerns about how to implement the ideals of human rights and occupational justice with persons who were
cognitively or mentally impaired; and whom may have limited capabilities for engaging in decision-making about their life and participation in occupation.

In addition to the uncertainty and complexities of enacting a duty of care, I now turn to discuss how co-researchers were required to give consideration to their statutory obligations. It was difficult to incorporate ideals of human rights and occupational justice into the messy world of everyday practice when people had been admitted involuntarily to hospital under the *Mental Health Act*. Audrey used the metaphor of “the fine line” to describe how people can be dealt with in an adversarial way if they were not accepting of medical decisions and norms:

I think that there are limits to what I can do. I believe in advocating for people and educating people about their rights. And I give people pamphlets and say, “While you’re involuntary you do have these rights”. But even that process for them to go up against their involuntary status can take 2 weeks before they’re even reviewed before the Mental Health Review Board… So if someone is being compliant and they’re working with the team and they’re improving then they’ll be taken off mental health status and be made voluntary. But just as easily if they kick up a fuss and complain and say, “I’m not taking my medication” and become more unwell, the doctor can turn around and say, “you’re back on it” and give
an injection. It’s not meant to be punitive, it is meant to be preventative to keep people as well as they can be and medication is a crucial part of treatment for people with these illnesses… there is this fine line of doing things necessary for people’s health and for their well-being and against their wishes and I think sometimes it gets very grey. (I3)

Co-researchers considered that education about human rights entitlements within the hospital, such as through the issuing of patient rights charters, undermined the building of participatory, collaborative partnerships between co-researchers and clients. Joshua questioned whether the idea of responsibilities needed to be given greater emphasis within the hospital, to lessen clients’ hostility towards the system and to encourage practitioners to take individual claims to human rights more seriously:

I understand that the patient rights movement is in a sense to readdress a balance… but I have noticed that basically they [clients] get more upset and cranky and no one wants to listen to them over time. So for clients who constantly complain that their rights have been violated, it creates a sense of entitlement or a lack of sense of responsibility for their actions and behaviours... To counter-address that a lot of organisations try to do rights and responsibilities charts, but the emphasis is usually on rights with a tokenistic emphasis on responsibilities. I would be looking at reframing some of
that work around looking at how you can build in a chart to look at how people can have their rights maintained and at the same time promote what control they have and what they can actually do, and at the same time promote the responsibilities of the organisation to do that. So there is more of a shared perspective I suppose, [where the current way of promoting human rights] sometimes sets up an “us against them” mentality. (EI1)

By underplaying responsibilities, clients were not supported to use or develop their capabilities for active citizenship beyond the hospital context. Ironically, then, the hospital’s emphasis on informing people about their human rights did not necessarily lead to just outcomes.

Co-researchers believed if the idea of human rights was to work in practice, it was important that clients take responsibility to participate in their occupational therapy. This is consistent with Ife’s (2008) framing of citizenship. That is, as a way of understanding not only the kinds of human rights that belong to citizens but also the citizenship obligations that accompany citizens’ rights. In this research, co-researchers appeared to conceive it was their role to enable citizenship by encouraging people to actively participate in those occupations that allow one to experience value and full inclusion in community life.
Chapter summary

In this chapter I briefly overviewed the finding that co-researchers set themselves on a beginning path to better enable human rights and occupational justice in practice. I then largely reported on the disjunction between the profession’s ideals for human rights and occupational justice, and co-researchers’ practice realities.

Co-researchers shared their individual and collective visions for a society and practice in which people have equal opportunities and freedoms to choose to participate in their desired occupations and to be understood on human terms. However, they were polarised about the extent to which they could enact their ideals for human rights and occupational justice; they described themselves as either “lucky” or “unlucky” in terms of their level of support and opportunities to promote occupational justice in their everyday practice.

Various national, cultural and professional forces shaped co-researchers’ understanding and enactment of human rights and occupational justice. Co-researchers had difficulty seeing the full breadth of occupational injustice impacting upon Australian citizens and they did not consider that justice was an explicit value of the occupational therapy profession in Australia. Further, co-researchers’ felt unable to advocate publicly about matters of human rights and
occupational justice because they perceived that there was no consensus view among occupational therapists about these matters.

Co-researchers experienced frustration that aspirational framings of human rights and occupational justice did not recognise the complexities and impossibilities of implementing these concepts in practice, particularly with persons who were cognitively or mentally impaired or who chose to live lives that were completely different from social norms. This situation was made more difficult because rights were foregrounded and responsibilities underplayed in the hospital.
In my second research question I aimed to explore the conditions that constrain and support occupational therapists’ practice of human rights and occupational justice. In this second findings chapter, I have elected to limit my findings to those conditions that constrained co-researchers’ practice of human rights and occupational justice. My rationale for this decision is that many of conditions identified as enabling the practice of human rights and occupational justice later evolved into emancipatory action, and therefore I detail them in the third findings chapter.

In this chapter, I discuss how the practice of enabling occupational justice was sidelined within the hospital. In part this was because occupational therapy was not well valued, funded or supported. I first overview how co-researchers’ view of clients was obscured by dominant medical and fiscal discourses and how co-researchers were unaware of their own contribution to discriminating and gate-keeping practices. Second, I outline how dominant technical risk discourses restricted risk-taking, contributing to an absence of occupational rights for the people with whom the co-researchers worked.
Impact of medical and fiscal discourses

Withdrawing services.

A dominant discourse of fiscal restraint in the hospital meant that co-researchers had to prioritise which people to see. Co-researchers explained how people admitted from residential care, once they had their acute needs met, were not a priority for intervention unless their discharge was in jeopardy or they had sufficient need for rehabilitation:

Kate: It is a difficult one because it is not something that we can necessarily have a great deal of effect on in the acute care setting. We don’t routinely see people from hostels and nursing homes, only in particular situations if we are looking at whether they are able to get straight back there or if they need to go to rehab first. Sadly, that is not something we do.

Liz: Actually there is more onus really on finding a place, a bed, a room for them and never mind all the other bits that the person might have been doing, or not doing, or would like to do; they are side issues. (FG5)

Liz perceived that the team would consider their work in enabling occupation to be an irrelevant issue compared to finding a speedy resolution to an accommodation need.

In response to fiscal pressures, the co-researchers tended to judge whole groups of people as having less need for occupational
therapy. However, choosing to see some, but not all people, meant that not every person received the occupational therapy intervention that might be of benefit to him or her. Sophie explained, “we stopped seeing anyone from hostel residences because we didn’t have capacity for that any more”. (FG5)

Funding constraints affected the level of service provided to many people within the hospital. However, Harry concurred that a need to prioritise resources according to who was deemed most deserving had a dramatic impact on persons transitioning to residential care:

From my time over in aged care, it was almost all patients were seen initially for initial assessments, and as soon as the decision was made for someone to go to aged care, it [the consensus] was “withdraw services” almost. That is how blunt it was. Over in the aged care wards, they do have movie afternoons, they have got breakfast groups and things like that, and there were some patients that you would still invite them to come if they were able to, but pretty much as soon as those words were [uttered] “for nursing home or hostel” that was it, they were off your list of who you were seeing. And it was purely just the caseload that meant if you spent so long with them, then two or three people that were going home would not have got the treatment or interventions that they needed. (FG6)
Co-researchers identified that this kind of withdrawal of services was a system-wide practice. It represented an indirect form of social discrimination, given that older persons comprise the majority of people living in residential care. As a consequence of this withdrawal of services, people’s rights and needs for participation in occupation remained unmet.

It appeared that the co-researchers were applying concepts of utilitarianism to make their decisions about who to prioritise. When using a utilitarian framework, a person considers the consequences of action on others and bringing about the best outcome for the majority of people (Ife, 2012). Harry could see that it was problematic to prioritise clients according to need, given that many clients had clear occupational problems or an absence of occupational rights. Therefore he decided how to allocate his time and resources according to utilitarian principles:

It is a judging, us/them judging. If I spent a lot of time trying to get someone who is at high level care to be able to transfer easier and spend 2 to 3 hours doing that, that means that two to three other people that also need intervention don’t get it. So it is deciding which one you are going to provide that intervention to. And then in terms of human rights, well how do you weigh that up, of almost who has got more of a right between being able to transfer versus being able to go home.

(FG6)
Co-researchers’ use of utilitarian theory evoked an ethical imperative to provide the greatest benefit to the greatest number of people. Prior to their participation in the research, the co-researchers had not consciously considered the human rights implications arising from this prioritisation system. Thus, not only might co-researchers miss opportunities to enable occupation for groups of people transitioning to residential care, by spreading resources for occupational therapy to more clients it might become more difficult to effectively enable occupational justice for others.

Clearly, the enablement of occupational justice was complicated when there were competing priorities for occupational therapy within and between disadvantaged groups. Co-researchers’ judgments of those who were more “deserving” of occupational therapy than others may have contributed to creating injustice, even as the co-researchers strove to try and to achieve occupational justice for all.

**Funding body policy prevents a quality of life focus.**

In addition to the implicit fiscal controls on occupational therapy resources, the co-researchers’ enablement of human rights and occupational justice was constrained by the policies and funding criteria of the organisation that paid for their services. Some co-researchers had their occupational therapy positions funded by the Department of Veterans’ Affairs (DVA), a department of the
Australian Government that provides particular supports for Australian armed forces veterans. However, co-researchers found that this service placed tight controls over what it would and would not fund.

Olivia: in the type of work that we do, because we are funded by DVA that pays for the clients, it tends to be they don’t even take into consideration quality of life and client choice, it’s not even a consideration with anything. If you want something put in for quality of life, it doesn’t happen.

Eve: Yeah, a good example is that if they [clients] have good front access and they can access the community, but it is really important for them to be able to water the garden or hang out clothes on the clothesline, DVA is not going to fund any mods [modifications] there because they have already got one functional access. (FG1)

Due to the nature of the political and fiscal controls imposed by employing organisations, co-researchers found it hard to meet their clients’ broad human and occupational needs. Olivia described the resultant narrowed focus in her practice; she provided physical interventions, such as prescribing assistive equipment and home modifications, rather than partnering with clients towards achieving their client-centred goals:

And I would say what we do, some of it enables occupation,
but I don’t think it’s that meaningful. I mean your gardening, your cooking, maybe that’s meaningful; someone is grateful that they get out of their chair but is that necessarily meaningful? (FG5)

The co-researchers struggled with the incongruent pull of occupational therapy philosophies and the cost-containment goals of funding bodies. Work for justice was commonly declined or not even considered if co-researchers’ requests did not comply with funding organisations’ strict criteria. The occupational injustices arising from this funding stipulation were that people’s human and occupational rights were not always realised.

Concerns about job security acted as a barrier to co-researchers’ work for human rights and occupational justice. Co-researchers were compliant with the tight funding regulations and controls imposed upon them because they were concerned that if they were to practise in a contrary way, the occupational therapy department would lose funding for their positions.

Eve: Our notes from DVA point of view we get audited, they look at our occasions and it has to fit into certain criteria. They will review our notes to make sure what we are doing fits into the specifics of what DVA will fund. Phone calls aren’t included; report writing isn’t always included, so how would you justify an hour in someone’s garden with them, in terms of
intervention goals? It is quite different from public health, to have these restrictions. It has to be an equipment assessment, an environment assessment. You could say DADL [Domestic Activities of Daily Living] or leisure assessment, but for a whole hour you are only to get paid one occasion, and you are just not going to get your stats [statistics: occasions of service provision] up. (FG5)

Co-researchers perceived that their funding organisations’ auditing processes could identify and punish them if their practice went beyond the bounds of the organisation’s criteria. Negative stories that had circulated about past auditing experiences, contributed to the co-researchers feeling as though, other than resigning, there was no option but to comply. At this point in the research, co-researchers’ sense of powerlessness restricted them from seeing other ways to access funding, such as by recording outcome measures linking participation in occupation to health and well-being.

Rights and governing risk discourses

Advocacy for risk taking is overruled.

In the previous section I discussed how co-researchers’ prioritisation systems were influenced by a lack of a mandate and resources to enable occupational justice. I now turn to the influence of a governing risk discourse on co-researchers’ practice. A risk-averse approach shaped co-researchers’ practice both in the hospital and with the other health and human services with which co-
researchers engaged. Indeed, occupational therapists appeared valued for their ability to find solutions by which people could live and participate in the community as safely as possible. Eve said: “I think OTs tend to be associated with an unsafe situation; get the OT in they will sort it out!” (FG2)

Occupational therapists were well regarded for their ability to problem-solve in risky situations, but this also meant that they could be inadvertently co-opted into not supporting appropriate risk-taking. Eve described how she had been asked to work with a war veteran, specifically to assess his safety for independent scooter use. In the course of this work, however, she was also asked to restrict his human rights, consistent with the imposition of the residential care setting in which he lived:

He recently on Anzac Day [an important national Australian day of remembrance for war veterans] took his scooter down to St Kilda and got drunk. He didn’t tell anyone in the nursing home where he was going and he managed to call himself a maxi taxi and get himself home. It was a huge issue for the nursing home. Where did he go? They didn’t know; they had to put in a Missing Persons [report], and get the police involved. And when he returned on his own, their big issue was, “We have a duty of care to you to know where you are” and his big thing was, “My rights as a person, you have to know where I am at all times”. That is his biggest issue, that
he has no rights… He doesn’t have the cognitive function to understand why he can’t go and live on his own, he doesn’t have the insight. But really for his day-to-day activity, he takes his scooter up to Smith St and just window shops. That is how he gets his enjoyment, but if he didn’t have his scooter he would just be sitting still. (FG4)

In this instance, Eve considered it was this man’s human right to make autonomous choices about his participation in occupation. Although the residential care staff doubted this man’s capabilities, it appeared that this man demonstrated a degree of cautiousness in returning in a taxi home. This was consistent with Eve’s assessments of this man as having adequate capabilities to independently access the community.

Eve judged that removal of the scooter could result in occupational risks to this client because it would mean his participation in occupation was unnecessarily barred. Eve appreciated the tenuous line in enacting a duty of care, but her assessment supported the case that this person ought to be afforded this dignity of risk and to be able to use the scooter for community mobility. “Dignity of risk” speaks to the importance of people having freedom of opportunity to enact their choices about participation in occupation. Eve’s non-occupational colleagues did not share her occupational justice perspective:
I’ve had that situation with the man on the scooter and that’s come to a head and I am really feeling outraged about his rights as a person. He had a neuropsychology assessment that was pretty grim. Much of it was very contradictory to what I’ve actually observed him doing. The neuropsychologist didn’t see him on the scooter, they just did the paperwork questions which he didn’t do all that well in. The geriatrician and the nurse take the neuropsychologist’s opinion over my observations which professionally is a bit of an insult… And I think I do feel that if he had a family or someone to advocate for him they wouldn’t be treating him this way, so that’s been a huge issue for me. (I3)

Enablement of occupational justice was constrained when colleagues did not have an understanding or appreciation of the harmful risks to clients’ health and well-being if not able to enact their right to participate in occupation. Compounding this issue was that technical practices were afforded greater value and respect within the hospital. Thus, despite holding strong ethical and empirical grounds for their decision-making and support of people’s risk-taking, co-researchers felt they were not powerful enough to affect the outcome. Joshua said that occupational therapy interventions were considered a “soft kind of option” in comparison to medical treatments and practices (FG2). Occupational therapists were not always believed or listened to.
It was difficult for co-researchers to enable human rights and occupational justice when occupational therapy views conflicted with the views of other, more powerful professionals. Thus, co-researchers were charged with the responsibility to work with vulnerable and marginalised populations and to represent their best interests, yet it felt difficult for them to achieve occupationally just outcomes alone.

**Defensiveness to risk-taking.**

Although co-researchers’ support for risk-taking could be overruled by other staffs’ concerns for safety, the practice of human rights and occupational justice could also be constrained by co-researchers’ own fears of harm befalling a client. Some co-researchers were afraid of attracting the attention of the Coroner’s Court or the field of public opinion. Joshua said:

There are two dominant paradigms concerning the patient in terms of decision-making. One is what my consultant psychiatrist likes to say, “the Herald Sun [a Melbourne-based newspaper] front-page test”. If this ends up on the Herald Sun front-page what would it actually look like? And secondly, the Coroner’s Court concern. The obvious conclusion of that is there is unduly an emphasis on safety and that is exactly the way it is at the moment. More and more, hospitals are becoming concerned with safety and more and more
monitoring and compliance of safety concerns are being used both structurally and clinically day-to-day. (EI1)

Co-researchers described a fervent desire among hospital administrators and in turn other staff and co-researchers to avoid ending up as the subject in sensationalist headlines of a newspaper. As a consequence of this fear, if there was even a slight risk of harm impacting a client then co-researchers would be highly cautious and deny the right to participate. This climate of solicitousness was effectively a barrier to occupational justice; people were denied the opportunity to decide for themselves what they could do or where they could go. Joshua explained:

Every day every person on the unit has a screen for what their risk levels are for vulnerability, abuse, risk to themselves or others, neglect; there is a whole host for a risk assessments every single day. It’s a clinician-led assessment. …The obvious one is what kind of leave they should have if they are under the Mental Health Act. So should they go to family, or should they go on their own? And how long can they go for? How often do they need to be observed if they go to the community? … Therefore what that practice means for a patient and from a rights point of view is that if we are in doubt whether someone is safe or not, those rights will be denied. That’s the bottom line, that’s what’s going to happen. So if someone wants to go and have lunch with his sister and there
was a concern about that we would wait a few more days; they would be denied the right to have lunch with their sister...
So the whole time it takes, the harder it is to advocate for someone to engage in an occupation they have chosen to do, want to do, or are expected to do under the *Mental Health Act.* It is affected by this new risk assessment, which might be necessary but it’s certainly creating a barrier to getting people off the unit, in some ways, at least initially. (E11)

Co-researchers felt they lacked power to effect decision-making about risk in the hospital and the broader institutional contexts within which they worked. The systems of risk assessment operating within the hospital and broader institutions aimed to reduce subjectivity in decision-making about participation. Thus co-researchers found that their judgments about risk (and support for risk taking) were sidelined by the risk assessment measure. Repeated experiences of opportunities being denied to people, acted as a deterrent to future work for justice.

**Dual loyalties: Justice is lost.**
Co-researchers were co-opted into ensuring that clients moved swiftly through the hospital rather than providing the full range of services that could promote an individual’s health and well-being. Joshua explained:
I think the service system still tends to think overly in its own self-interest at times, so not what’s the best outcome for this person is, and how it fits into the context of their life. It’s often framed with the clinicians and services in mind; how do we keep this person out of hospital so they are not blocking up beds? (EI1)

The challenges of enabling human rights and occupational justice were particularly pronounced when the co-researchers worked with people who were admitted involuntarily to hospital and who were legally compelled to receive medical treatment. Joshua felt an obligation to engage the client in “doing occupation”, even though this was not what the client wanted at that particular point in time:

I am working with a man at the moment, he has been in hospital for a while and his psychiatric treatment has kind of failed and there are lots of political issues around that and I have been given the task of giving him some “occupational enablement”. They didn’t say as much but basically they want me to put him on a rehab program to get him more active. The question about enablement that comes up for me is whose enablement is it? The hospital wants him to move on, they want him to be enabled…The pressure is coming from me to enable him but it is not coming from him to enable himself or to work with his own life or towards what he wants to do. So the challenges of then having to report back at the ward round
tomorrow about what I have been doing with him... But it feels like a treatment failure, on our part as therapists as well. The team is going, "I want you to move this patient along". (FG3) Joshua experienced intense pressure to find a solution that could improve upon this man’s health and well-being. However, the task was made all the more challenging because hospital expectations and timeframes for discharge were not compatible with the enactment of client-centred philosophies.

Even though co-researchers considered that they ought not to provide an occupational therapy program for clients against their will, sometimes co-researchers complied with hospital objectives and did what the team wanted rather than what the client wanted. This caused an occupational injustice for people when their right to full participation and inclusion was not realised. Joshua justified his coercion by considering the protective intent of the Mental Health Act:

The involuntary status of the Mental Health Act changes the game a little bit. The doctors are asking me to do an assessment with someone who needs to go home, in terms of are they going to be able to be safe to cook a meal and not starve because no one is going to come and see them for a few days. They [the client] don’t want to do it; they just want to go home. The doctor says, “This is part of your precondition for going home”, and they begrudgingly do it and they are
really pissed off. They do it and 80-90% of the time they are okay, but I always feel uncomfortable about that. This whole thing about in our practice guidelines when we are trained, people’s free will is very important. Working in a hospital, we work and we walk very closely to the edges of that free will, and in mental health we cross over those lines all the time. I find it quite hard to marry the best practice idea, in a sense people really should be coming to us as occupational therapists with ideas of what they would like to do and then we are enabling them, as opposed to us dragging ideas out of them to try and provide therapy for them. I struggle with some of those ideals in the profession and the reality of what we are trying to do. By trying to force it a little bit, which is sometimes what I feel like I am doing, am I then perhaps only doing it half way, or the disenabling if you like. (FG2)

Co-researchers’ loyalty in such instances of conflict was not to the client, but to the hospital objectives of facilitating a fast and safe discharge. Joshua did not speak up about the *Mental Health Act*, even though he was sub-consciously aware that it was potentially violating a person’s right to self-determination. Rather, he complied with the requests of the medical team because he considered he was primarily accountable to the medical team.
This idea of conflicting responsibilities has been described by Physicians for Human Rights (2002) as an issue of dual loyalties. Clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state. (Physicians for Human Rights, 2002, p. 12) Dual loyalties are particularly problematic when practitioners act in support of their employer, state, or other entity and in doing so fail to respect, protect, or realise the human rights of the individual (Physicians for Human Rights, 2002). In the research described in this thesis, co-researchers accepted without question that they were primarily accountable to the hospital (and the medical team that made the referral), and therefore they engaged in practices geared toward medical goals and safety assessment. This inhibited their ability to address occupational issues of inequity or an absence of occupational rights.

Chapter summary

Practice contexts dominated by a medical model and medical spaces were particularly antithetical to enabling human rights and occupational justice, and limited other occupationally just ways of thinking about clients. Fiscal and political controls also meant that co-researchers had to prioritise which people to see; co-researchers were not always aware of how their withdrawal of services
contributed to occupational injustice for their clients. In some instances, co-researchers accepted being told what to do because it secured their funding and positions in the hospital.

In the hospital, concerns about technical risk contributed to a climate of solicitousness regarding duty of care. Co-researchers were frustrated when other professionals overruled their advocacy and support for risk-taking. However, co-researchers also expressed discomfort about their own defensiveness to risk-taking, and their conformist use of safety assessments that were not meaningful and congruent with people’s occupational needs and rights.
Chapter 6

Findings: Taking action for human rights and occupational justice

My third research question concerned actions that occupational therapists could take to more closely align their practices with human rights and occupational justice concepts. Therefore, in this third and final findings chapter, I report on how co-researchers started on the path to transforming their ways of thinking, talking, doing and relating. These changes consisted of actions that co-researchers planned in order to redress problems that had been highlighted by the action research process. There were also some actions taken that had not been planned, but were taken due to changes co-researchers made to their thinking as a consequence of their involvement in the action research.

During the course of the research, co-researchers identified a number of strategies that they could enact to enable human rights and occupational justice. I first present the theme of re-humanising institutional practices; this theme describes the actions co-researchers took to create dialogical spaces to bring clients’ humanity to the forefront of their minds. Second, I present the strategy of creating permeable, participatory spaces, which enabled clients to maintain connection to their community. Third, I present the
strategy of advocacy; this is where co-researchers used the framework and language of occupational rights to enlist colleagues in collaborating for occupational justice.

(Re)-humanising institutional practices.

Re-claiming time for dialogue and stories with clients.

Prior to their involvement in the research, co-researchers had tended to be overly conscious of time pressures; they felt it was unacceptable to spend time talking and telling stories with clients. However, in some instances, there was nothing practical that could be done with clients, other than talking to the client, as one person to another. Kate said:

I was just talking about this guy that I saw who's been on the waiting list for 11 months, who's kind of put his life [on hold], his whole life is devoted to waiting for his liver... But it was a fascinating experience with this guy because I went out and saw him and he seemed relatively keen to try stuff and so I left him pieces of equipment and he then had a bit of a meltdown about the fact that it just made it all the more real to him. I suppose they're very clinical in some ways, which I forget about, to me they're just stuff I work with every day so it doesn't seem that abnormal. But obviously for this guy to suddenly have a shower stool, to see that in his bathroom just made him realise how sick he is. And so yesterday I went and brought it all back again; I think that often all we can do for
these kind of people is just be able to talk to them and listen to what their problems are. You know there’s not much really practical stuff that we can affect change with. (I1) Some people, particularly those who could not get well or who were focused on their survival, had different needs to what might otherwise be assumed by an occupational therapist. For example, they needed to make sense of the situation in which they found themselves.

As they participated in the research, some co-researchers felt an increased sense of conviction that by developing an understanding of clients as unique human and occupational beings; they could develop a fuller understanding of their needs and rights. One way that this could occur was by using dialogue to inquire about a person’s life and current situation.

Co-researchers took action to re-humanise their practice by actively making time to speak with clients, and to learn about their unique needs, interests, problems and injustices. Through her involvement in the research, Eve developed confidence to take the time to go beyond her usual pragmatic and outcome-oriented practices, such as providing equipment. Rather, she used dialogue and stories to engage with her client:

Eve: I had a palliative care client where I was involved; the daughter was caring for her at home until the end. They sent a
really lovely thank you card acknowledging that going beyond just setting up equipment and providing information but sitting down and listening to the patient tell her stories. And sometimes they [the stories] don’t make sense or they are all over the place, but just sort of allowing that time. The family was thankful and sent me a card, which was really lovely. But when I opened it and read it, I thought people are going to think I don’t do any work! Because it was saying “you took the time to sit and hold her hand and listen to her stories, you gave her a kiss on the cheek each time”… The daughter was sitting at the end saying, “I have never heard those stories mum!” I guess the confidence to take that extra time, that extra 30 or 40 minutes’ to feel confident and comfortable that it is still within your role to be allowing that to happen. Instead of going, “Right we have done the bed, we have done this, we have done that; I am out of here”. (FG7)

When Eve made time to listen to a client narrate her life story, the woman was transformed from being a patient who needed to be fixed into a human being with a unique occupational identity. Further, through this understanding of her client, Eve could better enable her client to continue to think and talk about aspects of her life that made it valuable and to create the ways that she wanted to be known and remembered.
Powerful practice stories.

The usual forums for professional development that were available to co-researchers focused on developing technical practices and competency-based learning. Thus, it was not common or routine practice for co-researchers to share their practice stories with other occupational therapists. Usually, discussing practice stories was considered not scientific or evidence-based. In contrast, during the research, I encouraged co-researchers to share and illustrate their practice tensions, issues and achievements through telling practice stories. This opportunity for story-telling within the research group filled a previously unmet learning need for co-researchers.

Matthew: Working in medical-dominated models, we become conditioned to not champion our own success stories… I think this [research] has provided the forum to make people feel safe again to say, “This is what I did with this person, and this is the impact it had on them and their occupational performance, and I think I did a really good job”, and everyone else is saying, “Bloody oath you did!” (I2)

Through sharing stories, co-researchers learned about other people’s lived realities, as well as about one another’s practices that were valuable or helpful for enabling human and occupational rights. Matthew found that listening to other co-researchers’ stories extended his learning and understanding about human rights and
occupational justice concepts in relation to his practice:

I don’t know if anyone else is doing a quality presentation? I have been spending so much time on it, and I can see myself sitting at that quality presentation and being pretty interested in most of the presentations, but I get so much more out coming here and listening to a story like that in however many months. And it doesn’t take nearly as much effort as what we put into the evidence-based practice and quality presentations. (FG8)

Learning about different lived realities and experiences of injustice evoked a passion within co-researchers to make a difference to their clients’ lives. Joshua described how his involvement in the research was “energising” and helped to “re-ignite some of those fires” for working with clients in occupational therapy practice (EI1). Joshua further explained:

I think we are often looking at occupational injustice, I suppose, as opposed to occupational justice. In a sense it is quite a heated term, so I felt comforted by that, the fact that I was getting annoyed, but because of the injustices. Because when we think about justice, it should actually make us angry to a degree, because that then fuels a conversation we can have about, well how do we then channel that? Obviously not to just whinge, but to look at how we can constructively work together to come up with some more reasonable outcomes for
our clients, which is what we are here for. (FG2)

Involvement in the research encouraged co-researchers to apply an occupational justice view, bringing to light the pertinent rights and justice issues that impacted upon vulnerable populations. Joshua found that thinking about occupational justice enhanced his leadership for a collaborative project with which he was engaging with occupational therapy students; the project was about exploring employment opportunities for people with mental illness:

That particular project I didn’t have very much time to dedicate to, but whenever I came to the study it would re-invigorate my ideas about occupational justice, if you like, and so therefore it would help me refine some of the questions I was already thinking about the project. Therefore I think I was probably a better supervisor to the students and was able to advocate more strongly for that… So keeping it in my mind is one and because I can keep it in my mind, I can act on any opportunities that I see if I see through that lens, whereas it might not have been as alive to me if I hadn’t participated in the study. (EI1)

Involvement in the research enabled Joshua to apply an occupationally just “lens”, in which he could then use to critically consider the human and occupational rights concerns and consequences of his practice.
The sharing of practice stories helped to highlight a greater range of occupational injustices. Prior to the study, the co-researchers tended automatically to think of human suffering and injustices that might arise internationally, or for particular minority groups within Australia. However, telling stories enabled co-researchers to see the ways that they had potentially contributed to occupational injustice through their systems of prioritising clients.

Sophie said:

I don’t think I’ve really thought about it in so much depth as we’ve looked at it. I’ve thought a lot about human rights and occupational justice when I think about developing nations and Indigenous communities, but I’ve never brought it back to us in comfortable Melbourne society. And yes, there are a lot of injustices and a lot of poverty but I’d always associated the two together. I’d never really sat back and thought about what are the injustices and the human rights issues about my aged care population? So putting the two together has actually been quite interesting. It’s been quite evident there are quite a lot, especially with who I see on the ward like the ones from low-level care who are much less a priority than the ones from home alone. And naturally I enforce that sort of injustice and say, “well your occupation is not as important as theirs simply because of your home situation”. (I3)

Sophie said that listening to other people’s stories helped “break down what the limits and the boundaries of practice are perceived to
be” (I3). Thus, the sharing of practice stories helped co-researchers to find ways of overcoming practice barriers that had previously inhibited their uptake of occupationally just practice.

Sophie endeavoured to re-define her occupational therapy practice to be more inclusive of older persons, including by educating her colleagues about the broad role of occupational therapy. When drafting up a list of referral indicators for occupational therapy, Sophie encouraged her colleagues to make referrals for people who appeared to have problems with leisure occupations. By challenging her colleagues’ preconceptions about what occupational therapy could offer, Sophie considered she could at least strive to practise in a more occupationally just way:

I did put in there a focus on leisure and accessing the community, a lot more than I perhaps feel like I have the capacity to do, but I don’t want to limit our service and for everyone to not have a really good understanding of what OT is and to think we will only look at shower and dressing and home set-up. I wanted the scope and the capacity of the service to be bigger than that. (I2)

A critical inquiry for supervision.
Through the research, the co-researchers considered more deeply how knowledge informed their practice. By undertaking research activities, such as selected readings and group discussion
about how these readings applied to practice, co-researchers were stimulated to consider how the concepts of human rights and occupational justice applied to everyday occupational therapy practice.

The net effect of this opportunity to engage in critical reflection and debate is that co-researchers began to interrogate the alignment between the theory, philosophy and practice of occupational justice. For example, Harry began to critically consider how voices external to occupational therapy might be absent from the debate:

The theories behind it are coming from people in OT practice… and we are the experts in that occupational field, but is that also limiting of where it can go? In that all our thoughts, and I’m not saying they’re all exactly the same, but they’d be very similar coming from a similar sort of thought process. (I3)

Harry was further concerned that the development of occupational justice theory was motivated by occupational therapists’ pursuit of political goals and power, rather than by the desire to enhance the health and well-being of people with whom occupational therapists worked:

It’s almost like we’re insider trading almost. We’ve got knowledge in an area and we’re pushing that area, which is great… but are we doing it to increase the profession’s worth
and the profession’s respect and all those things or are we doing it for trying to increase human rights and occupational justice? Or is there a bit of half-and-half; are they influencing one another? (I3)

Although this reflection and dialogue raised for Harry some uncertainty about how and why and the theory of occupational justice had been developed, co-researchers nonetheless wanted to create conditions where this kind of critical inquiry about occupational justice (such as engagement with theoretical concepts, open discussion, practice-based stories) was shared beyond the research group. Some co-researchers took action to create spaces within supervision in which they could continue to explore and promote this critical reflection and engagement with theories of occupational justice. Harry considered that foregrounding occupational justice in his own supervision and in his supervision of others could enhance its clinical application.

As a consequence of their involvement in the research, some co-researchers made changes to their supervisory arrangements. They wanted to receive and provide supervision that was more critical and participatory in nature. As well as making human rights and occupational justice the subject of inquiry, Kate enacted a plan to change the structure of her supervision so that it was carried out through reflective group conversations, rather than through individual
relationships:

That is something that we have been discussing with the grade ones, the advantages of having a reflective practice session in a group; just the grade ones in our stream, not necessarily across the board. Perhaps just to take that focus away from that one-on-one, and them feeling like we are watching over their shoulder. The benefit of learning from each other more than anything; you know, bring along something good you have achieved in the past couple of weeks and something you have struggled with. And if everyone just shares that then that is a good opportunity for learning. (FG7)

It was the view of co-researchers that a group format for supervision would enable both supervisors and supervisees to speak about and contribute their ideas for enabling occupational justice. Kate’s insights were that group reflection might change the usual supervisory arrangements that could be overly controlling and that may have resulted in supervisees conforming to supervisors’ ideals. Indeed, group supervision may be conducive to enhancing understandings of human rights because it allows for extensive dialogue and diverse views to be expressed and for the supervisee to actively partner with the supervisor in the production of knowledge (Ife, 2012).

Importantly, in making this practice change, Kate consulted
with the colleagues she was supervising about the nature of these proposed changes. Kate’s strategy of collaboration embodied a genuine respect for the people she was supervising as active co-researchers in the education process; she did not assume greater power and control in implementation of the changes even though she was a more experienced occupational therapist.

Permeable, participatory spaces.

Home: An enabling place.

Prior to the research, some co-researchers were reticent to do home assessments due to the tendency for them to be completed in a repetitive, routinised, and reductionist way. However, after involvement in the research, co-researchers took action to use clients’ homes home to more broadly access information about a person’s capabilities and resources for participation. This way of learning about clients could then assist co-researchers in knowing what to do in order to support people’s rights for participation in occupation.

When co-researchers visited clients in their homes, the visit helped to highlight the clients’ occupational needs, which then assisted the co-researchers to identify if occupational injustices were occurring. Occupational spaces in the home and community were viewed as more revelatory of people’s everyday lives, personalities,
triumphs and challenges. Eve said it was possible to see the “true person”, and how he or she was coping (FG1).

The home was an enabling place that assisted co-researchers to develop knowledge of clients as unique occupational beings. Through this fuller understanding, co-researchers could then take action to enable occupational justice. A home visit made it possible for Matthew to enable occupational justice for a man with cancer and resultant spinal cord compression; the client was described as being “desperate” to be discharged home. The client himself was unable to attend the home visit due to his high physical care needs.

Matthew: I did go out to his place and his wife’s, not to go through the motions but I suppose I used it as an opportunity to talk more to his wife one-on-one and get to know more about her a little bit more and get to know about him, and their relationship and all of the factors that were impacting on that… We found out from going to the house the one thing he wanted to do was just get his affairs in order and get all of his documents together. He had a real colourful life and life history and basically he had this enormous table half the size of this room with piles of his documents, which were anything from the original plans to his house to the extension he built, to the first car that he bought, to the crane that he’d bought when he was still in his twenties and all these sorts of things, and that was the main reason why he wanted to go home.
because he wanted to tie up those loose ends before he died.

(I3)

In this story, visiting the home made it easier for the family to voice their concerns about this man’s occupational needs. It also assisted Matthew to problem-solve solutions whereby he could best support his client’s participation in valued occupations; that is, the home visit helped Matthew to work for occupational justice for his client. For example, Matthew enlisted his client’s family to bring in the man’s material belongings so that he could carry out his desired occupation of putting his affairs in order, on the ward.

**Bringing the community inside.**

Institutional and clinical measures to promote safety had the effect of restricting people’s participation in the hospital; even the right to privacy during personal care was usurped on the ward. Rather than accepting the prolonged occupational disengagement that a stay in hospital can create, co-researchers took action to make the hospital more permeable to the outside community. Audrey considered that enriching the hospital with opportunities and choices for individual and collective occupational participation was a way that she could enable clients to experience self-respect and human dignity:

> It is a hard environment to be in promoting individual rights and social justice, just given the setting. So I have looked at other rights, which can be addressed, and that don’t need a
doctor’s sign-off. The group program, [is focused on] the right to be engaged, the right to have opportunities, the right to resources, the rights of people if they are well to get them out of that setting into a different environment. (I3)

Conceptualising the hospital as a permeable institution, as it is framed in sociological literature, is helpful for understanding the actions that co-researchers took to better link the hospital with the community. For example, in Asylums, Goffman (1961) identified permeable features of old mental hospitals, even though his focus was on the predominantly impermeable aspects of these settings. Goffman defined permeability as the degree to which the social standards maintained both within the institution and outside in society have influenced one another.

Audrey developed a group program that enhanced opportunities for people to engage in occupations they might usually do if they were not hospitalised, for example, art, music, and visits to the gymnasium or café. Without this act of enrichment, Audrey’s clients might otherwise have had lesser opportunities to participate, which from an occupational justice view, presents risks to the experience of health and well-being.

To support the group program, Audrey developed partnerships with her multidisciplinary colleagues. In particular, she
successfully lobbied the ward manager for a new nursing position, and she co-facilitated groups with a dietician and a chaplain. Audrey also partnered with a variety of community services that were prepared to come inside the hospital. For example, she organised visits to the hospital from a pet service, a reflexologist, and a major hardware company. This enabled people to access, from the hospital wards, “different occupational experiences and different perspectives on health and well-being” (FG9).

Audrey aimed to provide genuine opportunities for clients’ to take control and exert autonomy for decision-making about the group program, such as in the purchasing of resources and development of norms for group behaviour. The benefit of enabling clients’ active participation was illustrated with one of Audrey’s clients, who initially had no vision of his future possibilities, but who upon discharge had plans for where to live and what to do for work:

He has been on the unit for probably 8 weeks; he was not at all depressed but very suicidal that the world had failed him. He put his arms up and said, “Try but I doubt you can help”. The whole time I have been working with him quite consistently and most days I spend some time with him, just acknowledging him and building rapport, and trying to get him to do things and take responsibility for doing things. He helped with the barbeque and he runs movie nights and making him make choices even when we go and get food I say, “No, you
pick what we need. No, get what you want”. Then pushing him a bit further and being a bit decisive and saying, “Well you are going to be going home so what are you going to do with your time?” (FG8)

Audrey considered that by making the hospital more permeable to the community outside, she could enhance people’s choices and opportunities for participation in occupation, and possibly build their capabilities for transitioning to community life.

**Partnering with clients and families.**

Prior to the research, the co-researchers struggled to see how they could possibly meet the occupational needs of all people accessing their services, and therefore they prioritised their services for people taking leave or being discharged home. Through their involvement in the research, co-researchers developed awareness about the inequities in access to occupational therapy, and they took action to empower people who had previously received no service, by providing information and orientation so that they could implement occupations themselves.

Matthew took action to informally meet each week with one to two people who would otherwise not have received occupational therapy, and who he considered might otherwise be at risk from not knowing how and where to participate in occupation at hospital. So as not to spread his occupational therapy services too sparsely,
Matthew had additionally to identify ways that he could efficiently meet people’s human and occupational needs. Matthew adopted a strategy of partnering with individuals, families and volunteers, showing them the possibilities for enhancing various forms of participation:

One thing that made my mind start to tick over, was about not only some ways I can better enable these people to participate in their chosen occupations before they die, but how can I do it logistically and how can I do it without staying back to 6.30pm every night; because I don’t think there is any point in doing it if I am just going to burn myself out by staying back to see people… One very concrete example I am keen to try and do is to get people in a wheelchair or if they can walk outside in the grounds looking at the trees, flowers, birds and whatever else tickles their fancy. I have done this for a fair few people of late and almost what I have been doing is graduating their family member or carer to be able to do it. Often their family might be, “What if something happens to them?” So grading the experience by going down there with them and then maybe just a volunteer going down there with them and then them going down there by themselves. (I2)

Matthew empowered his clients and their families with knowledge about suitable places for occupational participation within the hospital, both on and off the ward. By sharing his professional
knowledge and expertise, he helped clients and their families to understand the different occupations that they might want to do in the hospital. Thus, enabling a greater sense of autonomy, an important aspect of one’s human rights.

Advocating for human rights and justice.

Developing autonomy.

Early in the research, the co-researchers felt powerless to implement their ideals of occupational therapy practice because they felt they had to comply with the controls imposed by their funding organisation over their practices. However, through their involvement in the research, co-researchers became more conscious of how their overly conformist behaviour might impede human rights. Therefore they decided to take back some control about deciding which practice actions they ought to take.

Olivia: As an OT you shouldn’t worry about money, you should be worrying about what the clients’ needs are, but I guess you get into that habit... And I walked away [from the focus group] and thought, we used to have a psychosocial aspect at our service, which we don’t have any more, but the OTs who worked in that area used to do a lot of things about structuring time and getting people out and about. I sat down and thought, we do have the capacity to do that with our clients and that all comes under your DVA [Department of Veterans’
Affairs] funding. So perhaps I need to think a bit more positively and broadly. (I2)

Through adopting a more critical perspective towards their practice, the co-researchers were sometimes able to better consider how they had been encultured into accepting dominant ideas and practice hegemonies operating within the hospital. Olivia learned that it ought not to matter if the cause of occupational disengagement for her clients was physical or psychosocial factors.

The co-researchers encouraged one and other to take action to develop greater autonomy in their practice. At the end of the study, Eve felt more able to justify her practice that improved her clients’ quality of life. She had more confidence to speak up about her reasoning and the need for funding to enable human rights and occupational justice. In essence, Eve tried to use the language of occupational rights to access funding, rather than through framing it in more general quality of life terms:

I’ll now see him every second month doing the formal assessment of scooter skills, and in between doing it in a social setting. And now I can justify that as saying, “This is an occupation for this man and yes we are going down the street and he’s having a coffee and a sandwich but there’s all these other aspects I’m able to see and I know it’s meeting one of his needs”. You’ve got to be able to pull it apart and look at those more clinical descriptions; I couldn’t just say, “I’m sitting
down and having a cup of coffee with him”. So I think having participated in this course [research] I can now feel more confident to say this is what I’m actually doing and even introducing the language of participating in social occupation because that’s important to him... Because of the way that I’m breaking it down more, it’s a justification on pen and paper and into the file so that when DVA are looking at it I’m able to justify it in those clinical terms where maybe I wasn’t as confident to do that before. So it’s a change in confidence. It’s not a change in the DVA rules, this is a change in the way in which I’m applying their rules. (I3)

Having an awareness of the hegemonic practices at play in their practice, enabled co-researchers to become more conscious and considered of the different possibilities for their occupational therapy practice, including how to use language to advocate for funding bodies to embed a focus on occupation.

**Putting human rights in real, occupational terms.**

Prior to the research, it was difficult for co-researchers to show their colleagues that an occupational view was as important as a medical view. They relied upon informal conversations with team members to advocate for human rights and occupational justice. However, through their involvement in the research, the concept of human rights and occupational justice became prominent in co-researchers’ thinking in the context of everyday practice.
Matthew: I probably wouldn’t say that it has vastly changed my practice, because I would like to think that I err on that side anyway. But it has definitely helped me to articulate it better, and make what seemed like a distant connection a lot closer connection between my everyday work and human and occupational rights. (I2)

Having developed more confidence and skill in identifying occupational injustice, the co-researchers were able to improve their ability to speak up publicly for clients’ rights and needs, and to help their non-occupational therapy colleagues to understand why taking risks was sometimes vital.

Matthew: Prior to being involved in this [research] I went about doing a similar sort of thing, advocating for a patient and getting them home when the majority of the team thought that it was not feasible and not safe. But I suppose I didn’t challenge doctors and other team members enough in our case conferences and in our discussions. I would sit back a bit and say my piece and then usually after the meetings grab her, her and him [colleagues] and say “This is what the doctor thinks and this is what we are going to do”. Now I have really taken a more active approach in trying to advocate for more choice and more decision-making power towards patients and families in our team and trying to highlight the benefits of them. (FG10)
Matthew developed confidence to advocate for a particular client’s occupational needs because he identified that speaking up for his client was promoting occupational justice:

He is a young guy, he is 32, he has had an awful, awful thyroid cancer, which unfortunately spread to his cervical spine and he is now a C5 incomplete quad [quadriplegic]…We were talking about Father’s Day, which is coming up and this person turned to me and said, “All of this stuff we have been doing to try and get me home, I would be more than happy to be lying at home in a bed and the only thing I want to do is to be able to help my children with their homework, and to hear my daughter read out her reading things”… So using that verbatim about what he had said about what were his occupational goals, the role of being a father, the occupation of helping his daughter with her homework. Nothing else really mattered to him, he was willing to forgo any other risk or danger or hazard to be able to do that. We got him home last Friday and he has been home for a week. I have just been speaking to one of the nurses who has been visiting him, and he is doing really, really well. I remember using those words in our meeting: “His main goal is to be a father to his daughter, and he didn’t say it out loud, but ‘to be able to help my kids out with their homework for the last time before it’s too late’”. The whole team went, “Wow, that’s pretty powerful”. It was putting
his right to be able to do that in everyday real occupational way. The right was for him to make the decision to go home, and us not to stop him and not to say you are not safe to go home. And instead of him just being, “I want to go home, I want to go home”; myself and another member of my team being able to tease that out and put it in real term, a real way I think. (12)

In this case, Matthew helped to illuminate the context influencing this man’s choices about participation in occupation. According to Ife, a human rights framework can enrich and contextualise ideas of needs and justice and therefore make them more useful for applying in practice. By more closely examining the rights that lay behind another person’s claim to rights or need; professionals can assign priority to meeting that need (Ife, 2008). Ife proposed a human right may be defined by applying means and ends questions to a statement of right (or need) until the inquiry reaches a point when the moral right in focus becomes a condition of “being human” or something similar. Thus, Matthew’s colleagues were able to see what needs and rights lay behind this man’s decision, rather than dismissing it as a request that was not feasible to support. He put it in terms that any human being or professional could understand.

**Speaking up about unfair use of professional power.**

Participation in the research sparked a realisation among co-researchers of how hospital and team practices could be overly
controlling of client’s lives, and this resulted in co-researchers taking a more proactive stance in speaking up about the unfair use of professional power. Joshua shared this practice story about a client with mental illness who had been admitted involuntarily:

He couldn’t go back home because he trashed the family home. He wasn’t talking to anyone except the doctors and that was only about his treatment. He didn’t talk about going home or talk to his parents so the only way to engage him was actually by what he wanted to do, which was return to study in the new semester… So I think that the study reminded me the power of the motivating force of occupation and after all things [other treatments] had been exhausted. He had been read the riot act many times, he was told by the [hospital] system “you can’t study, we are going to write a letter to Melbourne University and say we strongly recommend that you defer your studies until next year”. If the doctors had done that here, the university probably might have pulled the plug on it. If they had of pulled the plug on this young man, he might have had 9 months, who knows where, with nothing to motivate him. His whole life is built around this idea that he might finish a university degree. So as an OT advocating for his rights to study and saying, “this is almost a stretch of the Mental Health Act in terms of someone’s right to participate in activities. Treatment doesn’t mean you can control all aspects of his life”. (E|1)
In some instances, co-researchers enabled human rights and occupational justice by showing their colleagues that misapplication of legislation could lead to breaches of human and occupational rights. From Joshua’s perspective, the team was trying to use the Mental Health Act to enable them to have power over medical care and in doing so they could have infringed on the human rights of this client. Because Joshua spoke about the tensions in this case, his colleagues were able to arrive at a decision that was different from the one they would have made if only the medical issue was considered.

[The research gave] a way of articulating it within the framework of rights. And I was talking about it to some colleagues and feeling a bit despondent about the whole case and they are going to take this guy’s rights away and I started thinking hang on a sec, does the Mental Health Act in enforcing treatment for the person who is at risk to themselves or others, does that necessarily extend to someone’s choice to have education, even if we disagree whether they should do it or not? So that ethical dilemma could be brought to the ward round where it wouldn’t have otherwise… So without the reminder of those rights and the discussion about the rights and the reminder of occupational focus it wouldn’t have given the language therefore to have the discussion… I suppose in a medical system it’s very difficult to be the lone voice about
certain issues, it is a very lonely position. Unless you are very strong in the position and have power in the position you are likely to let it go, conform, otherwise there is potential for bruising. That was a good outcome; it was a big win for OT there. They took it on board. I basically took the case on and liaised with all the relevant parties to make it happen and he got out the door. It was great. (El1)

Acting without the client’s consent would have created an occupational injustice by marginalising him from decision-making about his life and participation in desired occupations. Increased knowledge about human rights and overt use of human rights language strengthened Joshua’s capabilities and conviction to advocate for a different, more occupationally just, view.

Chapter summary

In order to enable human rights and occupational justice, co-researchers realised that they needed to go beyond their usual practical and outcome-oriented practices. Instead, co-researchers listened to clients define their needs and tell their stories, and they were more responsive to enabling people’s needs to be. As the benefit of thinking with and about stories became clear to co-researchers, they also used this strategy in their supervision processes.
The hospital ward became more occupationally inclusive by making it more permeable to the usual kinds of occupations that are available to people in the community. Co-researchers collaborated with clients, families, management and service providers from the community to re-make an occupationally just space within the hospital context, reducing occupational exclusion and separation of clients from the community.

Co-researchers were empowered through the framework of rights and justice and used this language to advocate for their clients’ occupational rights. They shifted from private, informal forms of advocacy, to the use of public group discussions and deliberation with their multidisciplinary colleagues. Thus, helping to expand the kinds of occupational rights that were valued and supported within the hospital.
Chapter 7

Discussion: Creating spaces for human rights and occupationally just practice

This research provided participating occupational therapists with an opportunity to engage in dialogue and critical reflexivity about the concepts of human rights and occupational justice. In applying the work of Ife (2012) in particular, I rejected a positivist view that human rights exist in an objective form that can be uncovered through scientific inquiry. Rather, I took the approach that Ife advocated, which is that human rights (and occupational justice) should be constructed through human interaction and dialogue about what the parameter of shared humanity ought to be.

In this chapter, I first discuss the overall finding that emerged from the discursive approach taken in this research. This finding is that the co-researchers created participatory occupational spaces for enabling human rights and occupationally just practice. I then use the model for the process of creating occupationally just practice as a means by which to organise and discuss the research.

The process of creating occupationally just practice

In conceptualising how the co-researchers transformed their practice conditions to become more enabling of human rights and
occupational justice I use the idea of “creating participatory occupational spaces”. I have used the work of other authors to provide a stimulus for the development of my ideas. According to the geographer David Harvey (2001), space, or space-time (which is historically situated), is a dynamic construct that is always active and in motion, rather than a static or passive frame. Space is not only a material construct; it can be “mental” or “imaginary”, where people consciously consider and explore other alternative possible worlds and ways of being (D. Harvey, 2001, p. 224).

The idea of space is inherently related to the idea of place. D. Harvey (2001) argued that continuous space is “carved up” into particular regions, territories or places that are defined by special qualities. In some instances the boundaries of a place are clearly demarcated, yet in other examples parameters are left ambiguous or undefined (D. Harvey, 2001, p. 225). The geographer Yi-Fu Tuan (1977) focused on how space and place are experienced. Tuan contended that space is experienced through qualities such as openness and freedom, whereas place is felt as intimate and familiar. Importantly, “from the security and stability of place we are aware of the openness, freedom, and threat of space, and vice versa. Furthermore, if we think of space as that which allows movement, then place is pause” (Tuan, 1977, p. 6).
Some occupational scientists have conceptualised ideas of space and place in occupational terms. For example, Hasselkus (1999) used Tuan’s (1977) conceptualisation of space and place in her research about how staff experience occupation in day care settings for persons with dementia. Hasselkus defined occupational space as “an experiential space within which occupation occurs”, and occupational place as an “experiential place that exists during engagement in a particular occupation” (1999, p. 78). Hasselkus theorised that through partnering with and doing occupation together, an occupational therapist and a client make an occupational space into an occupational place.

Rowles (2008) argued that occupational therapists have a responsibility to enable people to transform the space and the various circumstances in which they find themselves into a place that can facilitate discovery and enhance meaning. Johansson et al. (2013) further argued that taking an occupational perspective can enhance understandings of “place-making”, that is, how “everyday doing is drawn upon to create and continuously negotiate place” (p. 7). I found in this research that co-researchers did take action to enable clients to re-make place through doing occupation. For example, co-researchers enabled clients to be and to find meaning through the telling of stories, rather than through usual practices geared towards practical and outcome-oriented interventions. Thus I agree with these occupational scientists that the idea of place-
making has merit as a way of enabling clients, through occupation, to proactively participate and create environments that enhance their health and well-being.

Although I have briefly touched on the relevance of the making of place to the research described in this thesis, I particularly draw attention to the process of creating or opening up of spaces for occupationally just practice, that is, to space-making, rather than place-making per se.

To discuss this idea of creating participatory occupational spaces, it is helpful to contrast the idea of spaces for occupationally just practice with Hasselkus’s (1999) conceptualisation of occupational space. Broadly speaking, the spaces created by the co-researchers were not limited to doing occupations in cooperation with an individual client for the purpose of developing meaning, as was characteristic of Hasselkus’s (1999) framing of occupational space. Rather, in this research, the co-researchers created and opened up spaces that allowed the participation of groups, families, colleagues and members of the community. In addition, these occupationally just spaces served two linked goals: firstly, in the process of enabling human rights, co-researchers were able to see their clients as fully human; secondly, in the process of enabling occupational justice, co-researchers enabled their clients’ rights to participate in occupation. Thus, the spaces created were geared towards meeting people’s
human needs and occupational needs. They therefore were not only “occupational spaces” but “enabling human rights and occupational justice spaces”.

I found that the making of occupationally just practice required the creation or opening up of particular kinds of spaces. However, it is possible to criticise this idea, given that space exists in a continuous form (and therefore it is not possible to create space). Therefore, I contend that the idea of a negative space as put forward by Kemmis and Mutton (2012) has resonance for understanding how space was opened up:

Actions and interactions that constitute practices are shaped by “mediating preconditions” that are like the living forest around the earth under a path, in relation to which the path is a kind of “negative space” – a space opened for the practice of walking through it. (p. 193)

I found this metaphor of a path useful for conceptualising the kind of journey of transformation that the co-researchers undertook during their involvement in the research. Early in the study, the co-researchers did not always see the path for enabling human rights and occupational justice. They felt that they lacked the power or the room to act in accordance with their ideals for occupational justice. This was therefore a space that needed to be excavated out of their usual practice. Significantly, the research appeared to enable the co-
researchers to imagine and envision what practice might be. To this end, co-researchers looked beyond the clutter of their context, and were able to see some open space and new ideas for enabling rights and justice in their everyday practice. The concept of what constituted occupationally just practice became more clearly defined to co-researchers. In achieving this realisation they created a new path in which they started to transition to occupationally just practice. Once created, the co-researchers “walked the path”; that is, they practised new ways of thinking, saying and doing as occupational therapists. Practice became more spacious and free, because co-researchers were able more fully to occupy the space that they had carved out for enabling human rights and occupational justice.

The first step: Understanding the context and conditions of practice.

Alignment with Australian human rights culture and utilitarian values.

In thinking about the nature of occupational injustices in Australia, the co-researchers initially considered that injustice was a problem that was relatively confined to particular groups of Australians. The finding that the co-researchers sometimes had a narrow view of who was affected by human rights is consistent with the proposition of Briskman and Fiske (2008) that Australian framings of human rights tend to denote rights as belonging to marginalised
groups. Thus, the co-researchers’ beliefs that human rights affected some but not all Australians were consistent with broader Australian views about who was affected by human rights.

A perception shared among many of the co-researchers was that breaches of human rights happened in places other than in Australia. This finding is consistent with other, broader Australian community perceptions. The National Human Rights Consultation Committee (2009) found that Australians associated human rights with places governed by dictatorships, rather than concerning people in ordinary circumstances. In a community consultation process, the Victorian Equal Opportunity and Human Rights Commission (2011) found that Australian citizens generally considered alienation from economic, social and cultural rights to be more of a concern for other countries rather than for Australia.

The co-researchers generally considered that Australians’ human rights were adequately protected through the provision of public services and existing safety-net mechanisms in Australia. Indeed, many Australians believe that responsibilities for meeting human rights belong to government organisations, systems, parliament, courts and so on (Briskman & Fiske, 2008). For example, Australia’s health insurance scheme, Medicare, which was designed to promote equal access to public health care, rates highly in terms of satisfaction within the Australian community (Duckett, 2007).
Similarly, the co-researchers trusted that Australian governmental institutions, including the hospital in which they worked, naturally upheld human rights.

The co-researchers’ view of Australia as a relatively free and wealthy country compared to nations elsewhere may have prevented them from recognising their own country’s injustices. The Victorian Equal Opportunity and Human Rights Commission (2011) found that many Australians experienced this inability to see injustice; this is because people’s understanding about the adequacy of human rights protections in Australia tends to be instinctive or based upon personal experience of their rights being breached. Therefore, the finding that the occupational therapists could not see injustices affecting other Australians is not surprising.

The co-researchers’ levels of understanding of and commitment to human rights appear representative of a lack of a well-developed human rights culture in Australia. A human rights culture is one in which “the essential humanity of all human beings – those like us and those not like us, is recognised and valued” (Briskman & Fiske, 2008, p. 66). In an established human rights culture, people can see themselves as “rights-holding entities”, and this in turn enhances people’s ability to assert their rights and respect the rights of others (National Human Rights Consultation Committee, 2009, p. 151). The National Human Rights Consultation Committee
(2009) found that Australian citizens knew little about the constitution of human rights, including what they are, where they come from, and how they ought to be protected. At the beginning of the study, consistent with those wider Australian experiences, the co-researchers lacked knowledge and understanding of human rights.

The concept of a “fair go” and equality for all is a distinctively Australian idea that may reflect typical Australian conceptualisations of how human rights ought to be enacted. When considering what was just and unjust, the co-researchers tended to rely upon their sense of what was a “fair go” to guide their decision-making. For example, on occasions the co-researchers restricted their provision of occupational therapy in order to be able to assist the greatest number of people needing help. They wanted as many people as possible to have a fair go at receiving therapy if it was needed. The co-researchers’ response is consistent with the widespread acceptance of the concept of providing a fair go in Australia (Byrnes et al., 2008).

Australian cultural traditions and values may, however, be problematic because they can limit understanding within the community about the human rights system. Byrnes et al. (2008) asserted that the lack of national human rights law “illustrates how thoroughly Australians have been persuaded that the discourse of human rights is contrary to traditions of mateship and the fair go, and
that human rights are a form of special pleading out of place in an egalitarian society” (p. 139). Thus, these beliefs may create a situation in which individuals need to speak up about their experience of injustice rather than accept interference upon their rights. Other Australians might perceive public voicing of one’s claim to human rights as an undesirable attribute:

There is something attractive – even noble – about Australian political utilitarianism with its attachment to the values of parliamentary sovereignty, equality, fairness, and its concern for duty towards others, collective wellbeing and substantive prosperity. Conversely, rights talk, particularly rights talk that makes absolute trumping claims, can seem inflated, inflexible, overly individualistic and even shrill. (Chappell et al., 2009, p. 23)

The findings of the research described in this thesis was consistent with the view that human rights discourse is not necessarily in keeping with Australian cultural values of a fair go and equality for all.

The co-researchers considered it problematic that rights were given emphasis and responsibilities were underplayed in the hospital. Understating the importance of responsibility limited clients’ active participation in therapy, and it also had the effect of reducing practitioners’ responsibilities to take clients’ claims seriously. Other Australian citizens have also raised concerns that an emphasis on rights without responsibilities might create a situation where people
are self-centredly focused on rights without thinking of their responsibilities to others (National Human Rights Consultation Committee, 2009). Baroness O’Neill (2002, cited in National Human Rights Consultation Committee, 2009) asserted that a discourse about human rights has less of an agentic emphasis than that of responsibilities:

The underlying difficulty of any Declaration of Rights is that it assumes a passive view of human life and citizenship. Rights answer the questions “What are my entitlements?” or “What should I get?” They don’t answer the active citizen’s question “What should I do?” (p. 63)

Co-researchers did not automatically consider the full range of issues that could create occupational injustice for their clients, and the net result of this was that co-researchers unconsciously engaged in discriminatory practices. Other authors have also described evidence of occupational therapists not being sensitive to diversity and thereby creating barriers and discrimination. For example, Kirsh, Trentham, and Cole (2006) undertook phenomenological research in Canada with 14 clients who nominated themselves as minority group members. Kirsh et al. found that the clients perceived that their occupational therapists did not view them as cultural, sexual beings with many layers of identity and differing experiences of injustice. Thus the clients felt invisible, and this was considered to be an indirect form of discrimination. Fitzgerald, Mullavey-O'Byrne, and
Clemson (1997) explored cultural issues shaping occupational therapy practice in Australian metropolitan health settings and found that although occupational therapists had little difficulty identifying cultural issues in practice, some therapists lacked a depth of understanding, which restricted them from bridging cultural differences in practice. Thus, whether or not occupational therapists see occupational issues or injustices, they may need to acquire greater awareness about the influence of their own Australian cultural and professional values on practice.

In some instances, discriminating practices were reinforced by co-researchers’ utilitarian values. I found that in foregrounding a utilitarian view, the co-researchers tended to sacrifice individual rights for the greater good, such as when they chose not to provide occupational therapy to older persons transitioning to residential care so that they had more time to give to a larger number of clients. I found that utilitarianism particularly influenced the co-researchers’ initial understanding of justice. This is consistent with a grounded theory study of occupational therapists in Canada by Freeman, McWilliam, MacKinnon, DeLuca, and Rappolt (2009), who found insufficient therapists for the number of clients requiring services. In such conditions, therapists’ practice reflected the goal of doing the best they could, such as by reducing services to individuals so that all could have their needs met (Freeman et al.). While utilitarianism is one ethical theory that occupational therapists may employ to guide
decision-making about resource allocation in everyday practice (Barnitt, Warbey, & Rawlins, 1998; Van der Reyden, 2008a), there is limited research about how various cultural groups within occupational therapy allow utilitarianism or other ethical theories to influence their decision-making.

Other authors have theorised that utilitarianism may thwart occupational justice by obscuring individuals’ differing needs for occupation and justice. In research exploring issues of sexuality and occupational justice with men with spinal cord injury, Sakellariou and Simo Algado (2006) opted to use an analytical framework informed by occupational justice. They contrasted occupational justice to utilitarian framings of justice that encourage comparisons among and between people in order to do what was best for the majority (Sakellariou & Simo Algado, 2006). Nussbaum (2001) similarly argued that utilitarianism “tends to think of the social total, or average, as an aggregate, neglecting the salience of the boundaries between individual lives” (pp. 218-219). I agree with these authors’ views; when a solely utilitarian framework for decision-making is used, the needs of individuals may be overlooked. Indeed, not only might opportunities for enabling occupational justice with some individuals be missed, occupational injustice may be perpetuated for others if in providing a service to more people, it results in an ineffective or poor quality of occupational therapy.
Justice is not a shared ideology.

I found that co-researchers, individually and collectively, held visions for an occupationally just society in which all people equally ought to have “opportunity to do” and it was the role of occupational therapists to enable this vision to come to fruition. Co-researchers’ visions for human rights and occupational justice have commonalities with the Capabilities Approach developed by Nobel prize-winning economist, Amartya Sen (2009) and philosopher Martha Nussbaum (2011). In the Capabilities Approach, the more freedom people have, the more opportunities they will have to enact their capabilities; a person may be less advantaged if he or she has less capability, that is, less opportunity, to do activities or to be in ways that are of value to that person (Sen, 2009). Nussbaum (2010) specifically listed ten central entitlements as a minimum of what justice requires: life; bodily health; bodily integrity; senses, imagination and thought; emotional health; practical reason; affiliation; relationships with other species and nature; play; and control over one’s environment. In the Capabilities Approach, it is the responsibility of government and its institutions to create and protect “contexts of choice”, which are places where people can be free to function in the way they would like to do or to be (Nussbaum, 2011, p. 29). In the early phases of the study described in this thesis, co-researchers similarly considered that it was their role to act for human rights and occupational justice by enabling contexts in which people lived and participated; however, they were uncertain as to how to implement
this vision in practice. This provides empirical support for the theorised relationship between occupational justice and the capabilities approach, both of which are concerned with how one acts in the world (Stadnyk et al., 2010) and with an entitlement to realise occupational possibilities (or ways of doing that are viewed and promoted as ideal and available in society) (Townsend, 2012).

Even though co-researchers held values and visions for an occupationally just society and practice, they tended to consider that this was not characteristic of their local Australian occupational therapy practice. Co-researchers doubted that their occupational therapy colleagues were united in their values about human rights and occupational justice. The finding that a focus on occupational justice was not an explicit professional value has both similarities and differences with two linked nation-wide studies exploring the professional values of Australian occupational therapists. In the first study, Aguilar, Stupans, Scutter, and King (2012) used interviews to explore 15 experienced Australian occupational therapists’ constructions of their professional values. Among the 25 values that emerged, human rights/justice was not an explicit professional value (Aguilar et al., 2012).

The qualitative data and findings that emerged from the study of Aguilar et al. (2012), were then incorporated into a Delphi questionnaire for a second study by Aguilar, Stupans, Scutter, and
King (2013) with 68 occupational therapists. Occupational therapists were asked to rate their level of agreement with the professional values listed in the questionnaire. Aguilar et al. (2013) found 61 professional values that occupational therapists considered to be essential for practice, including human rights (82% consensus) and fairness and equality for clients (81% consensus). In this research, I similarly found that co-researchers unconsciously or implicitly held values for human rights and occupational justice, but until they consciously focused on these values, the values did not develop into a guiding professional ideology or identity.

The co-researchers of this study appeared to consider that technical and instrumental goals, rather than goals in the pursuit of justice, were characteristic of what many occupational therapists do in Australia. Indeed, Australian research by S. Griffin and McConnell (2001) found that acute hospital practice was characterised by highly focused occupational therapy practices that could be implemented in a short period of time, such as initial and self-care assessments and discharge planning. Such practices do not take into account differences in people’s needs and rights for inclusion and participation in occupation. In interviews with people who were dying and their carers, Keesing and Rosenwax (2011) found that Australian occupational therapists focused on meeting physical needs, such as through equipment provision and discharge planning; however, these practice actions did not satisfy or support people’s human and
occupational needs. This kind of overly standardised and instrumental focus in practice is not consistent with an occupational justice approach. This is because as distinct to (distributive) social justice concerns for people to be treated as fair and equal, occupational justice takes into account differences in people’s life context and circumstances, through enablement of different opportunities and resources in support of people’s participation in occupation (Whiteford & Townsend, 2011). Thus, there appears to be a lack of emphasis on human rights and occupational justice in Australian occupational therapy practice.

The findings from the research described in this thesis challenge the view of Townsend (1999) that the occupational therapy professions in Canada and Australia, through a shared Commonwealth heritage and history of publicly funded health, educational and social services, experience similar barriers and opportunities for enabling occupational justice. The co-researchers’ general perception was that the narrow technical approach in Australia contrasted to the apparent emphasis in Canada, in which occupational therapists accepted responsibility for leading change to make a society that is occupationally just (Thibeault, 2006; Townsend, 1998b). The research described in this thesis supports the view that although there might be commonalities, there are also distinctly different ways in which occupational therapy is practised in Australia and in Canada.
Although occupational therapy practice in Australia and Canada may differ, it appears that other occupational therapists have valued Canadian ideas about enabling occupational justice. For example, in action research with 25 occupational therapists from a diverse range of geographical areas and practice contexts in Australia, Wilding, Curtin, and Whiteford (2012) found that some of the concepts discussed in *Enabling Occupation II: Advancing an occupational therapy vision for health, well-being and justice through occupation* (Townsend & Polatajko, 2007), such as enabling social change, were unfamiliar to therapists. Nonetheless, the process of engagement with critical occupational theory enhanced occupational therapists’ professional confidence and satisfaction in their occupational therapy role (Wilding et al., 2012). In action research with six occupational therapists from New Zealand, Reed and Hocking (2013) found that study of *Enabling Occupation II* helped occupational therapists to see and interpret their existing population-based work as occupational therapy. Thus, it appears that emergent concepts and models in Canada, despite the perception of difference, may assist occupational therapists in other national and cultural contexts to re-vision practice in new and different ways.

Although I have given emphasis to the relationship between Australia and Canada in this part of the discussion, other countries and cultures have also sought to explicate their own unique identity
concerning human rights and occupational justice. For example, in 1997 the Occupational Therapy Association of South Africa (OTASA) prepared a submission to the Truth and Reconciliation Commission about the role of the occupational therapy profession in contributing to injustice (Watson, 2008). This represented an effort by OTASA to reposition occupational therapy in South Africa as relevant and politically aware. To an outsider, such leadership appears to engender an active response within its membership, in comparison to Australia and to some other parts of the world. In South Africa, there is evidence of a number of texts and journals dedicated to making human rights and occupational justice issues explicit (Lorenzo, 2008, 2010; Watson & Swartz, 2004).

In addition to the South African context, Galheigo (2011) discussed the path taken towards human rights and occupational justice by occupational therapists in Latin America, where after decades of authoritarian regimes that restricted human rights, occupational therapists came to be viewed as “an agent of social transformation” (Galheigo, 2011, p. 62). In this research, I discuss the relationship between Australia and Canada, as co-researchers’ made comparisons between the two nations about occupational therapy practice.

The co-researchers considered that human rights and occupational justice ideals were not typically practised in Australia, in
part due to a lack of emphasis given to these concepts in their undergraduate or postgraduate education and training, as well as in their continuing professional development. I specifically draw attention to the views of some co-researchers' that OTA has missed the opportunity to provide leadership and engage occupational therapists in thinking and talking about how to implement human rights and occupational justice in practice. This is similar to a critique levelled by Carlsson (2009) of the New Zealand Association of Occupational Therapists (NZAOT) for not having its own localised position on human rights and occupational justice. In Australia, Nelson et al. (2011) criticised the lack of a national position and standards as contributing to occupational therapists' low efficacy about their capabilities to practise with First Australians. In the research described in this thesis, I found, as others have, that guidance from OTA about inclusive and participatory ways of practising might be highly valued by Australian occupational therapists.

In thinking about the national and cultural variations in the way occupational therapy is practised, Australian occupational therapist Cusick (2001) in her Sylvia Docker Lecture argued that the achievements of the Canadian Association of Occupational Therapists in developing a consistent national vision centred upon enabling occupation and justice could not be replicated in Australia. Cusick considered that if OTA were to make its stance for
occupational therapy practice explicit, it would be contrary to the cultural values of Australian occupational therapists about equality, practical knowledge and independence from authority.

To be told by an authority, particularly an institutionalised one like a professional association, what core concepts and processes are the preferred Australian way would be foreign. It would be “unAustralian”, as every therapist and every approach would not be having a fair go in the matter (Cusick, 2001, p. 112).

Cusick (2001) rejected the idea that OTA should articulate a unifying position, as it would limit the right of occupational therapists to have freedom of choice in their practice approach. Cusick considered that “unity in diversity” was more in keeping with Australia’s multicultural heritage and the character of Australian occupational therapists (2001, p. 113). This argument was shaped in part by an exploratory study by Cusick and Yule (2001) (cited in Cusick, 2001), which found Australian occupational therapists wanted the profession to be more unified and that there ought to be strong national leadership from the professional association; however, the therapists also valued a diversity of practice approaches.

In this research, I found that without an articulated and agreed ideology about what occupational justice was and how it ought to be implemented, co-researchers experienced some reluctance to speak up in the hospital. Their loyalty to occupational therapy constrained
their engagement with political issues and matters of rights and justice. This adds to Cusick’s (2001) work a more complex and complicated view, including that strong national leadership and education may be required if occupational therapists are to understand and meaningfully address issues of occupational inequity and injustice in Australia. In my view, what is important is for each occupational therapist is to have an opportunity to develop a raised consciousness of the theoretical concepts that frame their practice. Thus, my conclusion on defining occupational rights and occupational justice is that there is a need for occupational therapists in hospital practice to engage in the process of critical reflection and dialogue about what occupational justice might mean to them in their particular practice and context.

*The influence of hegemony.*

I found that enablement of human rights and occupational justice was dictated by the degree to which co-researchers accepted dominant ideas and practice hegemonies generated within the hospital. This adds to what is known about how medical and fiscal controls underpinning hegemonic practices interfere with occupational therapists’ enactment of occupation-focused practice. For example, in her action research project, Wilding (2011) found that occupational therapy practice (particularly in hospital settings) could be dominated by hegemonies of medicine and fiscal restraint. Occupational therapists became enculturated into roles that were not
those they might freely choose for themselves, and this acquiescence perpetuated the invisibility of occupational therapists (Wilding, 2011). Similarly, in ethnographic research of an Austrian hospital, Prodinger, Shaw, Rudman, and Townsend (2012) found that occupational therapists’ complicity with medical discourse and impairment or body-focused concepts rendered invisible their knowledge and intentions of enabling occupation. While the research by Wilding, and by Prodinger et al., particularly highlighted how occupational therapists’ acquiescence to dominant ideologies and practice hegemonies might perpetuate the invisibility of the profession, a distinct finding of this research relates to the mechanisms by which it may have contributed to the invisibility of clients.

A Foucauldian interpretation is helpful for understanding the difficulty of the co-researchers’ in seeing the full range of occupational injustices affecting clients in their hospital context. Foucault (1976) argued that the “gaze of power” is a particular technology of power enacted by expert practitioners to make the body visible and knowable to the observer; it defines the boundaries of what is hidden and what is seen. A medical gaze is a concept that represents the power of medicine to transform the person into an object for medical manipulation (Foucault, 1976). Thus, the body or bodily states take primacy over a person’s subjective experience of his or her life or injustice. In the research described in this thesis, I
found that as medical issues became more visible or pronounced under the medical gaze, people’s occupational issues could become less evident or obvious.

This finding that occupational injustices were not always as visible to co-researchers in clinical practice spaces might appear paradoxical given that I have discussed how people fall under the scope and watch of the person applying the gaze. In ethnographic research about systems of power and surveillance operating in a South African hospital, Gibson (2004) made clear how a gaze might not permeate everywhere in the hospital system. Gibson found that people only came into full medical view once they had passed particular medical rituals and practices, such as when their medical problem had been medically assessed and validated by people in positions of authority. I found in this research that when people were not in full medical view, it could be possible for co-researchers to apply an occupational justice view to the situation and to find out more about clients’ subjective experiences of life and injustice. Hence, it was possible for co-researchers to see injustice at home and in emergency department contexts, either because clients were not in a medical setting or because medical admission to the ward was not complete.

As medical issues became more visible and pronounced, it could limit co-researchers from considering other occupationally just
ways of thinking and talking about the person. This supports findings of Cheek and Rudge (1994) who completed Foucauldian discourse analysis of the case notes of two patients in an Australian hospital. Individual voice and identity were invisible when practitioners, including occupational therapists, discursively constructed the person from a scientific point of view. Thus the therapists failed to give import to the issues central to the person’s experience (Cheek & Rudge, 1994). In this research, the problem was that co-researchers were not always aware of the implicit way in which their ideas (and taking of an occupationally just view or lens) were dominated by hospital ideologies and values, rather than by theories of occupational justice.

In this research, foregrounding an occupationally just view appeared useful to co-researchers because it helped them to see the occupational issues of power and inequity that shaped people’s everyday lives. Whiteford and Townsend (2011) stated that an occupational justice lens:

stretches professional practice beyond individualized, technical or instrumental goals… taking into account in setting goals the presence of power, social structures, and important differences between groups in a range of contexts, rather than attempting to set goals that standardize and universalize what everyone else does in life or in a service context. (pp. 71-72)
An occupational justice lens enables occupational therapists to become more proactive and to challenge dominant ideas and hegemonic practices that otherwise hold practice in a kind of status quo (Whiteford & Townsend, 2011). Notably, Nilsson and Townsend (2010) applied an occupational justice lens to discuss and reflect upon the results of population-based research exploring technology and participation among very old people. An occupational justice lens promoted their reflection about occupational justice, global thinking about health and occupation, and combining of population and individualised approaches (Nilsson & Townsend, 2010). In the research described in this thesis, and also in both Whiteford and Townsend’s (2011) and Nilsson and Townsend’s (2010) work, an occupational justice lens was found to be a useful way of engaging occupational therapists in critical thinking and dialogue about injustice.

Although I found that an occupationally just lens could assist co-researchers to look at people in context, I found that co-researchers were sometimes uncertain about the way occupational justice theory and knowledge had been developed. In particular, co-researchers were concerned about the need for including a diversity of voices from outside the profession to construct occupational justice ideas. Other authors have also argued that deep consideration of epistemological foundations is necessary to increase the quality of philosophical and theoretical development in
occupational science and occupational therapy (Hammell, 2011; Kinsella, 2012; Rudman & Dennhardt, 2008). Kinsella and Whiteford (2009) stated that occupational therapists need to critically consider who makes epistemological choices and the implications for the kinds of theories that are adopted in occupational therapy, if the profession is to realise its historical mandate of working for social change through emancipatory action. Indeed, Abberley (1995) critiqued occupational therapy, a predominantly female profession, for adopting ideology as counterpoint to dominant patriarchal values espoused by medicine. In occupational therapy, the client is conceptualised as having a kind of power and autonomy that is not afforded in other medically aligned professions, and Abberley argued that this holistic ideology might similarly extend power and control over clients:

This theory does not constitute a challenge to the overarching domination of medical control. Rather it constitutes a plea for a specific approach to the management of the client. Yet the client is still managed; and whilst enhancing the status of female practitioners the professionalising project only superficially empowers the also predominantly female clientele. (p. 225)

Thus, if the occupational therapy profession is to promote an occupationally just lens and practice as a viable and legitimate alternative to dominant medical ideology and practices, it would
appear to require further reflexivity about issues of power, politics and morality.

*Imperfect balancing of rights, risk and responsibilities.*

In the research described in this thesis, a dominant technical and scientific paradigm underpinned risk-averse practices within the hospital. A technical-scientific paradigm frames risk as “an objective, neutral entity that pre-exists out there, independently from humans and their perception of risk” (Dennhardt & Rudman, 2012, p. 121). This finding about the propensity for risk-averse practice is consistent with a discourse analysis by Ballinger and Cheek (2006) about the construction of risk in a community day hospital. Ballinger and Cheek found that a dominant technical risk paradigm emphasised a narrow physical determination of risk, where people’s capabilities and preferences for participation “fade into the background” of everyday practice (p. 212).

A net effect of this technical risk focus in this research was that the hospital context could deprive people of opportunities and choices to participate in usual or desired occupations. Craik et al. (2010) also reported that an emphasis on risk avoidance contributed to an impoverished occupational environment on the wards of a forensic mental health setting in the United Kingdom. Clients reported that when choosing occupations, they could express interest or decline to participate; this was not a meaningful choice
(Craik et al., 2010). In an exploration of “risk geographies” in a new hospital in the United Kingdom, Curtis et al. (2013) found that security concerns restricted clients’ participation away from the site, and were applied to curtail clients’ freedom of movement to access occupational therapy, the gymnasium and other participatory spaces inside the hospital. In this research, I found, as these authors did, that a technical risk emphasis sometimes meant that clients’ rights to participate in accordance with their desired or usual routines could be usurped.

I found in this research that opportunities for participation in occupation tended to be denied to clients if risk assessments indicated that there was some uncertainty for a person’s safety. The time and effort required of co-researchers’ in putting forward their view and having it accepted within the multidisciplinary team acted as a deterrent to their future support for risk-taking. It was the view of A. Adams (2012) that a problem with risk is its prominence and the necessity for practitioners to constantly consider the risks involved in everyday practice. In this research, I similarly found that co-researchers experienced that risk and minimisation strategies in the hospital were ever-present.

Hospital colleagues who wanted risk-taking to be avoided could overrule co-researchers’ support for risk-taking. Co-researchers perceived that this was influenced by a lack of
understanding of the complexity of their clinical reasoning in occupational therapy. Wilding (2008) also found in her action research that other professions within the hospital might, due to their alignment with a scientific paradigm and knowledge, view objective and standardised forms of assessments as more legitimate than occupational therapists’ qualitative and contextualised forms of assessment. This is consistent with the trend for empirical research and scientific methods to be reified and valued more highly than interpretive forms of research and practice-generated knowledge (Whiteford, Klomp, & Wright-St Clair, 2005). Thus, it may be difficult for occupational therapists to promote human rights and support risk taking when their ways of knowing are not valued by other colleagues.

Co-researchers advocated risk-taking, yet they were also complicit with risk-minimisation practices. For example, on occasions co-researchers’ engaged people in safety assessments for the sake of enabling their discharge from the hospital; the client often had no choice but to agree. Townsend (1998a) similarly found that occupational therapists experienced conflicted relationships regarding risk in an institutional ethnography of Canadian occupational therapists’ practice in mental health services. That is, therapists advocated enabling risk taking, but they also strictly adhered to risk management policies that limited the possibilities of achieving transformative change through occupation (Townsend,
Townsend found that a problem in risk management was that professionals, not clients, had responsibility for managing risk; the net effect was that “no one is officially responsible for enabling risk taking” (p. 126). In this research, co-researchers found it difficult to balance their role and responsibility to enact a duty of care with their occupational therapy beliefs that people ought to be afforded the right to live and participate in occupations of their choosing.

The co-researchers’ overly protectionist stance was also influenced by a degree of fear that support for risk taking might result in an adverse event and enactment of legal processes. The finding that co-researchers had prominent concerns about being subject to legal inquiry aligns with research by Atwal, McIntyre, and Wiggett (2011) exploring risk-taking behaviours of occupational therapists and physiotherapists in an acute hospital setting. These authors found that a reliance on shared risk-taking with multidisciplinary colleagues may have been used to help mitigate concerns for litigation; therapists were unwilling to take on this risk alone. Further, Freeman et al. (2009) found that Canadian occupational therapists’ decision-making was influenced by their estimates of the consequences. Due to the motivation to avoid censure, occupational therapists’ priorities became more heavily weighted toward risk minimisation at the expense of people’s needs and rights (Freeman et al., 2009). A. Adams (2012) considered that it was problematic that matters of risk, rights, and responsibility have become
increasingly technical and bureaucratic, and as a consequence, decision-making about justice is understood as a legal matter rather than as requiring moral consideration and judgment. In the research described in this thesis, there were times when people in positions of authority within the hospital encouraged co-researchers to adopt this kind of legalistic thinking, in order to protect the hospital and practitioners from attracting attention in the event of harm befalling the client or others in the community.

The net effect of having limited opportunities to engage in moral reasoning and conversation about rights and risk is that co-researchers did not understand their responsibilities towards particular vulnerable groups, such as people with mental or cognitive impairment. This finding is consistent with that of Moats (2007), who explored occupational therapists’ views on discharge planning with older persons. When people were cognitively impaired and yet judged as competent for decision-making, therapists had greater difficulty balancing risks with people’s choices than if they had a physical impairment; and therefore practices became less than client-centred (Moats, 2007). Similarly, in interviews with 12 Australian occupational therapists, Russell, Fitzgerald, Williamson, Manor, and Whybrow (2002) found that when therapists doubted the client’s cognitive capacity to make safe choices, the relationship between rights and responsibilities was blurred. Therapists invoked concerns about safety and duty of care as a caveat to implementing their
professional ideals for independence and maintaining professional control (Russell et al., 2002). Thus, as Ife (2012) argued, it would appear that the discourse of human rights (to which I also add occupational justice) has not yet considered the complexities of enabling human rights and justice with diverse groups of people. In this research, it made for an imperfect balancing of rights, risks and responsibilities.

**The second step: Incorporating a rights culture.**

I have discussed the first step of the process of creating occupationally just practice, which generated for co-researchers and me, an understanding of how practice arrangements govern or influence how occupational therapists understand and enact occupational therapy practice. Here, I turn discussion to the second step of the process. This is where the benefits of the human rights culture created through the research were reaped or incorporated by co-researchers. That is, rather than a sense of internalised powerlessness, co-researchers became inspired and committed to set and make their own path to enabling human rights and occupational justice.

In this research, there were a number of ways that co-researchers developed their knowledge and action for human rights and occupational justice, including through: (1) formation of a
community of practice with like-minded, supportive colleagues; (2) an academic and practice collaboration, which created a dedicated and routine space for dialogue and interaction; (3) engagement with literature, encouraging discussion of complex, theoretical ideas; and (4) a focus on sharing real, case-based stories that bring to light immediate practice concerns about human rights and occupational justice. In this part of the discussion I profile the fourth aspect, because co-researchers and I found that the sharing of people’s stories was particularly transformative in shaping learning and practice of human rights and occupational justice.

A finding of this research is that the creation of a space in which co-researchers could join together and share their practice stories helped to cultivate a rights culture within this particular group. Stories brought to light the issues of rights affecting marginalised and “invisible” individuals and groups and also generated insights for co-researchers about the other kinds of successful actions that people had taken to enable human rights and occupational justice in practice.

In order to explore the potential of stories for making occupationally just practice, I first discuss the spatial qualities of stories. According to de Certeau (1984), stories have a delimitation role, whereby the telling of a story helps to draw up the boundaries of space. When people’s stories are silenced or disappear there is
therefore a “loss of space” and the person who was the subject of
that space becomes rendered into a “formless, indistinct, and
nocturnal totality” (de Certeau, 1984, p. 123). In applying the ideas of
de Certeau to the research described in this thesis, it is possible to
understand that people’s occupational needs and rights were less
visible to co-researchers at the beginning of the research, in part
because their different lived realities and experiences were not
spoken of in the course of the co-researchers’ usual forms of
professional development.

Early in the research, the co-researchers generally considered
that injustice was a problem that was relatively confined to nations
elsewhere or to particular groups of Australians. However, I found
that co-researchers’ reflective conversations about their collective
experiences of working with clients helped them to see and therefore
act to enable human rights and occupational justice in their practice.
For example, the co-researchers engaged in action to make their
practice more inclusive of a range of clients who might otherwise
have missed out on accessing occupational therapy, due to their not
being referred or as a result of co-researchers’ prioritisation systems.
The transformative impact of dialogue and stories is consistent with
the argument of de Certeau (1984) that a function of stories is to
create meaningful space for action. That is, stories “go in a
procession’ ahead of social practices in order to open a field for
them” (de Certeau, 1984, p. 125).
I found that stories helped co-researchers to understand clients' perspective and experiences about rights and justice issues in their lives. Osler and Zhu (2011) argued that telling one's own narratives and the “untold stories” of marginalised individuals or groups may deepen a practitioner’s learning about the various forms of oppression and injustice in society and help to “fill the blind spots” in the dominant discourse (p. 231). In the research described in this thesis, co-researchers became more aware of the values and power relations that shaped their practice, and of their own role in perpetuating hegemonies that impacted people’s rights for participation, occupation and well-being. In this way, the co-researchers developed a raised “occupational consciousness”, that is, practice wisdom that recognises how occupational therapists’ actions can perpetuate hegemonies that impact upon other people’s well-being (Kronenberg, Pollard & Ramugondo, 2011).

This finding that the use of stories enhanced co-researchers’ understanding of justice and rights is similar to the view of philosopher Upendra Baxi (2009), who stated that traditional forms of human rights discourse tend to tell large global stories or meta-narratives and are rather disconnected from the local, that is, local people and communities in struggle. Baxi therefore argued that the task for human rights discourse is that of “humanising human rights” by stories about concrete ways that people have experienced
oppression or human suffering (p. 184). I found in this research that the sharing of stories enabled the co-researchers to better understand local issues of human suffering and injustice, and evoked a passion to act for human rights and occupational justice. It is also consistent with Ife’s (2012) idea of a constructed rights approach to the practice of human rights, which requires a dialogue and focus on the idea of human and what that means in local contexts and circumstances, rather than a top-down focus on rights per se.

Inspired by their reflective conversations with one another, the co-researchers took action to profile stories about human rights and occupational justice in their supervision. This use of supervision as a strategy to expand and enrich thinking about new and different forms of occupational therapy practice agrees with the findings of action research by Reed and Hocking (2013) with six occupational therapists from New Zealand. These authors found that occupational therapists used supervision to disseminate new/reconceptualised theories and concepts that were originally discussed within a community of practice scholars, deepening connections made between knowledge and experiences of practice. In this research, co-researchers considered that supervision was another way that they could continue to give voice, and learn about, their own and other people’s stories of human rights and occupational justice issues.
The third step: Creating participatory occupational spaces.

Using stories to realise humanity.

I previously discussed the use of stories for education and for cultivation of a rights culture among this group of co-researchers. However, I also found co-researchers in turn took action to create participatory occupational spaces in which clients could voice their stories. Therefore, I draw attention in this section to the use of stories for engaging *with* clients in the present tense, rather than the previous section where co-researchers continued thinking and talking *about* clients in a forum with other occupational therapists.

The co-researchers could better understand their clients as fully human when they used dialogue and stories to engage with them. Using narratives with clients is consistent with Arthur Frank’s (2008) proposition that stories enable people to disclose aspects of their self and human identity and to hold on to what makes life valuable, which improves health and well-being. Put another way, A. Frank (2010) asserted, “the capacity of stories is to allow us humans to be” (p. 44). This description aptly describes the way in which I found the co-researchers used stories. That is, co-researchers often used stories to enable people to think and talk about aspects of their being. Thus, the finding that the co-researchers used stories to enable human rights practice is consistent with Frank’s contention that the telling of stories are needed to be fully human.
Although there is a body of literature describing the importance of stories for enabling the expression and experience of spirituality, I limit here the discussion to the use of stories to assist occupational therapists to better understand the client as a human and occupational being. It was this fuller understanding of the client that enabled co-researchers to better identify and address people’s human and occupational rights.

In occupational therapy, G. Frank (1996) argued that occupational therapists implicitly or explicitly use a narrative or storied approach to develop a rich understanding of clients’ lived experiences. In the United States, in an ethnographic and action research study of occupational therapists’ clinical reasoning, Mattingly (1994a, 1994b) found that the success of occupational therapy was influenced by an occupational therapist’s ability to set a story in motion that was meaningful to the client, and that could compel the client to see participation in therapy as integral to achievement of his or her goals for future life. This process of story-making, or imagining of possible futures, helped occupational therapists to frame their practical decision-making about what to do (Mattingly, 1994b). Whereas Mattingly found that stories assisted the therapeutic process and could be used to inspire the client and enact change for participation in occupation, in this research I found that stories served a different purpose. In particular, I found that by
listening to clients’ stories, co-researchers were better able to see people as human and occupational beings with rights rather than as medical objects to which things are done.

The finding that, by connecting with their clients on a human-to-human level, the co-researchers were better able to identify and address issues of human rights and occupational injustice might not be new or surprising. For example, Van der Merwe (2010) asserted that prior to engaging therapeutically with a person, occupational therapists need “to occupy an office that allows true equality: the office of one human being to another” (p.18). Thus, when a person is treated with human dignity, an occupational therapist can overcome differences and create “a space of freeness to communicate on equal ground” (Van der Merwe, 2010, p. 18). In the research described in this thesis, to enable occupational justice, co-researchers needed to first acknowledge and understand their clients as fellow humans. Having made this connection it was then possible to communicate with people about their pressing, injustices, problems, and needs.

Indeed, authors have argued that a practice that seeks only to do practical and outcome-oriented actions (and therefore that excludes people’s needs to be) might lead to interference or infringements upon people’s human rights. Wilkes (1981) argued that the net effect of seeking to treat or change a person is that certain
groups of people become undervalued, such as people who have chosen a way of living and being that might not otherwise be considered normal. Molke and Rudman (2009) argued that occupational injustice may result when occupational therapists take a limited view of occupational being as derived only through productive, purposeful action.

I found that there were times when co-researchers’ use of stories required them to resist the hospital press to engage in efficient, outcome-oriented actions. These acts of engaging in story telling might therefore be considered to be forms of generosity as described by Frank (2004). The ability to be generous in practice, as defined by Frank, does not necessarily rely upon a practitioner’s skills to treat a person’s medical condition; rather, it relates to a practitioner’s openness to consider the other person as fully human.

Generosity… always begins in dialogue: speaking with someone, not about them; entering a space between I and you, in which remain other, alter, but in which we each offer ourselves to be changed by the other. (A. Frank, 2004, p. 126)

In this research, there were instances when co-researchers decided to listen to their clients rather than cutting off their stories, because they considered it was their responsibility to create a therapeutic space in which a person could be seen as a human rather than as a medical object (a patient). I found, as argued by A. Frank, that stories
rendered co-researchers into a space where they were fully present with clients.

The finding that co-researchers used dialogue and stories in a way that Frank described as “generous” is similar to the finding of Rosa and Hasselkus’s (2005) that occupational therapists need to be open to the experiences of others and to be willing to explore differences with clients in relation to their goals and expectations for rehabilitation. Therapists’ “good intentions” were not entirely adequate for bridging differences with clients; skills in human relating and communicating were also important, to avoid reliance upon compatibility as a basis for finding common ground (Rosa & Hasselkus, p. 205). The findings of the research described in this thesis support the finding of Rosa and Hasselkus that an attitude of openness to engaging with the client is important, yet I also challenge their framing of this quality as somehow separate from skilful relating. I found co-researchers’ use of stories to be occupationally just practice because it required co-researchers to interrupt their routine and habitual ways of practising to critically reflect on what to do.

*Creating permeable, participatory spaces.*

To counter a lack of opportunities for participation in occupation in the hospital, some co-researchers took action to enrich the hospital with participatory spaces. This finding is consistent with
the perspective of Parr (2008), who completed ethnographic research into participation of people with mental illness in rural communities, gardening projects, artistic networks and Internet forums. Parr found that such “participatory spaces” opened up new possibilities for people to see their potential and re-make their identity so as to have greater agency and control over a lived reality. This occurred at an individual level through a developing sense of a more stable self and through fostered relations and a sense of belonging with others. I consider that the findings of the research described in this thesis help to expand upon Parr’s work. Whereas Parr focused on understanding people and their naturally occurring experiences of participation outside institutional spaces, I found that the co-researchers worked for justice by creating opportunities for clients’ participation within the hospital context. Further, Parr’s emphasis appeared to centre upon how various social processes, relations and spaces influenced people’s experience of participation and inclusion, whereas in contrast, my finding gives emphasis to a response by the co-researchers to make the hospital more occupationally inclusive.

One way that co-researchers made the hospital more participatory was by enabling people to access and engage in occupations in their homes and community. This finding is consistent with the idea of permeability that emerged in ethnographic research by Quirk, Lelliott, and Seale (2006) in three mental health institutions
in the United Kingdom. These authors found permeability as influenced by the temporary nature of ward membership (shorts stays of patients and staff changes); patient contact with the outside world; and, a blurring of institutional roles. The role of occupational therapists in increasing the permeability of the hospital context was also found in geographical research by Curtis, Gesler, Priebe, and Francis (2009), that explored the views of patients, staff and consultants about a new hospital in the United Kingdom. Curtis et al. found that occupational therapists’ work in enabling clients to maintain a connection to their home and community was a valuable contribution to supporting people’s transition to real life. Nonetheless there was also a sense of apathy in patients towards “regimented” or structured parts of the formal care plan (Curtis et al. 2009). In the research described in this thesis, co-researchers considered that making the hospital more permeable to the outside world, had positive effects of enabling clients to maintain and express their occupational identity and to enact roles and values that were important to them.

Although co-researchers took action to enable clients to participate in occupation outside the hospital, this was not always practical. Therefore, co-researchers took action to empower clients and their families with knowledge and skills about how to access non-clinical spaces on site, such as the café and outdoors. This partnering approach is similar to that described in the research of
Wood et al. (2012) about how carers might be enabled to feel like “insiders”, such as by organising hospital spaces to replicate family life and allowing for private living and garden spaces (p. 7). Thus it would appear that a key strategy for enabling occupational justice is to create or normalise spaces so that clients meet goals for citizen participation in all aspects of life, rather than only meeting hospital or occupational therapy goals.

To make the hospital more permeable and participatory, one co-researcher revised and re-oriented a group program to enhance opportunities for people to participate in desired occupations. This action is consistent with the concept of “occupational enrichment”, which is a process of “deliberate manipulation” of an environment in support of people’s participation in occupations they might usually engage in (Molineux & Whiteford, 1999, p. 127). This finding is concordant with Townsend (1998a) institutional ethnography of Canadian occupational therapists’ practice in mental health services. Townsend found that clients ought to not just be asked to comply with programs; rather, their participation might include doing “chores” and contributing to decision-making about the occupational therapy program more broadly (p. 134). In this research, I found that co-researchers’ considered they could effectively meet clients’ human and occupational rights by valuing their contribution to decision-making about the forms of participation made available in the hospital.
In ethnographic research in an Australian inpatient mental health setting, Fortune (2002) described deliberate occupational enrichment as creating an “occupational milieu”. In an occupational milieu, “the environment is consciously structured to arouse the interests of people to engage in the sorts of meaningful activities that utilise, and develop (where possible) their underlying capacities, enabling them to experience well-being and a sense of personhood” (Fortune, 2002, p. 179). Importantly, in order for an occupational milieu to be effective and sustained, it requires not only the individual actions of occupational therapists but also a focus on building the capacity of the organisation in support of the program (Fortune & Fitzgerald, 2009). For example, enabling nursing staff to be involved in planning for everyday routines as part of their usual role, rather than as helpers to the program, is an effective strategy for securing support (Fortune & Fitzgerald, 2009, p. 87). Fortune’s conceptualisation of an occupational milieu has particular resonance in the research described in this thesis, where I similarly found that co-researchers’ creation of opportunities and choices for participation in occupation relied heavily upon collaboration with other disciplines and service providers. Through the development of partnerships with services providers from the community, clients were able to participate in ways that were not wholly predetermined by an occupational therapist or other professionals in the hospital.
Advocating for collaborative forms of justice.

Through their involvement in the research, co-researchers began to develop increased surety about how to enable occupational justice, and they also took action to raise their colleagues’ awareness of occupational issues of inequity and injustice. The need for a shared undertaking of occupational justice is consistent with other framings of justice. Young (2011) argued that structural injustice occurs as a result of “many individuals and institutions acting to pursue their particular goals and interests, for the most part within the limits of accepted rules and norms” (p. 52). Thus, in her social connection model of responsibility, Young proposed that all persons who contribute by their actions to structural processes with some unjust outcomes ought to share responsibility for the injustice. In relation to theorising occupational justice, Whiteford and Townsend (2011) advocated in the Participatory Occupational Justice Framework, that in enabling occupational justice, an occupational therapist might typically first act to raise consciousness in others about occupational injustice, with the intention of inspiring advocacy for collaborative decision-making. In this research, the empirical evidence I collected was consistent with Whiteford and Townsend’s theoretical assertions that enablement of occupational justice is an inherently collaborative endeavour.

A finding of this research is that co-researchers discussed issues of occupation in the context of clients’ lives; however, they did
this by drawing colleagues’ attention to the rights and/or justice dimensions of a situation. This extends upon previous research about occupational therapists’ engagement in advocacy, which has differentiated reasons of human rights from reasons of occupation. For example, in interviews with 12 Israeli occupational therapists, Sachs and Linn (1997) found that occupational therapists used their knowledge about the impact of illness and disability on a person’s life either to act as “guardians of morals” in instances of mistreatment or misconduct, or to raise awareness of clients’ occupational issues and capabilities to other colleagues in the interdisciplinary team or in other institutional contexts (p. 210). Similarly, in phenomenological research with Canadian occupational therapists, Dhillon, Wilkins, Law, Stewart, and Tremblay (2010) identified matters of occupation and matters of rights/justice as separate imperatives for advocacy. In contrast to these authors’ findings, I found that co-researchers appeared guided by a belief that rights and occupation were inextricably linked. The co-researchers developed a closer connection between the concepts of rights and issues of occupation and were able to help their colleagues to develop a deeper view of the complexities of the practice situation.

Critically, the use of advocacy by co-researchers was not an end in itself. Rather, their advocacy was a means to invite their colleagues to engage in reflection and dialogue about the nature of clients’ occupational issues. This idea that co-researchers created a
space for public discussion about matters of rights and justice supports the view of Sen (2009), who argued that some rights are not recognised and therefore are better promoted through other means, including public discussions and advocacy. Indeed, Sen asserted that the force of a claim to human rights ought to be determined by its survivability in “unobstructed discussion” and public critique about the nature of that claim (p. 386). If a claim to human right is able to endure arguments coming from well-informed critics, Sen argued, it can be presumed as relevant and sustained within that particular culture or context. I found that co-researchers opened up the public space with their multidisciplinary colleagues, and they shared their knowledge and insights about clients’ situations and the clients’ needs and rights for participation in occupation. Thus, rather than electing to engage in advocacy through the usual informal corridor conversations with their colleagues, co-researchers became more public and open to discussing different points of view. By becoming more public, they could foreground occupational rights and occupational justice.

As co-researchers profiled issues of occupational injustice in public discussion with their multidisciplinary colleagues, these became matters that their colleagues better understood, and were more able and willing to address. It would appear that co-researchers’ action is consistent with a kind of civil society action, advocated by London and Schneider (2012), whereby formal legal
accountability for the right to health requires reinforcement, including through the action of health professionals. Civil society action is important because governments may not always respond in ways that are consistent with their human rights obligations, in turn “allowing the bureaucracy to determine the policy space in which the limits of health-related claims can be met” (p. 8). I found that through their advocacy in multidisciplinary forums particularly, co-researchers were able to start to widen the kinds of rights supported within the hospital, such that occupational justice developed value.

Chapter summary

In this chapter, I discussed a three-step model for the process of creating occupationally just practice, strengthening existing understandings in occupational science and occupational therapy about the relationship of occupational justice to concepts of space and morality.

The first step in creating space for occupationally just practice entailed generating understanding about the kinds of geographical and contextual influences shaping co-researchers’ practice of occupational justice. Of relevance to this research was that the co-researchers’ understanding and enactment of occupational justice was initially constrained by the particular geography and context in which they lived and worked. For example, their Australian way of
viewing human rights, a lack of a shared professional ideology of occupational justice, and the influence of hegemony meant that the co-researchers had difficulty identifying and addressing occupational injustices that were affecting their clients. The context and conditions of practice could crowd co-researchers’ practice, in effect limiting their sense of freedom and choice to practice for human rights and occupational justice.

The second step in this process relates to when co-researchers incorporated the human rights culture cultivated through the research. In particular, the sharing of stories within this group discussion helped to generate insights about the nature of oppression and injustice. Collective understandings of shared human rights values assisted co-researchers to see the possible ways of challenging dominant ideas and practice hegemonies.

In the third step of creating this space, co-researchers endeavoured to enable human rights and occupational justice, especially by intervening and targeting change in the context or conditions of practice. That is, they developed emancipatory practice architectures for human rights and occupational justice. The co-researchers created three kinds of participatory occupational spaces with their clients and colleagues: opportunities for listening to and connecting at a human-to-human level through using stories; creating more permeable boundaries between the hospital and the
community, which enabled greater participation and inclusion; and creating spaces for public, collegial conversations about human and occupational rights. This emancipatory action is consistent with the human rights and occupational justice goals of enabling clients’ maximum self-determination and control over their situation and participation in occupation.
Chapter 8

Recommendations and conclusion

In this action research study I engaged co-researchers in local, contextualised dialogue about the conditions that enabled or constrained human rights and occupational justice in their occupational therapy practice. Through this process of learning and critique, the co-researchers developed their agentic qualities and were more likely to implement enabling, emancipatory practices. Thus, this research provides an example of applying an occupational science concept (occupational justice) and using continuing discursive practices to develop occupational therapy practice. Moreover, the co-researchers discursively constructed new practice-based meanings of occupational justice, particularly in relation to issues of creating space for moral reasoning in occupational therapy. Therefore, this research also demonstrates the potential for shaping occupational science epistemology by testing occupational science concepts in different contexts. In this final chapter I outline some suggestions for the profession and practice of occupational therapy, as well as recommendations for future research and development for occupational science.
Recommendations for occupational therapy

**Education.**

The extent to which the theory of occupational justice can lead to improvements in people’s everyday lives is directly influenced by how occupational therapists are able to cultivate a human (and occupational) rights culture in occupational therapy. In a human rights culture all people are understood as having rights, not just members of minority groups (Briskman & Fiske, 2008). Thus, I contend that it is through improved education in undergraduate and postgraduate education as well as in the continuing professional development of occupational therapists, that occupational therapists can become more attentive and committed to identifying and addressing a range of occupational issues of inequity and injustice in their practice. I now discuss recommendations as possible ways of engaging clients, practitioners, managers, educators and national and world associations in the collective pursuit of rights-based practice in occupational therapy.

*Recommendation 1: Clients’ and citizens’ voices should be included in the education of occupational therapists.*

Importantly, the practice stories raised in this research were originally elicited in dialogue with clients whom experienced injustice due to their ill health or difficult life circumstances and conditions. Therefore, I recommend that occupational therapists create opportunities for clients to share their stories more directly in the
formal class-room teaching of students, and in practice-based education such as in-service programs. Client involvement in the education of occupational therapists could also extend to inviting clients’ participation in curriculum review, and in the supervision and evaluation of occupational therapy students and practitioners. It is also important that occupational therapists listen to the voices and stories of other people in the broader community who have experienced occupational disruptions and injustice. One way that occupational therapists in Australia could learn about the lived experiences of Australian citizens is by subscribing to the Australian Human Rights Commission (http://www.ahrc.gov.au); an organisation that features stories about human rights through e-mail updates, podcasts, and currently, a project called “Something in common” in which people contribute their inspiring stories of taking action for human rights.

Recommendation 2: Educators should explore ways of integrating human rights and occupational justice ideas in the university curriculum and in fieldwork education.

According to Ife (2012), the design of a university curriculum has a major role in determining how future generations of professionals will enact human rights. I therefore recommend that educators continue to foster dialogue and debate about the various ways to integrate the ideas of human rights and occupational justice into their university program and across the curriculum. An example
of how collaborative planning could lead to curriculum transformation was reported by De Jongh, Hess-April, and Wegner (2012) in a South African university. These authors described how educators engaged in critically reflective processes to identify the essence of the university and the occupational therapy department, and to build a theoretical and personal understanding about political consciousness.

It would also appear beneficial that educators support students to contextualise ideas about human rights and occupational justice with reference to a variety of different practice contexts, including medical settings. One such way that human rights and occupational justice ideas have been used to structure fieldwork was reported by Mace and Hocking (2010): students developed a program proposal for different organisations, showing the possibilities for incorporating concepts of occupational justice in practice. Opportunities for applying human rights and occupational justice concepts in traditional and non-traditional fieldwork contexts might enhance graduates' preparedness and capacity to act as agents of human rights and occupational justice.
Recommendation 3: Occupational therapists could create practice-based opportunities to engage in local, contextualised discussions about concepts and practices of human rights and occupational justice.

Occupational therapists’ engagement in reflective conversations about their collective practice experiences appears to be an important way of developing therapists’ capabilities and agency for enabling human rights and occupational justice. Although I have predominantly discussed large group reflective processes, a human rights and occupational justice framework could also be useful for guiding supervision, at either an individual or small group level. I recommend occupational therapists’ engagement with the theoretical literature, which can act as a stimulus for discussion. The text, *Enabling Occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation* (Townsend & Polatajko, 2007) would appear to be helpful for this purpose. It is also important that occupational therapists learn not only from Western theories and concepts, but also by reading literature from nations in the South and Asia, where a human rights and development focus has been particularly strong. Numerous texts serve this purpose (Kronenberg, Pollard, & Sakellariou, 2011; Kronenberg, Simo Algado, & Pollard, 2005).
Recommendation 4: Occupational therapists could proactively engage in communities of practice, such as OTA special interest groups, to help them to consider and apply new ideas about rights and justice to their practice.

Consideration of human rights and occupational justice issues is a complex undertaking and for occupational therapists, would appear to require deliberate thought and reflection. Therefore, it would appear beneficial for occupational therapists to participate in communities of practice with other like-minded colleagues who are similarly interested in aligning their everyday practice with the ideals of human rights and occupational justice. I recommend that this could occur through the special interest groups and online community of practice forums convened by OTA. This may also require occupational therapists to be proactive and consult with OTA about the need for creation of additional state- or region-based special interest groups, and an online community of practice network dedicated to human rights and occupational justice. It would appear that OTA is willing to support forums dedicated to human rights and occupational justice. For example, there is a state-based occupational justice interest group in Queensland, and in October 2013 OTA provided support for the group to host a national webinar on the topic of relationship building as a strategy for occupational justice.
Recommendation 5: OTA should engage in a consultative review and collaboration with its membership to develop a national vision for occupational therapists about human rights and occupational justice.

OTA could take a leadership role in supporting occupational therapists to engage with ideas of human rights and occupational justice through construction of a national vision for occupational therapy practice. This vision should embed a focus on human rights and occupational justice in all occupational therapy practice. It is important that OTA construct this vision, through consultation with its membership from across the different states and territories of Australia. Indeed, OTA has previously provided support and funding for consultative and collaborative reviews, such as that leading to the development of the Australian minimum competency standards for new graduate occupational therapists (ACSOT) 2010 (Occupational Therapy Australia, 2010). I consider such a consultative process could enhance occupational therapists’ understanding of human rights, as well as enabling their contribution the priority given to human rights and occupational justice within the profession. In order to construct a vision of human rights and occupational justice in Australia, OTA could appoint a committee that is funded to engage in dialogue and interaction with consumers, practitioners, educators, organisations, regulatory bodies, and national associations. In particular, OTA could complete international benchmarking to learn
about different national associations countries’ experience of building a human rights culture.

Recommendation 6: The WFOT could develop more online spaces for occupational therapists to use and thus enhance global dialogue and connectivity about matters of rights and justice.

According to Galheigo (2011), it is important that occupational therapists are able to transcend borders and language boundaries in order to learn about and develop their practice of human rights and occupational justice. The WFOT has enacted a range of actions with the aim of fostering worldwide dialogue and knowledge exchange about human rights and occupational justice concepts and practices. For example, in November 2010 the WFOT dedicated an issue of the WFOT Bulletin to exploration of human rights issues (Bryant, 2010). Furthermore, the position statement reflects WFOT’s official stance on matters of human rights, occupation and participation. However, I found the occupational therapists in this research had a limited awareness of, or understanding about, the position statement. Thus, I recommend that the WFOT issue further information online about the position statement, including who contributed to its construction on what basis decisions were made.

Another way I recommend that the WFOT should link occupational therapists from diverse geographies with one another,
is by developing a dedicated online collaborative learning network and hub for human rights and occupational justice. This could enable access to practice stories, live chats, webinars, material resources and so on, all related to human rights and occupational justice. This might occur through upgrades to the existing WFOT website or social media, for example, its Facebook page. The benefit of an online approach is that content and connectivity is developed through the participation of users, and therefore grounded in grassroots dialogue and interaction about real, practice experiences. In making this recommendation, it is important that I acknowledge that use of online forums and social media might in turn raise new issues and complexities for the WFOT, such as the need for moderating interactions and actions, which might be difficult with the limited funds and resources of the WFOT.

Practice.

In this exploratory study, I learned what an occupationally just, occupational therapy practice might look like in medical practice contexts. I recommend that occupational therapists who are interested in enabling human rights and occupational justice take action to create three kinds of spaces for enabling human rights and occupational justice: human spaces for human stories; permeable, participatory spaces; and spaces for public, collegial conversations. In taking action to enable occupational justice, occupational
therapists should include plans for monitoring their actions, and the effect it has on people’s health and wellbeing.

Recommendation 7: Occupational therapists should create human and dialogical spaces in which the essential humanity of all human beings is recognised and valued.

To enable occupational justice, it is necessary for occupational therapists first to acknowledge the client as a fellow human, such as through the use of dialogue and stories that allow clients to define their needs and rights. The use of dialogue and stories may be most effective if occupational therapists do as Ife (2012) suggested, which is to re-frame their interactions with clients, from those of “doing an interview” to become “talking with” or “having a conversation with” a client (p. 264). Further, I recommend that occupational therapists give clients greater power and control within these dialogic spaces by providing clients with choices, such as about the different time and places in which they might like to talk, or the ways in which they might like to be addressed.

Recommendation 8: Occupational therapists should create participatory spaces that link the hospital to the community and promote collective forms of engagement.

I recommend that occupational therapists consider different and new ways of making the hospital space more permeable to the outside world and community. Occupational therapists could
enhance permeability by offering a range of choices and opportunities for participation in occupation. When it is not possible to enable people’s access to their homes and communities, occupational therapists could take action to strengthen group programs. Permeability can also be enhanced beyond the formal, structured occupational therapy program; that is, without an occupational therapist present. I recommend that occupational therapists empower clients with knowledge about how to find or claim other enabling spaces in the hospital, such as outdoors or in the cafe. This may require occupational therapists to also collaborate with carers, families, hospital colleagues, volunteers, and community members.

Recommendation 9: Occupational therapists should articulate and advocate for rights and justice through conversations with their multidisciplinary colleagues.

I recommend that occupational therapists engage in public conversations with colleagues to discuss clients’ needs and rights for participation in occupation. These discussions may occur in a variety of meeting types, including multidisciplinary team meetings and also in planning days, meetings with funding bodies and so on. Occupational therapists might consider using tools such as the PEMO (People, Environment, Moral Standards and Outcomes for Daily Life) (Campbell, 2012) as a framework to prepare them ethically and politically for meetings where human rights concerns
are discussed. Rather than perpetuate clients’ dependence and experience of disadvantage by always speaking up for them, it is also important that occupational therapists find ways of enabling clients to actively participate in these kinds of meetings in which decisions that affect them are made.

Recommendations for future research and occupational science

Recommendation 10: Collaborative research should be undertaken with Australian citizens, including clients of occupational therapy services, about their experience of occupational injustice/justice.

The co-researchers in this research initially tended to consider that injustice was confined to nations elsewhere or to particular pockets of Australian citizens. Thus, I recommend that there is a need for further research that explores how different people and groups in different places within Australia experience occupational inequity and injustice. Some examples of this kind of research include that which has explored occupational deprivation among people who are refugees (Whiteford, 2005), in forensic mental health settings (Farnworth, Nikitin, & Fossey, 2004), and experiencing homelessness (Thomas, Gray, & McGinty, 2010). I also recommend it important that future research about occupational justice place at its centre clients’ perspectives about aspects of occupational therapy practice that help or hinder an experience of human rights and occupational justice.
Recommendation 11: Action research should be undertaken as a useful way of researching how occupational therapists learn about, and do, occupational justice in practice.

I found that action research assisted co-researchers to develop greater awareness of how their everyday actions perpetuate hegemonic practices, and to see the possibilities for new occupational therapy practices to develop. I therefore recommend that action research is useful for future research where there is a dual focus on developing understanding about, and aligning practice with human rights and occupational justice. Indeed, Pierce (2010, October 13) argued the need more generally for greater “doing of occupational science” or for more research-based knowledge, rather than consuming or translating knowledge from other fields and disciplines. The action research cycles of reflection and action made it a methodology well suited to exploring how occupational therapists reflected upon and practised human rights and occupational justice in the course of their everyday practices.

Recommendation 12: Research about human rights and occupational justice should utilise a range of key-informing sources to raise consciousness about issues of human rights and occupational justice.

Although in the research described in this thesis, the work of Ife (2008, 2012) was used as a key source, other sources of
information about human rights and occupational justice might also provide useful and valuable perspectives. In my experience, the human rights framework articulated by Ife (2008, 2012) offered co-researchers and me, a useful way of thinking and talking about issues of human rights and occupational justice. However, other critical perspectives could also have been used to raise questions about the tensions between ideals and the practice realities of everyday occupational therapy practice. For example, it would be useful to explore in research the application of the Participatory Occupational Justice Framework (POJF) as a conceptual tool for enabling occupational justice (Whiteford and Townsend, 2011). I recommend research about the practice of human rights and occupational justice should draw from a range of perspectives across the world, including those from other professions and other ethical theories and frameworks because a depth and diversity of ideas is important for increasing quality in the development of occupational justice theory, philosophy and practice (Hammell, 2011; Kinsella, 2012; Rudman & Dennhardt, 2008).

**Recommendation 13: Research about how occupational therapists enact occupational justice could be completed with other occupational therapists in different geographies and practice contexts.**

It is important that research generate understanding of the situated nature of occupational justice; that is, how occupational
justice ideas and practices are specific to particular people in a particular time and place. I engaged nine occupational therapy practitioners from a specific geographical and practice location in Australia in critical reflection and dialogue about the ideas of human rights and occupational justice. As the same study performed with different cohorts might yield different findings, I recommend that similar research be completed with occupational therapists in other contexts or geographies of Australia and internationally.

I also recommend that occupational scientists research the way in which different spaces and places of the practice context mediate occupational therapists’ perceptions of justice, such as in medical spaces and settings, or in the home and community. This may influence the way in which occupational therapists relate to and accept responsibility for enabling human rights and occupational justice.

**Recommendation 14: Research could focus on exploring how the theory of occupational justice relates to other ethical theories, such as utilitarianism.**

Durocher, Rappolt, et al. (2013) argued the need for occupational justice to be conceptualised in relation to various ethical theories. In this research, I found that broad cultural beliefs and utilitarian views sometimes affected the co-researchers’ practice in the particular way that people’s individual needs could be sacrificed.
for the good of the majority. It is unknown whether these effects are similar for other occupational therapists and in other locations or points in history. I therefore suggest there is a need for research to explore more specifically the kinds of ethical theories employed by occupational therapists at this particular site and in other localities across Australia. Although in the research I found that utilitarianism limited occupationally just practice, I recommend that this research also explore how differences in ethical theories within particular practice settings can help or hinder the practice of occupational justice. For example, utilitarianism might be helpful in assisting occupational therapists to shift alignment from usual forms of individualised practice to community-based programs that could benefit the majority.

Recommendation 15: There are benefits in encouraging interdisciplinary collaboration about occupational justice, particularly with the discipline of human and cultural geography.

Wright-St Clair (2012) argued that the potential for occupational science to engage in interdisciplinary collaboration is yet to be fully realised. In thinking about what interdisciplinary contributions should be acknowledged within occupational science, G. Frank (2012) considered that it ought to be those perspectives that can necessarily confront moral philosophy. I recommend that research and study of occupational justice link to the field of human
geography. In human geography, a context-specific approach is understood as offering a basis from which groups of people come together to “find identity” and contest the dominant “moral ideology” that governs what it is that they do (Smith, 1994, p. 10). Therefore I recommend collaboration with geographers could enhance research at the nexus of occupational justice, morality and space/context.

Conclusion

This action research study has potential as a tool that enables occupational therapists and occupational scientists to unite to address common concerns of human rights and occupational injustice. Indeed, this research illustrated that applying the concepts of human rights and occupational justice to practice, and using continual discursive practices, is one way of assisting occupational therapy to realise its historical mandate of working for social change through emancipatory action. Furthermore, with its emphasis on a constructed rights approach, this research has added new practice-based meanings to occupational justice which foreground the concepts of participatory occupational spaces. Participation and partnership are two central and interconnected features of a flourishing group, community or society (Christiansen & Townsend, 2010b). With its emphasis on both reflection and action, action research is a methodology that is well suited to embedding participation and partnership in the ordinary, everyday-ness of occupational therapy work in medical practice contexts.
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Appendix A: Interview guides

Interview one

• Professional information: Year of graduation, years of clinical experience, level of education/postgraduate study, years working at Austin Health, area of practice.

• Tell me about your career so far. What attracted you to occupational therapy?

• What do you find is most satisfying about your practice? What aspect is most challenging?

• Tell me about a client that you typically work with. What do you understand to be the role of occupational therapy with this client?

• What ideas and beliefs are important to you in the way that you approach your work?

• What is the fit between these occupational therapy values and your personal values?

Interview two

• What are you most enjoying about your participation in the project and what is most challenging about it?

• How are you finding the readings and reflection sheets, newsletters and focus groups?
• Has your involvement in the study affected the way you or your colleagues think or act in your occupational therapy practice?
• Can you recall an instance of when your participation in the study influenced your practice of enabling occupation and occupational justice?
• Do you have any other questions, comments, or suggestions to make about your experience in the study?
• Would you like to discuss some of your ideas for taking action in the next phase of the study?

Interview three
• What did you most enjoy about your participation in the project, and what was most challenging about it?
• Has the study highlighted human rights and occupational injustice issues affecting your clients?
• What have you learned about the approach of enabling occupation and occupational justice?
• How has your practice changed? Can you tell me about a typical client that you work with and what you now do differently?
• How do you think your involvement in this study might influence or change your future practice?
• What features of the study did you find helpful for your learning, were there any that were less helpful (i.e. readings, newsletters, community of practice)?
• Is there anything that could have been done better or differently with the research process or that you think you could have done differently?

Exit interview
• Has the study highlighted human rights and occupational injustice issues affecting your clients?
• What have you learned about the approach of enabling occupation and occupational justice?
• Has your participation in the study changed the way you think, say, do or relate to others in your professional practice?
• Can you tell me about a typical client that you work with and what you now do differently?
• How do you think your involvement in this study might influence or change your future practice?
• What features of the study did you find helpful for your learning, were there any that were less helpful?

New member interview
• What attracted you to occupational therapy? How did you find your undergraduate training?
• What do you find is most satisfying about your practice? What aspect is most challenging?

• What ideas and beliefs are important to you, in the way you approach your work?

• Have human rights been something that you have learned or applied in occupational therapy before?

• In what way do you take an approach of enabling occupation and occupational justice in your practice?
Focus group one guide: Occupation

Reflections

• Welcome to the research, overview of expectations, action research processes, and group norms for participation.

This session

• How is occupation the focus of your occupational therapy practice? Give consideration to your practice spaces, assessments, treatment media, and models of practice etc.

• Does thinking of occupation beyond performance have the potential to broaden your practice?

• How do chronic illness or disability restrict your clients’ participation in daily occupations? Consider a particular client story.

• What effect has it had on your clients over a lifetime, or with a sudden loss or change in occupations?

• How do general life circumstances such as living conditions, affect your clients’ ability to make choices about occupation? Draw upon your experience with a client.

• Have there been situations where your service, despite its best intentions, has not fully supported your client’s choice?
Focus group two guide: Enablement

Reflections

• What did you take away from that focus group? Did people have any ideas or experiences from practice that related to last month’s discussion and which they would now like to share with the group?

• What comments or feedback do people have about the newsletter? Were there any clarifications on my interpretations, such as things that I may not have interpreted accurately?

• What issues did this month’s reading raise for you? Is there anything that particularly resonated with you, or challenged you?

This session

• What enablement skills do you use in practice, and how do these compare to what you value?

• Can you recall a time when your attempt at enablement was not successful? What happened?

• How do you ensure the voice and narrative of your clients is heard?

• Is there a tendency in your practice to over emphasise one approach above others, such as independence? Provide an example.
• Do you feel that focusing on social change falls within the scope of your occupational therapy practice?

• Can you recall a time when you engaged groups or the community to which your client belongs? How did this go?

Focus group three guide: Occupation-based enablement

Reflections

• What did you take away from that focus group? Did people have any ideas or experiences from practice that related to last month’s discussion and which they would now like to share with the group?

• What comments or feedback do people have about the newsletter? Were there any clarifications on my interpretations, such as things that I may not have interpreted accurately?

• What issues did this month’s reading raise for you? Is there anything that particularly resonated with you, or challenged you?

This session

• Do you use occupation-focused assessment and treatment media for therapy?

• Can you recall a time when it was difficult to engage a client because of limited options?
• What trends or issues in society (local and global) influence the lives of your clients, or your own practice?

• What is the role of occupational therapy in these matters? Is there something you might do?

• Can you think of an instance when you enabled your client, such as to connect with nature or others?

• Could you extend your practice to incorporate any preventive occupational therapy?

Focus group four guide: Human rights and occupation

Reflections

• What did you take away from that focus group? Did people have any ideas or experiences from practice that related to last month’s discussion and which they would now like to share with the group?

• What comments or feedback do people have about the newsletter? Were there any clarifications on my interpretations, such as things that I may not have interpreted accurately?

• What issues did this month’s reading raise for you? Is there anything that particularly resonated with you, or challenged you?
This session

- What does the WFOT position statement say to you about human rights? What do you like about it? What don’t you like about it?

- What is your vision of human rights?

- What are the rights issues in this practice story? How do you take those claims seriously?

- What duties go with those rights raised in the practice story? Who is responsible for meeting these rights?

- How do you work towards human rights as an outcome in this practice story (what you do), and/or as a process (how you do it)?

Focus group five guide: Developing visions of occupational justice

Reflections

- What did you take away from that focus group? Did people have any ideas or experiences from practice that related to last month’s discussion and which they would now like to share with the group?

- What comments or feedback do people have about the newsletter? Were there any clarifications on my
interpretations, such as things that I may not have interpreted accurately?

- What issues did this month’s reading raise for you? Is there anything that particularly resonated with you, or challenged you?

This session

- How do you envisage the perfect occupational therapy?
- What significance does a human rights and occupational justice approach have in this vision?
- How does the reality of your practice fit with this utopian vision?
- How might this utopian vision become your practice reality?
- What responsibility do you have to practice towards human rights and occupational justice?
- What do you see as the potential for changing practice so that is more closely aligned with this vision?
- What action could you aspire to take?

Focus group six/seven guide: Plan

Reflections

- What did you take away from that focus group? Did people have any ideas or experiences from practice that related to
last month’s discussion and which they would now like to share with the group?

- What comments or feedback do people have about the newsletter? Were there any clarifications on my interpretations, such as things that I may not have interpreted accurately?

- What issues did this month’s reading raise for you? Is there anything that particularly resonated with you, or challenged you?

**This session**

- What kinds of human rights issues evoke your interest?

- How will you make a difference through enabling occupation and justice?

- What positive impact do you expect it to have for your clients?

- What changes will you need to make to your own knowledge?

- What changes will you make to the systems and processes in which you work?

- What changes need to be made in the short-term and/or long term?
• What supports e.g. mentors, literature will help you to achieve this vision?

• Will you take this action individually or with others inside/outside the group?

• How do you think it will be received e.g. by management, colleagues?

• How will you monitor your actions and the effect it has?

Focus group eight/nine guide: Act and evaluate

Reflections

• What did you take away from that focus group? Did people have any ideas or experiences from practice that related to last month’s discussion and which they would now like to share with the group?

• What comments or feedback do people have about the newsletter? Were there any clarifications on my interpretations, such as things that I may not have interpreted accurately?

• What issues did this month’s reading raise for you? Is there anything that particularly resonated with you, or challenged you?
This session

- What did people think when reading the group’s plans for action in the newsletter?
- What changes have people gone about doing in their practice over the past month?
- For those who have started, what worked well and what did you learn could have been done differently?
- What effect did this have (either positive or negative) on you or upon others around you?
- For those who have not yet started to enact their plan, why has this been difficult to do and what supports could help you in this process?
- What do you plan to do next; will you continue on, stop to revise your action plan and try again, or do something else?

Focus group ten: Final evaluation

Reflections

- What did you take away from that focus group? Did people have any ideas or experiences from practice that related to last month’s discussion and which they would now like to share with the group?
• What comments or feedback do people have about the newsletter? Were there any clarifications on my interpretations, such as things that I may not have interpreted accurately?

• What issues did this month’s reading raise for you? Is there anything that particularly resonated with you, or challenged you?

**This session**

• Sharing of practice story.

• Tell me about what has been important about this research project and what it has meant to you.

• How was it being part of a group, and in what way were you and your colleagues able to work together to improve practice?

• How would you describe the quality of the group actions i.e. the effect they had, ease of implementation, level of response?

• What would you like to see happen next, or what ideas do you have for continuing on the groups’ work in enabling occupation and justice?
Appendix C: Reading and reflection guides

Reading and reflection guide one: Occupation

Readings


- Chapter 1: 1.5 Specification of an occupational perspective: Our Canadian model p. 22-27
- Chapter 2: 2.3 How: Occupational development and change p. 54-58 (and text box 2.4 on p. 59)
- Chapter 3: Occupational science: Imperatives for occupational therapy p. 63-82.

Reflection questions

- How is occupation the focus of your occupational therapy practice? Use a practice story to illustrate this.
- Which occupational models do you use in practice? Give an example of how you use an occupational model with a client.
- Does thinking of occupation beyond performance have the potential to broaden your practice?
• How do chronic illness or disability restrict your clients’ participation in daily occupations? Consider the experience of a particular person.
• What opportunities have typically been afforded to your clients across their lifetime?
• What effect will a sudden loss or change in occupations have on your clients?
• How do life circumstances affect your clients’ ability to make choices about occupation? Think about this in relation to a specific case story.
• Do the spaces your clients live in enable occupation?
• Have there been situations where your service, despite its best intentions, has not fully supported the choice of your clients?

Reading and reflection guide two: Enablement

Readings


• Chapter 4: 4.7 Enablement skills: p. 111-116 (can exclude Table 4.6 & Text Box 4.6)
Chapter 5: 5.2 Enablement foundations and skills with individuals, families, and groups p. 137-140.

Chapter 6: Enabling social change p. 153-171

Reflection questions

• What are all the different ways you enable your clients in practice?

• Are there enablement skills that you lack confidence in and would like to develop more fully? What would assist you to develop these skills?

• Do you consider your practice to include political strategising?

• How do you help your individual clients to reach their occupational potential?

• Do you allow your clients to define and voice their own needs? Or do others, such as the client’s family, yourself, and your colleagues, do that for them?

• Is there a tendency in your practice to over emphasise one approach above others, for example, independence?

• Do you feel that focusing on social change falls within the scope of your occupational therapy practice?

• Can you recall any times when you engaged groups or the community to which your client belongs? How did this go?

• Who else in your community would benefit from occupational therapy?
Reading and reflection guide three: Occupation-based enablement

Readings


- Chapter 7 - 7.5 Characteristics of occupation-based enablement: A practice mosaic, p. 185-191. 7.6 Occupational enablement (pick a practice exemplar that you would like to read).


Reflection questions

- How do you keep an open mind to the possibilities for occupation and enablement?
• Do you use occupation-based assessments such as the COPM to get a better sense of your client’s occupational goals?
• Can you recall a time when it was difficult to engage a client in occupations because of limited treatment media?
• How might the processes in the Canadian Practice Process Framework (CPPF) guide your practice? Consider your work with a particular client.
• What key elements of the societal context have influenced your practice in this case? Are they societal issues that call for a response?
• Consider a time when your occupational therapy did not follow a typical path. Did funding, policy, daily life, personality or something else affect it?
• What types of unique solutions do you see for your clients? Can you recall an instance when you enabled your client to connect with other people or the natural environment, through occupation?
• Could you extend your practice to incorporate any preventive occupational therapy?

Reading and reflection guide four: Human rights and occupation

Readings


**Practice story**

I would like you now to reflect about how human rights applies to your occupational therapy practice, by thinking about your current (or recent) practice with a particular client, which you can then share with the group. You may have found your practice with this client to be particularly satisfying, interesting, tricky, complex, or challenging. Your practice story might either be about something tremendous and positive that you are doing in terms of human rights, or it might be an honest appraisal of needing or wanting to do better, or it might be anything in between (which will most likely be the case!).

- What is your relationship like with this client?
- What rights issues are raised in this case?
• How do these rights relate to occupation and participation?
• What things in your client’s life restrict or permit their rights?
• Is the client aware of their rights (or experience of injustices)?
• What do you think is your responsibility in this case?
• What responsibilities might other people have e.g. family, services, colleagues?
• What things help you, or hinder your practice for human rights?

Reading and reflection guide five: Developing visions of occupational justice

Readings


• Chapter 12 – 12.2 Professional autonomy issues in a biomedical context p. 299 – 304.


Reflection Questions

• How might you envisage occupational therapy at its ideal?
• What significance do human rights have in this occupational utopia?

• How does the reality of your practice fit with this utopian vision?

• What opportunities exist naturally for you to get closer to this ideal vision?

• What responsibilities do you have to bring about other practice changes?

• What support do you need to better enable occupation and justice?

• Do you need to put a case forward to management to support change in this direction?

Reading and reflection guide six: Plan

Readings

N/A

Reflection questions

• What kinds of human rights issues evoke your interest?

• How will you make a difference through enabling occupation and justice?

• What positive impact do you expect it to have for your clients?

• What changes will you need to make to your own knowledge?
• What changes will you make to the systems and processes in which you work?
• What changes need to be made in the short-term and/or long term?
• What supports e.g. mentors, literature will help you to achieve this vision?
• Will you take this action individually or with others inside/outside the group?
• How do you think it will be received e.g. by management, colleagues?
• How will you monitor your actions and the effect it has?

Reading and reflection guide seven: Act & evaluate

Reading


Reflection questions

• What avenues and formats do you use to routinely engage in self-reflection about practice?
• How do you reflect upon your human qualities in practice i.e. biases, assumptions, bad habits, etc?
How do you reflect upon systemic injustices affecting clients, as may be seen through their eyes?

Could processes like the confessional and critical tale be helpful for your practice at various points of your career?

**Reading and reflection guide eight: Act and evaluate**

**Reading**


**Reflection questions**

- What occupational themes do you notice to be reflected in the popular media? What occupational challenges receive the most attention?
- How do these issues relate to human rights, such as the right to health?
- Which issues do you feel are most relevant to your practice and professional identity?
- How does your practice recognise, or act upon, these occupational needs?
- What do you perceive to be occupational and human rights issues of the future?
- How might your model of service evolve to meet this future agenda?
• What opportunities or resources can you see in the media for occupational therapy?
• How do you see occupational therapy needs to be better profiled in the media?

Reading and reflection guide nine: Final evaluation

Readings


• Epilogue p. 359-363


Practice story

We have decided that writing a practice story would be a helpful way to individually and collectively celebrate our time together in the research group. So for our final focus group I ask that you write about a client or another type of practice encounter that you found interesting, problematic, challenging, enjoyable, satisfying, or so on. You may choose to explore an old story that you have previously shared with the group but in greater depth, or take the opportunity to
reflect upon a different practice experience. Think about what this study means for your practice in terms of enabling occupation, occupational justice, and/or human rights.

We will be sharing and reading out our stories with one another, or parts of it depending on their length and what you feel comfortable with. If you are happy to do so, please bring along a copy for me to incorporate into the research findings. Any questions or issues, I am happy for you to get in contact with me.

Reflection questions

• Please tell me about what has been important about this research project and what it has meant to you.
• What has been your experience of being part of this group, learning and doing together?
• What have you learned about the contribution occupational therapy can make to human rights and occupational justice?
• In what way were you and your colleagues able to work together to make these improvements to practice?
• How would you describe the quality of the group actions i.e. the effect they had, ease of implementation, level of response?
• What could have been done differently (in terms of group actions and/or the research process), or what else needs to be done?

• What would you like to see happen next, or what ideas do you have for continuing on the groups’ work in enabling occupation and justice
Appendix D: Newsletters

Enabling Occupation & Justice

Welcome to the project!

I would like to welcome all of you to this study. It’s exciting to have it underway and I am sure you will find it to be an interesting and integral part of your professional development program at Austin Health.

As you can see by the email list, there will be six therapists involved in the study (though it seems there are one or two, yet to join). This is a good number of people for exploring the concepts of enabling occupation and justice, in an in-depth way.

Starting Dates

The project is starting this month. As March is well underway already, I would like to propose some dates to you for the first individual interviews and focus group. Ideally, they will be done in that order, as this will allow me to get to know you on a more personal level first. I will be ready to start the interviews from March 16th onwards. I can complete these at any time of the day and at the Austin Health site that is most convenient to you. I am flexible to meet around your other practice commitments e.g. meetings and clinics.

This newsletter contains information about the project and will be sent to you all on a monthly basis. This month it covers organisational issues such as starting dates, recommended readings, guidelines for group conduct and so on.

In the future, the newsletter will contain my emerging and de-identified findings of the study. You will be asked to feedback on these findings and to use the newsletter yourselves to communicate absolutely anything you think is relevant.

It has been suggested that the focus group be held at the Heidelberg Repatriation site, at the start or end of the day so that people can go to leave. As soon as you have a chance, please email me directly with the most convenient times for your interview, and also with details of any days that you are unable to attend the focus group? This will get the ball rolling, and then we can revisit times and locations for future focus groups when we are all together in the one room. Expect to hear from me by March 13th with confirmed dates.
Readings & Reflection: March

Early next week I will be visiting Austin Health to drop off copies of the Enabling Occupation II texts. Please stay tuned as to how these texts will be distributed so that you can have easy access to them for the whole study. Whilst you are welcome to read the whole of the introduction and section one of EO II, I have selected particular parts of them for this month's reading. They are:

- Chapter 1: 1.5 p. 22-27
- Chapter 2: 2.3 p. 54-59
- Chapter 3: All p. 63-82

Don't be scared off by this workload! In the future, the readings will lessen and you will have more time to complete them. You have a few weeks to read these before the first focus group. I have also emailed a sheet of reflection questions. Again, this is for the focus group, not for the individual catch-ups. Hopefully this will help you to know what to expect in the focus groups, and to think ahead about some difficult concepts. You can use the sheet as little, or as much, as you like. Writing down your thoughts may be a good way of committing yourself to the reflective process, and the sheets could act as a record of your practice and research experiences.

Participatory Action Research

The style of research you are involved in is called Participatory Action Research (PAR). PAR is increasingly relevant to health care practice as it allows people to not only reflect on practice, but to simultaneously make changes to practice. Using a PAR approach, we will go through cycles of reflection and action, though not necessarily in an orderly way. In the first four focus groups we will be mainly reflecting on the four sections of Enabling Occupation II. The first focus group will focus on 'occupation', the second group on 'enablement', the third group will bring both of these concepts together, and the fourth group will be about enabling the profession itself.

What you learn and discover in the first four focus groups will help you to plan and implement changes to your practice later on. Your interests, ideas and beliefs, as well as that of the group, will drive this process.

In PAR, your active participation is vital, and you will be referred to as 'co-researchers' in the study rather than 'participants'. Please feel free to speak up along the way about any aspects of the research that you are happy, or unhappy with.
Group conduct

So we can get straight into the meaningful discussion on our first day, I have put together a few suggestions ahead of time for how we can conduct ourselves in the focus groups:

- Be good listeners without judging others. Support and inclusion of everyone within the group is very important.
- One person speaks at a time. Wait for the other person to finish speaking before you start.

- Be mindful that other people who want to speak should have the opportunity to do so.
- Ensure the privacy of group members. What is said within the group stays in the group.
- Remember not everyone within the group will share the same opinion. Disagreement and debate may in fact bring about creative ideas and insights.

I will check to see that these are sitting well with you before we start.

Human rights

Before finishing up the newsletter, I wanted to touch on the notion of human rights. As mentioned at the information meeting, I expect the theme of human rights to play an important part in this research. In 2006 WFOT released a position paper on human rights in relation to human occupation and participation. In doing so, it highlighted occupational injustice as a concern for the profession. As we go on, I will be interested in finding out what this position statement means to you, as an Australian OT working in a major metropolitan hospital. For instance, what are the important human rights issues affecting your practice? What does this mean for occupational therapy? In the meantime, if you are interested to look at the position statement (it is a quick 2 page read), follow this link and then click on the appropriate title:

www.wfot.org/documents.asp?cat=31

Cheers,

Danika
Enabling Occupation & Justice

To start with...

I trust you are well on your way to winding up for the Easter period, and already planning (or more likely in the process of enjoying) your celebrations and days of leisure.

This is the second EO & J newsletter for our research. It is rewarding for me to see the research rolling on forward, and I hope you have enjoyed the interesting and challenging discussions that we have shared.

This month's newsletter will include the yearly focus group schedule, the readings and reflections for April, and some of my beginning reflections.

Enjoy the read, and see you again on 24th April.

Year at a glance

So with a bit of luck, we identified a time for the focus group that seemed to suit everyone: 3:00pm on the fourth Tuesday of every month. I couldn't see any clashes with public holidays (including the Spring Carnival festivities!), though please let me know if any arise.

For the record, the two rounds of interviews will be completed early July and early November - we will chat about the specifics closer to the date.

FOCUS GROUPS

Friday 24th April
Tuesday 26th May
Tuesday 23rd June
Tuesday 20th July
Tuesday 25th August
Tuesday 22nd September
Tuesday 27th October
Tuesday 24th November
Tuesday 22nd December
Readings & Reflection: April

This month, the readings & reflection are centered on the concept of ‘enablement’, in Section 2 of the EO II text.
- Chapter 4: 4.7 Enablement skills; p. 111-116 (can exclude Table 4.6 & Text Box 4.6)
- Chapter 5: 5.2 Enablement foundations and skills with individuals, families, and groups p. 137-140.
- Chapter 6: Enabling social change p. 153-171

Similarly to last time, you are welcome to read further should time permit. Please allocate some time to think through the reflection questions, they will in some way, shape the direction of the next focus group.

Last time, I was interested to hear the very real practice examples that you talked about. It helped to make the discussion more relevant to practice, which is why this research is so important in the first place!

First thoughts on the focus group

First of all, I found the depth of discussion in the interviews and the first focus groups so interesting! Each person contributed a great amount to the conversation; in fact I was surprised at how little I said!

The group has a very good synergy. You were all willing to share your own thoughts and ideas, and to ask questions of each other. This was done in a supportive and encouraging way, which of course is important.

I also want to acknowledge that at the moment we are focusing on the problematic parts of our practice. It may at times be disheartening. This is a difficult, but necessary part of the research process. Be reassured that by reflecting on our practice, and being critical in our thinking, we can start to learn how to practice it in a better way. As we go through this phase, continue to provide positive support and encouragement to each other.

The next sections will explore some of the themes raised in the March focus group, and they are by no means exhaustive. I would appreciate your feedback, either personally via email, or when we are all together again.
Issues of occupational injustice

In the first focus group, we began to talk about the concept of occupational justice. Whilst we are not always aware of it, the practice stories exemplified the ways in which we do justice, or injustice, in our everyday practice. On the whole, we talked about occupational injustice implicitly, themes such as meaning, fulfillment and choice came up often.

We also talked more directly about the occupational injustices arising out of illness or disability. For instance, how scary it might be for a 25-year-old woman to die in a hospital setting, or what it might be like for an elderly person to be ‘stuck in the house’ with no means to access the outdoors or community.

It was interesting to also discuss some of the ways that life circumstances impact upon a client’s engagement in occupations, such as how chronic illness from a young age and frequent interaction with the health system, may restrict development of decision-making skills.

Instances were raised when therapists became aware of a client’s occupational injustices in the midst of practice. This therapist was planning a home assessment when she learned that a client’s partner had just been diagnosed with a terminal illness: ‘I thought, is this really a priority for you right now?’

By exploring the context of occupation, therapists were able to create enabling environments. Consider, for example, how one therapist engaged people from the home, school, and community context in order to enable a 16-year-old client to access a coffee bar with his schoolmates.

The health care context was profiled as potentially contributing to occupational injustices for clients, by ‘channelling’ resources to medical interventions such as medication, rather than creating the housing, employment and other conditions that are necessary for health.

Crucially, the institutional context was thought to bring about injustices for occupational therapists themselves. The lesser value afforded to occupational therapy in contrast to medicine was highlighted by the challenge of obtaining research funding, and time constraints mean some therapists may have only 15 minutes with each client.

Many of you have reported feeling ‘tired’ and burned out, personally and professionally. Is it sustainable not to enable occupation and justice? If we are not satisfied in our roles, what impact will this have on our ability to enable occupational justice for others?
Constraints on EO: Safety and biomedical discourse

The focus group discussion raised many practice challenges linked to working in a modified setting. I think this comment, highlights the large contrast between medical and occupational models in practice:

"If I want to team meeting and said 'actually what we are going to do tomorrow is go shopping because this person really wants to,' they would laugh at me'.

Whilst some therapists reported they were 'lucky' to practice in areas where safety 'is not even on the radar', others talked about how their practice is grounded in a safety and biomedical discourse, such as determining a client's safety for discharge.

In occupational therapy, we minimise risk by focusing at the level of the person, occupation or environment. We talked about practising our duty of care by installing a handrail or making a splint to protect a tendon repair.

Therapists shared their different strategies for dealing with this predominant focus. For example, they educated colleagues about occupation as a 'protective factor' for health, they accepted that 'you cannot reduce the risk to 0', and they are trying to incorporate therapeutic use of activity into hand therapy.

It was pointed out in the focus group that determining if a client is safe for simple occupations, such as transferring on and off the toilet, is enabling occupation in its own right. Indeed, a safety or impairment-focused approach can even 'launch' a client to engage in a range of other meaningful occupations.

However, one therapist believed that once you reach safety goals, 'that is where the medical model stops you'. I agree that this is often the case. In occupational therapy we may focus on healing at the impairment and safety level, without conscious consideration for a client's future occupational goal.

Could it be that by focusing on safety we overlook other important qualities of occupational performance, such as satisfaction and efficiency? Do we limit our practice to occupations that people do, rather than have?

Further, in having an emphasis on safety, are we really using our professional expertise? If occupational therapists are not adopting an occupational 'lens', then who else is?

This discussion in the focus group has made me think, why do we - and many other therapists - emphasise safety? Is it because we think it is expected of us from the hospital, our colleagues, our profession or our clients? In what way may we be asking this of ourselves?
Enabling features: Holistic definitions of the client & home

The definition of client became a talking point in the focus group. Therapists considered that the medical model, generally views the patient as the person who has an injury, illness or disability. The patient is one body, one human being.

In contrast, therapists felt that occupational models consider occupations to be interdependent. People share, or are connected by, occupation. For this reason, occupational therapists consider it logical not to consider the client as the individual person and their family, carer, groups, and community.

When a client has a problem in their occupational engagement, we naturally see the implications for the family, and vice versa, and we instinctively get about forming relationships with the client’s significant others.

"Mr Jones might be the person who is dying of lung cancer but Mrs Jones and her two kids, his neighbour, his ex-wife, his estranged children, that is the space that is thrown and effects their occupational repertoire for however long."

Similarly, one of the ‘best things’ about occupational therapy is visiting a client’s home. You learn more about their occupations, and it empowers the client - "when you go to somebody’s home you are on their territory, so you kind of have

Occupational therapists understood the need of carers, this allows therapists to ‘break it down into the practicalities’ so that clients can make choices about their caring responsibilities.

Nonetheless, the medicalised setting creates ethical tensions for occupational therapists. For example, when a spouse or carer is also affected by ill health and yet policy – hospital, DVA or other – restricts occupational therapists from assisting them.

In occupational therapy, we value home as an occupational space. Some therapists noted the limitations inherent in hospital spaces, and provided examples of how despite, their best intentions, it may not afford natural engagement in meaningful occupation.

“We do occupation-based assessments but it always in the hospital and sometimes it’s a simulated space, like breakfast group where we ran tables along a wall.”

Is it possible to enrich our intervention settings, at home or in the hospital setting? What are the consequences of choosing not to take action on these matters?

If you have any questions about the research, please contact:
Danika Galvin
dgalvin@csu.edu.au
Upcoming in May

Thanks for your participation in the April focus group. It was another interesting discussion, and it will be great to hear your further thoughts and ideas via email or when we all next meet together on Tuesday 26th May.

I have attached the reflection sheet for this month. The readings are a small sample from the chapters in section three of the CO II text, which explores ‘occupation-based enablement’. Also attached is a paper to skim through by Rachel Thibeault (some of you may be familiar with this from the WFOT conference in Sydney, 2006).

• Chapter 7, 7.5 p. 105-111.
• Chapter 9, 9.2 p. 233-235 &
  Chapter 10, 10.5 p. 265-271.
• Thibeault (2006).

Reflections on the research process

We began the April focus group by discussing some of the positive effects of participating in the last group. People mentioned that they had found it ‘comforting’ to learn that colleagues were experiencing similar practice issues to them. Talking about occupation and the challenges of practicing in an occupation-focused way ‘is not something we often do’. Sharing these thoughts and ideas in a community of practice, and with ‘people on the same wavelength’, was viewed as important in order to build the ‘courage to advocate for what you know as an OT is important’.

People reflected about the ‘healed’ nature of occupational justice and how they felt ‘annoyed’ when talking about injustices. This passion was reasoned as a positive thing because it can be used to make a difference in the occupational lives of our clients. Importance, therapists also talked about being more conscious of practice after the focus group ‘like a new grad who has just come out all eager to do things that way’. This is a great achievement! If we can be conscious of the way in which we use (or don’t use) occupation, we can practice in a more ethical and just way.
Enablement: Our core competency

This month’s focus group centred on enablement. Therapists commented that the CMCE embodies what it is that occupational therapists actually do in practice, not just with clients but with everyone else, including carers, families, colleagues, and students. Whilst different people integrated the ten enablement skills to varying degrees, they were all considered relevant. ‘There is no one (skill) that makes me think “no I very occasionally do that”’. As well as using an enablement framework to reflect on our own professional competency, therapists discussed how it might help to think about the interests or talents of students and to direct them to areas of practice where those strengths are the core skill that you need.

Advocating for clients through ‘stating our case for funding’ was an enablement skill used in some areas. Coaching was also described as an approach that fits ‘nicely’ with the empowerment-oriented philosophies of occupational therapy. For example, rather than asking routine questions to the client, ‘What are you interested in?” therapists might try to motivate and inspire clients by asking ‘what types of things help you to come alive?” These coaching questions help clients to learn about their unique selves, and are of benefit to their ongoing growth and development. Therapists also discussed practice areas in which enabling occupational change is not the goal of therapy e.g., when people are dying, and therefore where coaching is ‘rarely’ employed.

Significantly, therapists discussed how enablement is often invisible and taken-for-granted by clients and other health professionals. ‘We know the impact that we are having, it sounds very simple and straightforward to others, but we know it is not’. This invisible complexity may in fact be a logical reason as to why it appears that people do not value what occupational therapists do. It is so surprising and good to see it written down and this is the first time we have seen it, how are we expecting all these other professions to?” Therapists proposed that the language of enablement might help to better convey the value, benefits and ideas underpinning the profession (thereby avoiding the ‘eyes glaze over’ scenario!).

I agree that enablement language can be a powerful way to promote the profession, and it seems a more satisfying option than continually articulating ‘exactly the ins and outs of our profession’. Nonetheless, the automatic and habitual ways in which we communicate and interact might make it difficult to adopt this approach. ‘I can read all this and think great. When I am pressured, I write notes or communicating with someone, I go back to my old way of doing things’. To overcome this, it is important that our language reflects a deep change in what we actually do with clients. It is through our work in enabling occupation and making more visible its link to health that occupational therapy will earn greater respect.

Political competence refers to a dynamic set of critical knowledge, skills and attitudes that enables one to engage effectively in situations of conflict and cooperation that are about responding to people’s needs and demonstrating the relevance of the profession. Examples of components of political competence are: political reasoning (ADR), strategic planning and decision-making, networking, lobbying, debating.

(Pollard, Sakellariou & Kronenberg, 2009, p. 31)
The enablement continuum

The EO J text profiled an enablement continuum that highlights not only effective enablement, but also the way in which occupational therapy might result in minimal enablement, missed enablement, or ineffective enablement. This effectiveness is influenced by the choices that a therapist makes and the conditions of practice. Whilst some therapists wondered otherwise, I suggest that these concepts may help us to better understand practice, and to enable individual change in a more effective way.

Despite the common belief that a primary skill of occupational therapists is to engage clients in occupation, the group raised challenges of involving a client in the occupational therapy process. For instance, a client may bring to the professional relationship a ‘self-idea’ of what occupational therapy is about. During the goal setting process, a client may state their sole goal is ‘walking’ and despite the best efforts of therapists, it is difficult to engage the client in occupational goals that are meaningful to the client. This can create an ethical dilemma of what to do ‘well it’s not important to them, so what, do I do nothing’?

Whilst this common situation may arise because a therapist has missed the opportunity to be proactive in helping a client see the possibilities of occupational therapy, generally the client has made a well-informed choice about what is, and what isn’t meaningful to them. Thus not engaging the client is perfectly client-centred. However, there are other times when therapists feel ‘trapped’ within a discourse of safety ‘because that is what we are employed to do’. However, it might be problematic when we engage people in occupations that lack meaning to them, such as when pursuing involvement of the client in a personal care assessment or a group activity when they really don’t see the point.

This notion of ‘free will’ is an interesting talking point. Therapists wondered ‘by trying to force it a little, which is sometimes what I feel like I am doing, am I perhaps only doing it halfway’? Whilst there will always be varying degrees of client participation and collaboration, I propose that this approach may be less effective and in fact be at risk of compromising a person’s right to human dignity. Instead, can we improve the way in which we explain the therapeutic value of occupation to clients? How do we ensure that we allocate sufficient resources to find out what occupations are meaningful to clients? Are there other enablement skills (as opposed to engaging) that would bring about a more effective result?
What’s in a need?

I would like to reflect on the notion of need as it was implicitly raised quite a bit in the first focus group (and then by me in the second). Occupational therapists help to meet human needs on a daily basis, and the word need commonly comes up in practice. At the point of referral for occupational therapy, other health professionals have often defined the needs of a client, for instance ‘this person needs a home assessment’. In certain areas of practice, medical practitioners define the needs of the clients and ‘it might not be for a good week or two later that occupational needs are explored. The need of the referral will generally correlate to their understanding of what you can provide’.

Occupational therapists seem to be instinctively and expertly aware that these definitions of need may not in fact be what is actually needed ‘this person needs a shower chair, can you see them? – My favourite referral’. Indeed, there may be times when occupational therapy is entitled for the very reason that therapists are skilled at helping the client to define their needs ‘get the OT in they will sort it out’. To this end, occupational therapists generally help clients to voice their needs by doing a ‘holistic’ assessment of occupational needs ‘it is not in our nature’ to do otherwise.

According to Professor Jim Le (we will talk about his writings on human rights practice in social work more throughout this study) different people at any given time define a need in different ways. Whilst therapists may be aware that their definition of need and the client’s perspective of need ‘are often two quite different things’, they may be less sensitive to the fact that need is a value-laden concept. For example, in defining that a client needs a shower chair, we (or our colleagues) may be promoting the belief that it is better to be independent than dependent, in contrast to the client who for cultural reasons may prefer to enlist family assistance. In some ways, the ways in which therapists define their client’s need might actually ‘disable’ them.

Another thing that came up in the focus group but was not fully explored, is the relationship between needs and wants. As we know, there is not an infinite amount of resources in health care ‘I cannot say be needs it any more than any of my other patients, then that is an equity thing’. So how do people make the distinction between need and want, for the purposes of enablement? Le proposes that when the word need is used in practice, we should take a long hard look at it. He suggests that not only should therapists ensure that it is the client who defines their needs, but also that we should look at the rights that lie behind the need. Does this approach have scope to help occupational therapists prioritise what they do?
Developing our political competence

In the focus group therapists provided examples of creating change at a social level, including how to make the health system more efficient and effective for clients. Therapists did this through enacting a variety of political skills. For instance, one therapist is lobbying for an internal vocational consultant position by consulting with other settings on best practice principles and enlisting the help of students during their project placements. Another therapist is advocating for new occupational therapy positions in non-traditional practice areas by collaborating with the special interest group to design a business strategy.

However, we were generally hard-pressed to illustrate how we use our political skills to enable social change (even in the immediate local environment of our clients) on a day-to-day basis. This made me wonder, do we need to be more politically active in practice? For instance, to lobby for social change such as improved occupational spaces for clients in the hospital, or to advocate against clinical pathways that overly standardise practice? What is the ethical responsibility of occupational therapists to link our practice with individual clients to what is happening at a broader policy level?

Factors that support therapists in developing their political competencies were also profiled. Some employment experiences such as transdisciplinary positions in an emergency department or case management in a transitional care program provide a "steep learning curve" for development of these skills. Otherwise, social work has a "well developed tradition" for social and political action, and might offer insights into building competency in this area. Therapists suggested that enabling social change requires the profession to be willing and prepared to "take on a bit of everything, everything you can make a change with really".

Therapists also made a conscious decision not to use their political skills for enrollment, such as when a client asked for something beyond the therapist's professional training and level of expertise. To practice within the mandate of the occupational therapy in an important ethical responsibility, and one that maintains the integrity of the profession. Yet how do we figure out what is "inside" and what is "outside" the scope of occupational therapy? What are the boundaries of what we do, and what should they be? Is political competence and enabling social change something that warrants greater emphasis in our practice?
The future of the profession

The conversations about professional competence occurred hand-in-hand with a debate about the future of the occupational therapy profession. In Western society we value individualism and its ideas of autonomy, independence etc. As discussed previously, the medicalised settings in which we work define the client on these individualist terms. Despite the fact that in occupational therapy we recognise the significance of other people in our clients’ occupational lives, there remains an emphasis in practice on enabling at an individual level.

In the focus group, therapists discussed how leaders of occupational therapy have proposed that we alter the name of the profession so that occupational therapists are otherwise known as ‘occupational enablers’. The implications for making a complete paradigm shift towards enabling social change raised concerns among some therapists about how the profession would maintain its relevance and fit within health settings that are dominated by a medical model. By doing all these things that yes in theory are what we are wanting, will it then result in us not existing anymore?

Some therapists proposed that the profession should ‘be more smart and more pragmatic into challenging our energy and power into areas that we can change and all the areas we can’t’. Alignment with the primary health and community care might enable the occupational therapy profession to have a greater impact on ‘clients who are actually out there’, and at the same time be ‘more satisfying to us’ as therapists. Whilst the profession may need to broaden its professional objectives in order to meet wider community needs, I encourage therapists to remind ourselves of the very real and substantial ways in which we enable occupation within acute and other medicalised settings. What negative outcomes could you envisage if our clients were not able to access these occupational therapy services?

Interestingly, it was suggested that building an inclusive society is an ethical responsibility not only for occupational therapists but also for all people. I think that the point out of the failings of society is a human duty, not just the province of the OT or the campaigner! This brings up some important points about what it means to practice as a therapist and as a human being. I wonder if the current challenge in occupational therapy is not so much about deciding where to situate our practice, but about how to ensure the profession is grounded in human practice. In thinking about practice with ‘people’ rather than ‘clients’, are we able to better enable occupation and justice at an individual and social level?
Enabling Occupation & Justice

Austin Health

Next month

The months are rolling on forward! We are near completing the intense reflection phase of this research project and following the June focus group we will start to plan to take action to improve upon our practice. As mentioned, the focus group on Tuesday 23rd June will be based on the idea of human rights in occupational therapy practice. Despite the fact that the theme of human rights is emerging in the profession, such as in the 2006 WFOT Position Statement, there is a limited understanding about what it means for our clients, for occupational therapists themselves, and for everyday practice. This is largely new territory, and I think very exciting discussion to be a part of! Have a look at the reflection sheet for the readings and for how you can best prepare for the session. Unless you have any particular thoughts or feedback, I will see you at our focus group in a couple of weeks.

The knowledge that we value and use

Similarly to previous discussion about political competence in practice, therapists talked about not having all the skills necessary to impact upon decision-making within the health service, ‘we don’t present the business case very well’ and ‘we don’t know about the money!’ Therapists perceived that the hierarchical organisation of a health service was also a limiting factor to their getting involved in influencing change ‘we can only take it to a certain level’ i.e. to management. Some therapists felt that they were ‘a very small fish in a very big pond’ in terms of forums dominated by medical professionals with a strong research background.

This led to a general discussion about the way in which knowledge and evidence is valued in a medicalised setting – with a higher emphasis on quantitative data over that which can be obtained through qualitative means ‘the system is geared for statistics’.
The knowledge that we value and use (cont.)

occupational therapy elsewhere the nature of knowledge and evidence-based practice (EBP) is being explored. EBP places knowledge on a hierarchy, whereby systematic reviews and randomised controlled trials are at the top and expert opinion and qualitative research are at the bottom (Whitford, 2005). Whilst the movement towards EBP has been integral for the development of best practice principles, it might also create situations where narrative data and qualitative research methods don’t appear to carry as much weight as the numerical data commonly the focus of medical research.

According to Whitford (2005), a hierarchical view of knowledge reinforces the false belief that it is possible to determine truth and certainty in research, and to this end that context can be controlled for in research. Therapists recognised that there are multiple influences on a person’s health and recovery. We can’t prove that having a program, engaging a certain number of clients, running a certain amount of groups per day per week necessarily needs to better outcomes...there are different treatments at the time. This recognition of context is important. Yet in actual practice, I wonder if at times occupational therapists still try to ‘prove’ things about what they do, and thus afford greater value to quantitative research methods?

EBP in occupational therapy, but it is just one means for understanding our clients and for humanity more broadly, it is not an end in itself (Yerxa, 1992). It is important that we remind ourselves of the benefits of qualitative research, such as how it can help us learn about the complex and contextual influences on what people do and the state of their health. Narratives of shed light on what life might be like for people affected by illness, disability or difficult life circumstances, as well as for the experiences of therapists themselves as they go about practice.

Many in the medical profession also recognise the benefits of drawing upon both quantitative and qualitative paradigms. One therapist commented on how doctors ‘see to that the clients, the patients, are more than just the sum of their biochemical pathways and any broken bits. So there is more focus now on looking at how that person responds to the treatment, how they feel about the treatment, what they feel their narrative is, how they cope with having whatever interventions that they have had, and then slotting it back into their lives’. Whitford (2005) suggests it is important that our research methods in occupational therapy – either quantitative or qualitative – are selected and guided according to the nature of our research question.

Scientific inquiry is certainly important for
The context of accountability

Therapists also described being increasingly accountable to clients as a result of technological advances in biomedicine, such as development of drugs that are readily published in the media. This, in turn, 'can really impact your relationship with them, what they think is achievable' in health care, and in occupational therapy. Therapists discussed the reduction in their human resources to help meet consumer expectations, and how 'people are pretty flat' as vacated positions for colleagues on extended leave or who have vacated their position, not being filled until at least the end of the financial year. One therapist reported not being able to do 'half the interventions' that she would like to, and that the AHA 'has the same limitations'.

The discussion raised questions about how we choose to spend our time. What should we allocate more time to in practice, and what sacrifices might we be prepared to take? According to Whiteford (2005), the pressures of accountability are likely to have heaviest impact on people living on the margins, and thus when engaging in practice and research endeavours we must ask the question 'whose purpose does this serve? Our priorities should focus on our clients and their needs. For example, how do we monitor what happens to our clients after therapy? What occupational outcomes could we capture?
Social & ecological occupations

Inspired by Thibeault’s article, we discussed the profound ways in which occupational therapists have considered social and ecological dimensions in their practice. We heard one practice story about how a therapist enabled a client hospitalised with Guillain-Barré syndrome for 4-5 months to access the fresh air and space outside “she had nothing over head except sky and I think that was quite important to her because she had been trapped in the ceilings for far too long”. This opened up the communicative space between the therapist and client as they shared parts about their life, the positive effects of which were evident for the client “she was so delighted for days afterwards”.

Another therapist talked about taking a client with a mental illness to the local park, which was “calming from a sensory point of view ... he felt less distressed”. These acts in enabling occupation involved varying degrees of just-right risk taking, such as when advocating for the least restrictive environment under the principles of the Mental Health Act.

The story of enabling clients to meet and interact together in the tea room similarly held risks and could “go aways sometimes”, but which were viewed by therapists as a worthwhile way of enabling clients to receive ordinary human contact and support that they may not necessarily be able to provide clients.

On occasions, enabling occupation in a social realm was not necessary, for instance if the client did not have an occupational challenge, need, or goal. These elements were missing in the case of a 19 year old girl as a therapist shared how team members feel like it’s our job to find her some new friends, which is a fascinating view of what we can do for our patients. For other clients, it was challenging to engage clients with poor social interaction skills in occupational therapy, and thus therapists creatively practiced “through stealth”, such as in observing the client in the television area.

Given the inherent value derived by the client from these practice stories, do you think we engage people in occupations that are social and ecological in nature enough as what we should? I suggest that therapists may choose not to at times, because of time and other resource constraints. I wonder if in occupational therapy we could be more cognisant of the link between occupation and health, and how for example enabling a client to sit in the sunshine, enhances therapeutic value in terms of regulating blood pressure ⇒ improved stress levels ⇒ occupational balance, and so on, with the advantage of also having cost-beneftists. Might thinking about the economic value of social and ecological-based occupations help us to justify its meaningful use more often?
What does it mean to care?

An 'ethics of care' is a practice approach that is known to be well aligned with nursing practice. Health professionals who enact an ethics of care make an effort to imagine what a situation must be like for a client, and act compassionately to help them. In the focus group, we heard a wonderful story about a nurse who brought in some decorated, silk hospital gowns that had been worn by her own grandmother for another client. This had a powerful and positive impact on the client '…she has got something more wonderful to wear. That has made the greatest difference in her life. Really you know the fact that she is not just this white person in a white bed, she has some other noticeable characteristics.'

In occupational therapy too, there were very rich examples of this approach. For example, one therapist described talking with and not to a client 'to give her a bit of social interaction that doesn't involve “how are you feeling? Where is the pain?” Sometimes, clients had difficulty engaging in basic occupational forms, such as communication. For a client who had had a tracheostomy, the therapist allowed the gesture of time when others might have rushed the client ‘he painstakingly wrote and told me about all the trail rides he used to go on. I can get the gist of his sentence pretty quickly, but no he is putting every word down.'

In the community, people might be socially isolated and there are simple things they would like to share about their daily experience with therapists ‘there are times where that person just needs to talk to somebody about the TV show they saw last night’. These caring skills influence our ability to develop rapport with our clients, though can also be problematic, such as when 'the team very much feel that they need to do everything for everybody’ or as one therapist described in a previous case management position ‘in 43 degree days I am thinking of that person – have they opened their windows, are they drinking enough water, is anybody checking on them?’

Therapists of course raised things to be learned in terms of how we might want to define the parameters of our practice. Nonetheless, I think these practice stories show how a caring gesture, attitude or words of an occupational therapist can positively impact on the lives of our clients. This made me question, are there times when (despite our best intentions) we may not be kind towards clients? For example, is a reluctance to provide ‘diversional’ therapy not only an occupational justice issue, but one about caring?
Social justice & human rights

In her article, Thibeault identified how her own and occupational therapy practice more broadly has been influenced by a social justice approach for more than 25 years. Whilst therapists ‘love that this is what she has written about and what she is passionate about’ therapists believed this not to be the case in their own education ‘I don’t know I don’t get a strong feeling here’ in Australia. Social justice was viewed as something more applicable to a therapist’s personal life ‘I went home and did that’ rather than an explicit focus of practice. ‘I never really saw it as part of occupational therapy’.

Therapists suggested that social justice comes ‘naturally to some and not to others’, and that it requires a ‘different skill-set’.

Potential reasons for feeling a disconnect to a social justice approach within occupational therapy was posed in relation to the fact that in Western societies there are not the same ‘glimpse diversities’ as elsewhere around the world, especially when a client is not seen in the context of their home and community. The example was given that if a client was to make a claim to an indoor toilet as a condition for their health, then this would be addressed on an ‘individual basis’ rather than through population health measures. However, others raised the ‘very obvious’ disparities in the work and income conditions for people with disabilities employed in a sheltered workshop.

Whilst many of the practice stories related to human rights practice, we heard a most powerful example of an Iraqi man who experienced many injustices as a result of his cultural, familial, health, and employment circumstances. The therapist, with an interpreter, opened the possibilities for this client to ‘let out the pains he was going through for the past 4 or 5 days’.

We also heard an example of how it is not always possible for a therapist to apply their interest and skills in social justice, such as when a therapist was not approved leave to help in local humanitarian efforts.

This conversation raised many questions such as what is our ethical responsibility to practice towards rights (and injustices)? How do our systems help or hinder us to develop the skills necessary for working towards justice and human rights? Moreover, our discussion centred upon social justice rather than the concept of occupational justice, and yet we as a profession seem to have a unique perspective to offer these concepts, such as in our appreciation for ‘existential’ rights such as balance and meaning, and in broadening the discussion of human rights beyond civil and political realms - ‘I was trying to be all occupational and trying to convince them that should be a human right’. Our conversation next time, will take off from here.
This month in focus

In the June focus group, we discussed the idea and practice of human rights in occupational therapy. After giving a snapshot into the theory of human rights, this newsletter will consider these reflections. Please have a read, and contact me with any thoughts or feedback. In our next group on Tuesday 28th July at 3.00pm, we will further develop and share our own visions and aspirations for how occupational therapy can work towards human rights (and injustices). I look forward to seeing you all there.

A brief introduction to human rights

It was in response to the atrocities of the Holocaust and World War II that the theory of human rights made its most significant advance by being conceptualised in the 1948 Universal Declaration (UDHR). Human rights are generally classified into three kinds of rights. ‘First generation rights’ are civic and political human rights, such as the right to vote and to freedom of expression; these rights need to be protected. ‘Second generation rights’ entail the right to health, employment, education, and so on; these rights are important if one’s human potential is to be realised. First and second generation rights are recognised in UN covenants and international law.

More recently included are ‘third generation rights’, the rights afforded to peoples as a group such as the right to self-determination or the right to live in a non-polluted environment. These collective rights are highly influenced by Asian cultures and worldviews, and so represent an increasing appreciation that human rights can be universal and contextualised. That is, relevant, informed, and shaped by diverse people and their contexts.
Human care

We resumed our discussion about caring in occupational therapy practice, and how simple acts such as the appropriate use of physical touch enable a patient to feel more ‘humanly connected to what was going on’. Therapists believed that the positive effects of caring are not indifferent to human relations in broader society. ‘If you go anywhere and someone treats you kindly your response is much better than if you are not. If you are at a restaurant or a coffee shop, it is not just related to us as OTs.’

Clients do not necessarily perceive an approach as caring, such as when the therapist will not help them during an assessment. Therapists also described how a Community Treatment Order where ‘people are forced to have treatment, is actually caring in the sense that people get to live with their families rather than be institutionalised’. Caring was perceived by therapists to increase motivation and compliance to treatments - ‘to build that relationship so they kind of hopefully do what I ask at home, they get a better result quicker and it saves me time’, though its positive effect on subjective well-being is not as clear ‘I think so often we don’t find out about the client satisfaction side of it’.

Therapists described the likelihood that they might not naturally be drawn to care for clients 'I am sure there are times when certain people, who really rub you up the wrong way, who you are probably not that kind to', such as because of personality or uncaring and busy work environments. Therapists also proposed it as helpful to have teams in which different individuals provide different (i.e. more or less) levels of care ‘if you had all of them that were 100% caring in every way, you probably wouldn’t have the best outcomes in certain clinical areas’. This is certainly an interesting point, though I think we need to be cautious about distancing the therapist-client relationship as it is regarded to impede the therapeutic process (Wright-Ste Clair, 2001). My reflection is that caring relations are the foundations for good and ethical practice. This does not mean for a universal approach to caring, rather the extent to which it is in the foreground or background can be up to the therapist.
Utopian visions of human rights

Therapists contrasted traditional perspectives on human rights that focus on ‘the right to freedom of speech and voting rights, and democracy’ and so on with their unique occupational view. For instance, therapists described helping clients in their human right to participate in personal care occupations through doing simple things like ‘changing environments, and giving aids, and dressing techniques’, or by advocating for discharge to rehabilitation to meet their goal of increased independence. Therapists also focused on rights interdependent with the right to health, such as by writing letters for housing needs.

There was a sense that the language and concepts embedded in the WFOT Position Statement on Human Rights was difficult for therapists to relate to. ‘Do they make these things as complicated as possible so people don’t understand?’ The ‘aspirational’ nature of the WFOT Position Statement was commented upon, with some viewing its utopian visions as distant from the realities of everyday life. ‘I just read it and thought, could you take me to a place in the world where you can tick off all these boxes, and we are all happy and dandy?’ This idealism was seen as problematic ‘sometimes when you set goals so high they are so far out of reach that it makes them not worthwhile’, particularly in relation to the point made by WFOT about ‘people having a right to be supported to participate in a range of occupations’.

It was queried as to whether such statements should be altered for a more ‘realistic’ interpretation, such as to read ‘for people of sound body and mind’. I am not sure it was the intention to propose exclusion of people on the grounds of their qualities or characteristics i.e. disability (undermining the very notion of human rights). Rather, I wonder if some of our frustrations stemmed from taking on too much individual responsibility for the role of supporting participation in occupation. A human rights framework emphasises the need for collaboration with clients, family, colleagues, and others. Thus, when faced with a client’s occupational issue the question we could ask is not “what should I do?” but “whom should I talk to?” and then “what should we do?” (Ila, 2008).
The human rights of vulnerable people

Similarly to past discussions, therapists suggested that in local Melbourne, in the general population, people (do) have a right to participate in a range of occupations. Therapists considered that in the ‘Westernised, affluent society that we live in’ people have access to fundamental human rights such as ‘shelter, safety food’. Thus, human rights and their injustices are sometimes less visible than what they would be elsewhere in nations affected by situations of conflict, political insecurity, or repression. It was wondered if the perception of human rights violations as occurring somewhere else is ‘why we haven’t talked about it in our particular context’?

In addition, the practice of human rights beyond a legal realm is only just beginning to be explored, and so therapists shared their practice stories about individuals and groups of people who are disadvantaged or powerless, such as the elderly and people with disabilities. One therapist advocated for a client with a terminal illness to be discharged to a home despite poor hygiene conditions ‘the social worker and myself were arguing heavily that - is it our job to say that the way you have lived your life of 30, 40, or 50 years is unacceptable and that we are not going to let you go back home into that environment?’ Another retrospectively questioned how they might not have respected a client’s human rights by advocating at VCAT for Guardianship and their placement in residential care. ‘I probably didn’t struggle with it at the time, but I have struggled with it a lot since. I feel like I did that to him’.

We may never know the full consequences of any action we take in practice, yet such critical reflection is imperative for developing our ethical decision-making. Thinking more generally about vulnerable clients, how do we make the distinction between people who have a capacity to make life choices e.g. people with a physical disability, and clients who do not have that capacity e.g. dementia? Concerning the former group, do you think we have a tendency to act in their ‘best interests’ when in fact we should be encouraging them to advocate for themselves? Do we still maximise participation of people who are deemed ‘non-competent’ in decision-making in other ways?
Institutional context & human rights

Therapists noted how various institutional contexts afford or constrain the human rights of vulnerable people. Residential care settings were described as ‘clinical and sterile… everyone has to sit there’, with little opportunity for people to engage in their right to meaningful leisure, productivity, and so on. One therapist explained how a client who was a war veteran ‘recently on Anzac Day took his scooter down to St Kilda and got drunk. He didn’t tell anyone in the nursing home where he was going and he managed to call himself a maxi taxi and get himself home… When he returned on his own, their big issue was “we have a duty of care to you to know where you are” and his big thing was “my rights as a person.”

For this client, the scooter provided many health promotive benefits through engaging him in occupations such as the theatre and dining out. Removal of a scooter, as requested by the residential care setting would have ‘taken the only joy of life away from him’. In hospital settings, team members similarly ‘err on the side of legal caution’ concerning discharge planning with a concern that cases might end up in the Coroners Court. Yet our perception of risk might not necessarily be accurate, as many clients continue to live happy and fulfilling lives in the community ‘if people didn’t happen to come into hospital for whatever reason we wouldn’t have known about these people living for another ten years in the same situation’.

In certain situations, legal institutions such as VCAT act as a ‘tie-breaker’, by judging whether clients can continue making their own life choices or if there is a need to appoint a Guardian to advocate on their behalf. Despite the ‘protection’ provided by this system, therapists seemed wary of potential bias in that it operates on the ‘judgment that our profession, our training in medical backgrounds or whatever is better trained than them (clients) living for over 30 years’. Thinking critically about the influence of the institutional context on human rights and injustices means that we are less likely to make decisions that further oppress our clients. Do you think you routinely considers such things?
Do therapists deflect issues of human rights?

Therapists shared innovative examples of how they have enabled occupation and human rights. For example, with the introduction of smoke-free zones in an inpatient setting one therapist was involved in purchasing games such as Wii and table tennis to promote client participation in leisure and recreation. An occupational perspective was similarly used to break dominant medical talk and objectivity ‘I suppose the way I try and look at advancing some of these human rights, is looking at even at doing the ward rounds asking occupational kinds of questions… I ask (clients) do they work? What do they do with themselves during the day?’ This ‘holistic picture’ that occupational therapists provide is thought to generally of interest to our colleagues.

Therapists also noted ‘how restricted our rights are by all those systems and all those things, and also by patients sometimes’, for example when clients themselves are not able to identify the things they want to be enabled in. I would also like to query if occupational therapists themselves also sometimes deflect on our moral responsibilities to take up, or create new opportunities for enabling occupation and justice. For instance, we might invoke the policies and procedures of the health setting as problematic, ‘we are so constrained by rules… If we wanted the patients to make their own cups of tea, infection control would have a hissy fit’ without having explored it further, or we might allow our role to be defined narrowly by others ‘because of our funding we can only come in as a consultation role and I was called in to assess his scooter skills’.

Importantly, human rights are the most powerful form of rights available to human persons, and they eclipse all other forms of rights – including the rights and directives issued by managers (Ife, 2008). I wondered if in practice we might get drawn into being increasingly busy rather than challenging some of the practices that oppress the human rights of clients. Can you think of a time when you passed up an opportunity to take action to enable occupation and justice because you thought it was not possible? Are there special cases in which you might lobby for management to make changes so that you can better practice human rights in occupational therapy?
Enabling Occupation & Justice

**Upcoming in August**

Well, we are nearly half way through the study, yet there is still plenty to do (well so I am feeling!). Here are some of my thoughts on the July focus group for you to read and feedback on. I have also attached a schedule for the second round of individual interviews and would appreciate if you could get back to me about the time you would like, prior to the next focus group (which is on 25th August 3.00pm). Please see the reflection sheet for August - I thought you could do with a break from set readings this month!

Cheers.

**Reflections on rights and risk**

We commenced the focus group with some reflections on rights and risk. Consideration of risk-taking beyond the bounds of occupational therapy helped therapists to appreciate that many people take risks within their day-to-day life. ‘There are people who take risks all the time that we can’t influence and won’t influence’. This revealed contradictions for the way in which the community (and its health care institutions) define and tolerate risk. For instance, irrespective of the banning of smoking in public spaces it is generally accepted that people have the right to engage in occupations such as smoking that are harmful to individual and collective health. This provided a platform to discuss the way in which occupational therapists’ values influence decision-making about client risk-taking. For example, when making decisions about the hazards posed by clutter it is almost your own personal opinions on how much clutter is acceptable’. Such decisions may appear tenous and yet have far-reaching implications ‘how many piles of newspaper do you make them move, before you allow them to go home?’ Therapists suggested it important that they consider their own values and where possible, privilege the perspective of clients, ‘it is the human right of the person is to calculate that own risk for them and say, “I am going to do it anyway”’.
Our own utopian visions

In the focus group we shared our utopian visions for how we think human life and occupational therapy practice ought to be. The themes of meaning, equality, choice and empowerment were discussed. To start with, we envisaged what it would be like if society had a better understanding about what it means for a person to be healthy and well ‘to about having meaning in our lives, about developing as a person and feeling that our lives are fulfilling and worthwhile’. Therapists saw the potential in practice for enabling clients to experience this meaning through a greater breadth of occupations ‘my utopia would be to have more time to do not discharge but just people’s occupations, thinking more about their leisure, their interests’. Underpinning the human right to participate in meaningful occupation was that of equality. Therapists suggested that resources and opportunities for participation in meaningful occupation should be available to all people ‘so that there is not a specific thing that one person can do and others can’t do’.

Therapists raised the human right of clients to exercise choice about their engagement in occupations, as a utopian vision. Choice was viewed to include that a person is able to ‘express their wishes and opinions very clearly without being influenced by their families’, and where appropriate that the family can make decisions to protect the client’s rights. For example, one therapist advocated for a woman with a long-term disability and recent diagnosis of cancer to be admitted from home into palliative care, when the family expressed their distress at the unjustified ‘pain and agony’ their mother was going through towards the end of her daily courses of treatment. Therapists envisaged that ‘maybe in our utopia all the patients would be fully informed, and have all the knowledge’ such as about their options for treatment. Indeed, therapists wondered if this notion of empowerment could be extended so that clients are presented with information about what all members of the multidisciplinary team do, ‘so that they can then choose which is most important to them, seeing which person is most important to them’. This is just a snippet of your thoughts about the ideal occupational therapy practice, fairly grand don’t you think?

“I cannot tell you with truth that, when this belief came to me, I discarded everything immediately. I must confess to you that progress at first was slow. And now, as I recall those days of struggle, I remember that it was also painful in the beginning”

Mahatma Ghandi
(Brown, 2008, p. 78)
When practice does not meet the ideal

In talking about our utopian visions, it appeared to highlight for some therapists a distance between their ideal and actual practices. Therapists suggested this was more pronounced in certain clinical areas and services. ‘I think your area is one which is the ideal OT… a lot of us don’t do that’. Financial reasons appeared to be a major limitation on the focus of occupational therapy, with some organisations/payers having a different frame of reference to therapists, in terms of what clients require. Policies on fee structure limited a focus on quality of life ‘our funding will not look at quality of life’, thus it was challenging to focus on, for example, leisure occupations as it would mean that therapists would not get their ‘stats up’ and hence funding for continued positions. Often, these regulations just made it plain difficult to practice ‘I had a situation with DVA where a man couldn’t get his walking frame alongside his bed….. DVA home maintenance service who will clean windows, and clean gutters and do all this fulfilling physical stuff, wouldn’t move the furniture half a metre to one side to allow him to get to alongside his bed’.

Therapists raised instances of when services were precluded for whole groups of people, such as the elderly ‘we stopped seeing anyone from hostel residences because we didn’t have capacity for that any more’. This has important implications for the human right of the elderly to access timely and appropriate healthcare, particularly given they may feel they lack the power to speak up about such issues. Therapists may continue to meet clients’ occupational needs through their ingenuity or by taking practice underground, it is still difficult to make a stand. However, if therapists are experiencing controls on their practice, they are faced with the challenge of deciding if this is an issue they have the time and energy to take up with management, or not. It also is one that emphasises the role of therapists in ensuring that clients have the opportunity to discuss their human rights, and in a language that they understand. Do you provide the space to ‘let clients have their say’ about ‘what type of service would best meet their need’?
Striving towards our utopian visions

Therapists believe it will be challenging to go about changing their practice towards a vision of enabling occupation and justice 'it is going to be very hard to get with the therapists that have been born, bred and run through the ringer of the medical model for our entire professional career involved in these sorts of things that do just feel so unbelievably hard to contemplate yet along to take action on'. This was felt in all areas of practice, and yet particularly in the acute/subacute area where 'You do your initial, your PADL, your home visit, and that is it'. Some therapists viewed that the future generations of occupational therapists trained in broader health and human rights paradigms will be 'a lot more adept and a lot more open to putting themselves out there for all these sorts of ideas'. Yet others were wary of the process of entrenchment 'you get put into the job that you do and you can't do all of those occupations and enable people in those occupations because the model doesn't work like that'. This discussion brought together important parts about the nature of change in professional practice. It highlighted how education is imperative to changing practice and yet that it will only succeed if it engages people who are willing in the workforce (which is where you come in).

As pioneers of practice, we talked about where to begin planning for change. One therapist shared their unique opportunity 'it's a brand new ward and I have met the NUM and she said, "oh I don't actually know much about OT" ... that's a clean slate!' For other therapists, it's about starting small, really small and by being willing to 'push the boundaries' in order to make more visible the positive potential of occupational therapy 'those little battles that we win every now and again that no one necessarily sees but I do think that a lot of OT's out there do... we just need to give it more voice'. It was also suggested that creating change is just as much about 'doing it with integrity where you are'. This made me think about the fact that taking action and being political might mean using your energy and passion wisely, and enabling the decision-makers to feel comfortable or less threatened with the direction that you are heading.
The client’s story

In the focus group therapists reflected on the ways in which health professionals relate to and communicate about their clients. Therapists viewed it as the special role of occupational therapy to bridge the gap between a ‘medical mind’ and the lived realities of clients. This includes educating medical colleagues that the client is more ‘than a mechanical creation, a mechanical thing…they do go home and take dogs for walks and they have grandchildren and they do other things’. This notion of occupational therapy as a translational profession was illustrated in one therapist’s story about advocating for medical research to incorporate measures such as a quality of life questionnaire. In reflecting about the benefits of having health professionals with a lived experience of illness or disability, therapists also indicated a belief in the unique capacity of the profession to have ‘the foresight to see without going through that experiential situation’. In taking an individual approach with clients, therapists used client storytelling to get a better understanding of what this particular person might be going through and ‘to tell the little bit of the story that they want to tell’.

Despite the value of eliciting client stories for assessment of occupational needs, therapists describe limitations in the usual process. For example, a multitude of health professionals ask the client to ‘tell their story time and time and time again’. Similarly, because therapists enter into the interview with some knowledge of the client ‘we kind of already know their story’ they are the ones controlling the questions and format of the interview accordingly. It appears the traditional ways in which we ‘interview’ clients carry forth an unequal power relation between therapist and client. Could we as a profession be more mindful of taking the approach of ‘having a conversation’ with the client. Do you consistently check with the client if it is a good time to meet or what he/she would like to get out of the conversation? Do you suggest meeting in private or comfortable spaces such as over coffee? How do you write up an interview in the medical history, such as do you use the person’s name or refer to he/she as the ‘patient’?
Reclaiming our time

In everyday practice, therapists experienced pressures of high caseloads and increasing expectations for what can be achieved, which made it difficult for therapists to always be truly present with a client ‘without twenty things running through your head’. The notion of ‘reclaiming our time’ at a societal and practice context was discussed in the focus group. Therapists wondered if in some circumstances the profession could be more critical in the way they use their time at the point of client referral ‘...if I go and see them and they clearly not interested or they are clearly not in the headspace... I will give them all my contact details and all the information they need, but I will move on very quickly to somebody else who will get a lot more benefit’. Therapists proposed groups to be a way of creating more time for an individual approach with existing clients, as well as for opening up the service to more individuals. For example, we heard the prospects of the department getting involved in supervising occupational therapy students doing project placements about ‘some sort of walking group, gardening group, or something else for cardiac patients’ in the early transition from hospital to community, or engaging the elderly in occupations within their homes and community by ‘linking together elderly people with young people who wanted to volunteer’.

In talking about the potential for working collectively and collaboratively therapists critiqued the way in which traditional occupational therapy groups operate, such as whether they hold the interest of clients and if there is sufficient resources to support their infrastructure needs ‘how do they get out of the house, how do they get to the group’. I do think that if done well, working collectively holds promise for human rights practice. Are you involved in any occupational therapy groups, and if not why do you think that is? Do the groups that you are involved in enable participation in a breadth of occupations relevant to your client’s real life? Do clients have responsibilities for organisation of the group, in order to experience interconnectedness and to meaningfully contribute to its long-term sustainability? Are client’s asked to make suggestions for changing the groups, or is this only within certain parameters?

If you have any questions about the research, please contact:
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Welcome!
Welcome to the study! As well as catching up together, I have selected some things that may be of interest to you from past newsletters. The newsletters are sent to the group on a monthly basis, covering organisational issues and mainly by emerging thoughts about the focus groups. I make a point of asking for feedback on these newsletters in the focus groups, and at any other time via email or phone. After the August group (I am glad you can make it), we have another four focus groups scheduled for Tuesday at 3:00pm–4:30pm on 22nd September, 27th October, 24th November, and 22nd December. In December, the final phase of interviews will also be completed. So it appears you can have arrived exactly mid-way through the project!

Participatory Action Research

I thought it would be worthwhile to just provide a little background information on the research process itself. The style of research you are involved in is called Participatory Action Research (PAR). PAR is viewed as increasingly relevant to health care practice as it allows people to not only reflect on practice, but to simultaneously make changes to practice. Using a PAR approach, we will go through cycles of reflection and action, though not necessarily in an orderly way. In the first four focus groups we have used the four sections of the Enabling Occupation II and other readings to guide our in-depth reflection on the topics of ‘occupation’, ‘enabling’, ‘enabling occupation’ and human rights. In the fifth group we used these readings and reflections to stimulate a discussion about our own utopian visions of occupational therapy, that is, what it would look like in a perfect world. We are now at the point where what we have learned and discovered so far in the research will be used to plan and implement changes to our practice in order to improve it. The interests, ideas and beliefs of individual therapists, as well as that of the group, will drive this process, so it is important that you feel free to speak up along the way about any aspects of the research that you may be happy or less happy about.
Group norms for the focus groups

These were some of the suggestions I put forward to the group in terms of how we can conduct ourselves, and get the most benefits out of our participation in the focus groups. They include:

- Be good listeners without judging others. Support and inclusion of everyone within the group is very important.
- One person speaks at a time. Wait for the other person to finish speaking before you start.

- Be mindful that other people who want to speak should have the opportunity to do so.
- Ensure the privacy of group members. It is important that you do not publicly identify the members of the groups, nor attribute anything that they may have said.
- Remember not everyone within the group will share the same opinion. Disagreement and debate can bring about creative ideas.

Readings

The therapists participating in the focus groups have just completed a period of in-depth reflection and readings particularly from the Enabling Occupation II text. I think they are enjoying a break from it, you may have more energy! You are welcome to read any parts of the book that take your interest, though I thought you might be interested in following a similar albeit abbreviated path to the others. Here are some that you may like to start reading from the first section on occupation:

- Chapter 2: 2.3 How: Occupational development and change p. 54-58 (and text box 2.4 on p. 59).
- Chapter 3: 3.10 Occupational justice and injustice p. 80-82.

When reading, take the time to think about some of the following questions in relation to your practice:

i. How is occupation the focus of your occupational therapy practice?
ii. Does thinking of occupation beyond performance have the potential to broaden your practice?
iii. How has illness or disability restricted a particular client's participation in occupation?
iv. How have the occupations of the client changed over their lifetime?
v. How do general life circumstances such as living conditions, affect your clients' ability to make choices about occupation?
vi. Have there been situations where your service, despite its best intentions, has not fully supported your client's choice?
Monthly reflection...

It has been an active month for the research project having held the second round of interviews and our usual monthly group meeting. In the interviews I enjoyed listening to how you are all finding the research processes. It was particularly pleasing to know that people are finding their participation in the focus group has challenged them to think more deeply about what they actually do in their occupational therapy practice. This is a fantastic achievement for us all individually, and for the research group as a whole.

I also wanted to acknowledge that in the August focus group we welcomed a new member into our group. The fact that this process of learning and discovery can be shared with another therapist will add a new dimension to our study. At the last focus group I noticed too the different dynamic that came about due to its smaller size. Whilst this may have taken us some getting used to, it created another opportunity to more deeply explore certain other aspects of our practice, so well done. See you again on Tuesday 22nd September.

The nature of change

We are at the point of starting to plan to take action on things in our practice that we feel would benefit from improvement. It is not surprising that this has been a difficult part of the research. Practice is rarely straightforward and we are focusing on some of the most significant concepts to the profession: enabling occupation, occupational justice, and human rights. These do have big picture relevance, yet our conversations have been concerned with the ways our practices might enable, or constrain, our client's participation in occupation. Thus, there are things we can influence in the here and now! I wonder if this step has also been challenging because you are under the impression that you must take up a project for this phase of the study. This is not the case, it is more important that you choose an action that you are comfortable with and that should provide you with a positive experience. Starting small may then act as a platform upon which you can more powerfully transform practice in the future.
The nature of change (cont.)

According to Stephen Kemmis (1998), changing practice requires actions across three different levels. It involves making changes to our language and discourse (what we think and say), our activities and practices (what we do) and in our social relationships (how we relate to one another). Kemmis’s framework is relevant to our research because it shows the variety of levels at which changing practice is possible. In choosing to take a small action we might choose to enact change in even just one of these levels.

There is no doubt that practice changes have already occurred naturally throughout the study. Nonetheless, there is scope for therapists to make changes to their thinking about practice, such as to commit to consciously evaluate the occupational impact of each new organisational policy. Making a change to our usual ways of saying or relating might mean that we choose to adopt and profile enablement language when interacting with our students, colleagues, or with management. Making a change to doing practice might entail broadening the assessment and treatment media that is available in the department.

The reality is that in enacting change in one level of practice we are likely to bring about positive change elsewhere. Whilst it is not a linear process, changes in our thinking may lead to changes in our taking, which may lead to changes in our relationships, and changes in what we do. One therapist’s story about their experience of trying to be occupation-focused seemed to well illustrate how this transformation unfolds, and how one practice change might invite or merge with another:

‘It was actually quite difficult for the first month or two when I was thinking about it and doing it but now I just talk about it constantly, whereas previously it was ‘now is the strength in your hand going, how are you able to do movements’ now it is purely function and I talk about grip and range of motion and all that at the end of it…. now if we then transfer to bringing in the majority of the patients to do functional stuff rather than one every couple of days then that will slip into the routine as well and become pretty standard’.
Thinking... access to occupational therapy

In the focus group we continued our reflection for the extent to which elderly people are able to access occupational therapy services. In acute, therapists felt they had an important role in advocating for a client’s human right to realise their potential through rehabilitation. For example, if a client had a stroke and dramatic occupational loss then the therapist would make recommendations to the team that ongoing occupational therapy be provided to enable the client to make “any kinds of improvement... if it is getting to the point where they can feed themselves.”

Therapists might be involved in the initial assessment of clients admitted from home, yet this would often cease promptly upon the team’s decision that the client be newly discharged to residential care. As soon as those words were for nursing home or hostel... that was it, they were off your list of who you were seeing.” In a cost-controlled environment, there was “more onus really on finding a place, a bed” for the client rather than in helping them to make their occupational transition to care.

Clients admitted directly from residential care appeared to receive even lesser access to occupational therapy. We don’t routinely see people from hostels and nursing homes.” This was viewed as a resource issue as therapists juggled busy caseloads. “If you spent so long with them, then two or three people that were going home would not have got the treatment or interventions that they needed.” This posed a significant human rights dilemma for therapists “how do you weigh that up of almost who has got more of a right between being able to transfer versus being able to go home?”

This is a compromising situation for any therapist. As a first step, rather than a blanket approach to seeing or not seeing client groups, could we change our thinking to be more informed and inclusive? For example, in deciding whether to accept or decline a referral for residential care clients could we routinely ask ourselves “how will this client be advantaged or disadvantaged by my decision?” or during our assessments could we ask in our own mind “what occupational injustices may be affecting this client?”
Talking... about a person

In the focus group we extended upon previous conversations about the way we use language in our professional practice. Some therapists reported that they acknowledge the client’s name in documentation ‘we always write their names down in the notes’. Others refer to the client as ‘patient’ in medical histories. There seemed to be an understanding that not using the patient’s name was an expectation or regulation of the organization ‘I thought you weren’t allowed to?’

It was queried as to whether this practice stems from an assumption made by occupational therapists ‘I don’t know whether it’s a rule or whether it’s just the way we write’. In any case, therapists implied that this was illogical for the purposes of protecting privacy ‘it’s not a secret!’

According to Lile (2008) our language for clients has human rights significance. He explains that there are four competing discourses that each conceptualise the client differently - the managerial (consumer), the market (customer), the profession (client) and the community (citizen).

Life contends that the use of ‘client’ and the medicalised concept of ‘patient’ represent a professional discourse, and may perpetuate the misconception that therapists’ knowledge and experience is superior to the client’s. In a move a little more aligned with a community discourse, could we change our sayings to acknowledge the client as a human being foremost? For example, could we respectfully use the client’s name in the documentation or represent their experience through their own words? Could other terms such as ‘intervention’ also be reframed?

Further, therapists reflected upon how they refer to the self when documenting their recommendations ‘I frequently write ’I too which people are very against’. Some therapists consciously went against their inclination to use ‘I in medical histories ‘I got to that point where I think oh that next bit of the sentence I have got to try and steer it around so I don’t have to write I said or I do’. I think that you should not counter your natural instincts for communicating. Where appropriate, could changing to use ‘I’ help others to see the human dimensions of health care?
Relating... at and beyond discharge

In the focus group we reflected upon the diverse ways in which we relate to other people in the health care context. Therapists in acute care reported having difficulty maintaining relationships with clients beyond the point of discharge, ‘someone else comes straight in to fill that bed, and you just sort of forget about the people who are gone’. Therapists therefore endeavour to maintain the paths of communication with the client beyond discharge, ‘we always give them our contact details’.

Some follow up on clients through making a phone call or a home visit, ‘just to kind of go in and check when they have landed and settled’. The extent of involvement with a client following discharge is linked to the therapist’s level of concern about client safety. We tend to weigh up how big the risk is or of the negative consequences of non-attendance. ‘If someone that we think definitely needs the therapy then we might call them’. Could we make changes to our relating by setting aside time each month to follow up on a sample of clients, or could we follow up on a range of clients (not just those we are worried about) might this help our learning about practice?

Therapists also described how discharge planning brought about challenges for relating to community services. For instance, the council might operate under a paradigm that is not consistent with occupational therapy values about independence. If the client wanted to be able to get out and do their shopping... somebody would go out and do their shopping for them’. Community occupational therapists might also have ‘very long waiting lists’, thus deterring referral of the client ‘I wouldn’t refer on because there is nowhere to refer on. I would try to put into place things that will solve that problem but not necessarily make their quality of life better’.

This raises an important ethical tension for occupational therapists. Continuing a referral cycle when clients do not have the need may serve to perpetuate client dependence and further marginalise (Townsend, 1998). Yet not referring may preclude the client’s occupational needs from being met, and impede community services from stating their case for increased government funding. Could you make changes to how you strike this balance?
Doing... by reducing privileges

In the focus group, we again talked about the challenges of transforming medicalised settings into occupational spaces for clients. One barrier related to the security of property for leisure pursuits, including portable technology such as DVD players. "History says that anything like that on the ward disappears within moments". Therapists realised that their inclination to control access to resources might limit its access when most needed. 'So you sort of feel perhaps as OTs we should keep hold of it but then it means it is not available over the weekend'. Therapists put forward practical solutions to help make ward property more visible and recognisable. 'I was just thinking of a TV on a DVD player that was pretty big that you can't walk away with'. In addition, therapists raised the imperative to empower clients with positive experiences. 'the Wir is still there and the guys are all really enjoying that' as well as to invoke a sense of responsibility within the client, 'that they bring their own DVD or get a family member to bring in their own DVD player'.

This topic might appear trivial though it does illuminate a human rights dilemma in our everyday practice. On the one hand, payers do not have unlimited finances to support participation in occupation, and it is important that resources are looked after for collective use. On the other hand, safeguarding of resources contributes to bleak occupational realities for clients, which therapists seem all too well aware of 'isn't having something to watch better than not having anything?'

I believe that in the health professions there is a tendency to practice from a position of privilege. We take-for-granted the basic human and occupational needs that our clients continue to have during hospital admissions, such as the simple luxury of watching a favourite television show. Could we make changes to our doing of practice in order to reduce these privileges? For instance, could we take a chance in making property more secure and accessible? Could we be less separate from our clients by sharing eating areas, the library, and so on?
Monthly reflection…

I trust you have all survived the AFL Grand Final festivities, I know of a couple of very happy supporters amongst the group! This newsletter will start by reflecting on our past focus group according to a certain theme. It will then profile our plans for taking action to improve our occupational therapy practice. Thank you for sending in your plans, as you will soon read they are excellent and will help us individually and collectively to align our practices with an enabling occupation and occupational justice approach. Writing this newsletter really was a pleasure as your ideas speak for themselves!

For your information, I did do some minor editing of the plans in order to protect privacy and confidentiality, as well as to provide consistency in format. I trust you are all happy with this. In reading on you may notice that some plans are linked together; this is because they are from the same person and yet I was keen that each plan was emphasised. At our next focus group on Tuesday 27th October, 3.00pm, we will take the opportunity to discuss how people are going with implementing them and how we might best be able to support each other. Cheers!

Dialogical praxis

What is dialogical praxis? Well I am just beginning to understand the concept myself. Dialogical praxis is premised upon the work of Brazilian philosopher and activist Paulo Freire. A key element of dialogical praxis is that consciousness can be raised through dialogue, and as people become more aware of the social structures and situations that lead to oppression or injustice, it opens up possibilities for their taking action (Ife, 2008). The idea of dialogical praxis underpins the format of our focus groups. That is, through coming together and engaging in dialogue we have become more conscious of the personal and political dimensions of our practice and how to take action to improve practice. I wanted to profile this concept now because in my view it also resonated with the discussions we had last month about relationships with clients, students, and colleagues. See what you think!
Dialogue in professional supervision

In order for occupational therapists to raise consciousness about their own professional practice, it is critical that they view the people with whom they are working as having equivalent wisdom and expertise. In the focus group we talked about the challenges of fulfilling this ideal when working with students at the beginning of their career. This conversation thread stemmed from our talking about therapeutic use of self as being ‘something you develop throughout your career’ and yet at the same time having intuitive elements ‘there are some parts of the way you relate to people you can’t learn’. It was noted that it could be a significant challenge with students, especially those who may not naturally have the skills for human relating and communicating ‘as long as you have got the learning there, there are some students you wonder have they actually ever spoken to a human being before?’ Therapists shared their experiences for how they struggled in university and on fieldwork placements to take the ‘massive jump’ to having professional conversations with clients, and this lead to a conversation about how OT could best structure supervision of students and therapists so that both people in the relationship are able to learn from each other, together. Therapists put forward an option of having greater familiarity with an occupational model, which could help to ‘frame’ discussions with students in a structure and language consistent with theory learned at university. This could then act as a platform for further dialogue and mutual exchange of knowledge and ideas ‘you can then say how does that fit in with what you have learnt about this model… or do you think there is another one that would be interesting to look at in light of what we do and don’t do?’

Therapists also raised the potential of fostering dialogue within group formats that promote a range of perspectives and in a less-intimidating environment, ‘just to take that focus away from that one on one’. I believe that these ideas aptly demonstrate how we can apply human rights practice to the supervision processes of the profession itself (as well as talking about human rights within supervision) i.e. by altering supervision to be less controlling and more reciprocal in nature. Are there other ways that supervision can be dialogical? Do therapists/students currently have a say on the appointment of their supervisor and the direction supervision is taking? Further, are clients actively involved in supervision or performance reviews?
Meaningful dialogue with clients

As we have talked about before, health professionals may have specific knowledge and training for practice, and yet clients bring their own life expertise and wisdom gained through lived experience. According to Lea (2008), entering into a dialogical relationship with clients can be difficult because it requires a ‘letting go’ of the status and security that being in a professional role provides. In the focus group, I believe therapists shared their stories of letting go with clients. For example, one therapist described using a less structured assessment to promote dialogue around parts of the client’s life that ‘they were actually interested in talking about and that they were having difficulties with’. Another therapist formed an inpatient group with pastoral care centred on spiritual themes such as peace, love, and hope in order to provide clients with the opportunity for all to connect about issues that are often otherwise excluded from dialogue with professionals. ‘I think it is the core element of individuals that is not addressed on my unit anyway in any other context at all or in any other format’.

We heard a rich story of when a therapist supported a client with the necessary equipment to die at home as well as providing the opportunity for the client to share meaningful life stories, ‘the daughter was sitting at the end (of the bed) saying I have never heard those stories mum!’ For this therapist, enabling this dialogue required ‘confidence to take that extra time’ and it came with some concerns as to how practice might be perceived by colleagues, ‘The family were thankful and sent me a card, which was really lovely. But when I opened it and read it, I thought people are going to think I don’t do any work!’ This lead to a suggestion of keeping a ‘record’ of such achievements and expressions of gratitude, which I do believe we should do more of. I take from Arthur Frank’s work in also wondering if we could take this one step further. That is, is a part of creating the space for meaningful dialogue with clients also about ensuring that we experience joy in our practice (as we are doing it)? Frank proposes that we should ask of ourselves: Do I experience pleasure in the presence of my client? Does my client seem pleased to be with me?
Taking action to enable occupation & justice

Here are our plans!

Harry:
What: To encourage other OT's within own stream to focus on occupation, through changing language, thought processes and focus of therapy to be more occupation-focused
How: By education, setting examples and giving tutes or inservices.
When: I aim to do this over a period of two or three months.

Sophie:
What (1): Advocating for EO&J in practice by sharing information with colleagues
How: Conduct education / in-service with nursing staff, complete written document of occupational therapy and referral indicators, use occupational language

What (2): Advocate for occupational spaces for therapy
How: Use of therapy areas on ward to promote occupational activity, equipment, liaise with allied health team members for occupational group on ward

Kate:
What: Enable opportunities for junior staff to engage in reflections on their practice with a particular focus on occupation and personal achievements/difficulties
By whom: I will facilitate with at least my two Grade 1's possibly one of my colleagues Grade 1's and possibly our new Grade 2, involvement of the other Grade 3 as facilitator may also need to be considered
Where: To occur in the OT dept at Austin, or to stimulate a more relaxed environment may consider holding it in the cafe
When: Likely to only happen monthly and the first occasion may not be for a couple of weeks as one of my Grade 1's is about to rotate at the end of next week. With the commencement of a new Grade 1 this will be a good opportunity to start this
How: I will need to look at formulating some semi-structure for the group, consider what is out there about peer supervision; I think I already have some examples of how this is done in other health services. May need to think of some kind of evaluation or goal setting for the group at the beginning and the end.
Taking action (cont.)

Matthew:
What (1): Enabling day leave for palliative care clients who are non ambulant and otherwise restricted in this due to lack of specialised equipment
By Whom: OT and team, and private donation from family of a former client
How: Monitor the number of clients who are enabled their goal of day leave by this equipment; use this information to lobby further for more equipment (till-in-space shower commode, laptop computer, portable DVD players etc)
When: Already purchased till-in-space transit wheelchair and for first trial is scheduled for this month.

What (2): OT role typically focuses on enabling clients with certain occupational needs, at the omission of seeing others. Goal is to make contact with one client per week who is not otherwise referred to OT in order to explore their occupational needs
By Whom: OT
When: Starting now
How: Providing intervention outside the usual scope of day leave/d/c planning i.e. encourage participation

Matthew (cont.):
I.e. encourage participation in own care/encourage using breakout spaces/making cup of tea/cooking/going off the ward for fresh air/counseling
Meeting with families to encourage and enable the above etc

What (3): capturing positive outcomes enabled by OT
By Whom: OT
How: Recording positive feedback, including these examples in presentations, keeping data and records, cards, letters, highlighting these outcomes in the Dept OT Meeting or newsletter
Where: Wherever there has been a positive outcome enabled by OT’s (both myself and OT’s which I supervise directly)
When: Starting now
Taking action (cont.)

Liz:
What: Enhance student education and the clarity of own practice by putting into practice the Canadian Model of Occupational Performance Model.
How: Apply aspects of Person, Occupation and Environment, but also including the performance, enablement and justice aspects of the process.
When: However long this will take, as I am not used to putting my practice into a framework.

Audrey:
What: Group program
By whom: Self
How: I'm putting proposals forward, informing staff, facilitating activities for mental health week (movie night, BBQ), and encouraging patients to advocate for what they want.
When: Still a work in progress.

Eve:
What (1): Language in written documentation and report writing i.e. using individuals name in documentation instead of client/patient
Whom: My own practice

Eve (cont.):
Where: Medical history and written reports
When: Every time completing above.
This will be part of a long term plan that I can self-monitor and to establish a change by reviewing my own notes. I have already noticed that I have an increased awareness when I automatically revert to writing "client/patient"

What (2): Increasing awareness of occupational deprivation issues and how to address them through intervention in a community setting
By whom: Primarily myself, but improving awareness of OT colleagues whom I supervise by getting them to think and talk about how occupational deprivation effects our client group and how OT might assist.
How: During assessment and intervention planning consider how O might be able to assist with situations of occupational deprivation; improve resource awareness including about services and programs in the community
When: This will definitely be a long-term plan and be difficult
Enabling Occupation & Justice

The home stretch

We are getting into the home stretch of the year, and that of the research project. In the past focus group we shared some pivotal discussions, such as bringing forward our final focus group to December 15th so that we can schedule in some relaxing drinks together afterwards! I think this will be a lovely reward for the time and energy we have committed to the project this year.

An outcome of our research

However, there is much to do before then. For starters, I would like to schedule in a 30-minute individual interview with you all that same week. It would be great if you could all look at the attachment and email me with your availability options or preferences for meeting; and bring along any questions you have to our focus group on November 24th at 3.00pm.

This newsletter will be devoted to some key conversation themes that came from the previous reading and from our checking-in about the implementation of the action plans. But I wanted to pre-empt something first. Having been inspired by each other's stories (as per the following section), it was proposed that we all collate one example of our own, as an outcome to mark the end of the research. I think this is a fantastic idea to consolidate our own reflection skills, and to collectively illustrate the many ways in which occupational therapists do think about, and seek to address occupational and human rights issues in practice. It is my plan that we will share these practice stories together in the December focus group, and the group can then decide how they best be used. More information and ideas will follow on this next month.
Finding passion in a narrative

In the focus group we discussed the significant energy required for our relationships with clients. Therapists reported that the enjoyment of a day can become "clouded" by other problematic or difficult aspects of practice, or that it can lead to personal exhaustion, "I get home and I am buggered". Being in a client's home was one instance where therapists experienced particular pressures in the way they communicated and related, "I find those home visits it is almost like a performance". Whilst it can be a real challenge to maintain the right amount of energy and passion for practice, therapists shared their suggestions for how to manage this, such as holding tricky or complex sessions when they were "feeling prepared" after a rest at lunch or selecting times when clients have energy, "so not waking them up from a sleep". Another therapist enjoyed observing past clients coming in from the community to share their story with other clients, "they ended up talking for over an hour and they were meant to talk for twenty minutes". It was perceived that this had greater value for all than "listening to me talk about energy conservation or something."

What I have been most inspired by in this research are your illustrations for how occupational therapists enable occupation, occupational justice and human rights. It seems that others too have noticed this, "I get so much more out of coming here and listening to a story like that". Therapists suggested that sharing stories about practice with real clients is much needed 'because most of the time you work by yourself and you don't know what other people are doing', and it even 'doesn't take nearly as much effort' as some other forms of professional development. One of the privileges of being a health professional is that we meet and form relationships with people who have faced disadvantage and/or shown great resilience or determination to get better; we are able to uniquely learn from them about their day-to-day experience of human rights (Ife, 2008). Thus, it makes perfect sense that giving voice to our clients' stories, and practice narratives might be the key to rekindling the energy and passion for human rights practice. How will you give voice to these stories at the end of our research?
Targeting attitudinal change

In the focus group, we reflected upon a paper (Mj, 2008) that raised the importance of changing social relations and attitudes towards people with disabilities. Some therapists felt comments about homeless people in the paper might have been 'a bit strong', and others deemed that they could be 'appropriate' to a cultural context in South Africa. The negative societal attitudes raised by Mj were viewed as not dissimilar to those found locally in Melbourne where there is 'that classic sort of response - “go and get a job” to people on the street who are begging'. Therapists shared how in their personal lives they reduce the 'fear' of mental illness by supporting people to build connections with this marginalised group, and took it upon themselves to educate others through debate, often with mixed results - ‘it often ends in a “we will agree to disagree”’. However, it was also raised that occupational therapy lacks the ‘power’ and funding to create a significant positive shift in societal attitudes, such as that which occurred as a result of the Quit-smoking program.

Whilst practice aimed at shifting societal attitudes towards marginalised groups may seem tricky from a medical-oriented setting, I do think it is a moral imperative that occupational therapy take leadership in this area given we have expertise in understanding the influence of the environment on occupation. I wonder if a place to start a shift in attitudes is by critically reflecting on the suitability of our own attitudes. For instance, towards older adults I believe occupational therapists might emphasise the negative and debilitating aspects of ageing; rather than as Wilcock (2007) says, asking older clients about the occupations that help them to feel young or excited about living, and engaging them in those occupations that promote their feeling of well-being. To promote positive attitudes elsewhere, I believe that occupational therapists could lead collaboration across departments in the network to more prominently and comprehensively promote public health campaigns that focus on attitudinal change such as active ageing. Where could you start leading attitudinal change?
Our actions: Planning for practice

Throughout the research, our discussions have brought up some of the occupational and human rights issues affecting clients, and aspects of our practice that restrict our efforts in enabling occupation and justice. What is distinctive about the work that we are doing is that we are giving these conversations a practice reality by taking action to improve occupational therapy practice. Therapists noticed how their practice changes could have an immediate impact, such as in the creation of occupational spaces, ‘straight away, changing the way I do my assessments’, and comprise a long term vision ‘I have been gathering some data about who I would use that space with, so I can say ‘well this week we could have had ten patients in therapy groups’’. When a planned in-service for nursing colleagues was postponed, one therapist sought a day-to-day opportunity to educate nursing staff to promote client independence, ‘I think the patient could actually do this, if they were allowed that time that they would normally when they are at home’.

Whilst one therapist perceived that an action was not ‘terribly successful’ in terms of meeting own expectations, it was clear that their use of specialised equipment to enable leave for a woman who had been hospitalised for five months, was in fact extremely special to the client ‘her husband said she got sunburnt on the legs the other say, so he was very happy about that’. The taking of action to broaden a client base meant therapists may need to juggle their routine, ‘I have just found myself a little bit more time to introduce myself to probably two people per week, just doing small things’. This made me contemplate again, how do we find this time? It is my own experience that due to practice being fast-paced, occupational therapists may not give sufficient thought to what we would like to achieve with clients or how to get there. At the same time, I feel cautious against spending too many hours planning for practice e.g. in meetings as it takes time away from our work, and it may erode the possibilities for transformative human rights. How do you strike this balance?
Our actions: Impact of organisational structures

Organisational structure and management decisions such as allocation of funding can make it very difficult for occupational therapists to implement changes to practice. For example, therapists covering additional caseloads were too busy to enact their plan of having occupation-focused discussions with colleagues. 'I think at the moment and I know this is what happens is when caseloads are up, stress is up, the pressures on, we lose some of that focus.' Taking action to improve aspects of occupational therapy practice is also complicated when there is continual change occurring in the organisation. For instance, a therapist's action to commence a group supervision program needed to allow for the transition of new staff, 'I think she needs a bit of time to settle in before she has got stuff to talk about in group', and take into consideration the perspectives and attitudes of existing senior staff, 'It could be perceived as stepping on toes of whatever supervision they always do.'

Organisational constraints such as the focus on cost-efficiency impede occupational therapists from taking action to enable occupation and occupational justice, yet there also exists less formal channels through which support for practice can be negotiated. For instance, the action of one therapist in putting in proposals and knocking on my manager's door most days, saying we need to do more things led to acquisition of funding towards a part-time nurse who could support client engagement in meaningful occupation, and visits from a reflexologist. According to me, in an ever-changing organisational context there are opportunities to move towards more or less empowering forms of practice that may enhance or restrict human rights. It would seem to me that for innovation to occur in the profession it is important that occupational therapists do not accept one set of rules or guidelines, rather that rules or policy etc be creatively interpreted to fit with an approach of enabling occupation and justice. How do you apply a discretion to rules?

If you have any questions about the research, please contact:

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Its officially December…

I imagine you are well and truly gearing up for a final month of hard work! I have attached in what will most likely be the final newsletter for this year, some feedback from our discussion in the last focus group. Given there was a lower attendance at this one, it obviously does not share all of your reflections and evaluations of individual actions; I will be sure to add these in future newsletters or feedback in 2010.

… And beyond 2009!

As you are well aware December marks the end of our structured meetings together, and the completion of the data-gathering phase of the research. Over the next 18 months (at least!) I will focus my time and energies on starting the data analysis, the writing up of a thesis for my PhD, and making public the research project to a broader audience. Whilst I understand you will have other commitments throughout this period, I do envisage I may need to make contact with you from time-to-time to seek your feedback or comments especially in relation to the preliminary findings of the study. This is important given you are all active co-researchers in the project from start to end.

So the plan from here on in is to complete our final focus group on Tuesday 15th December, meeting please at 3.00pm sharp so that we can have our final session and finish in time for a relax afterwards (venue to be announced on the day). Interviews will follow on later that same week, I will post around confirmation times to you separately. Until then, enjoy the reading and writing!

Whilst the formal aspects of your participation will end at this point, I do hope that the incredible support and guidance that you have provided to one another, as part of our community of practice will be an important aspect of your future practice together. You all may like to have a think about what could happen next at Austin Health, in order to keep alive your work in enabling occupation, occupational justice, and human rights. I will quickly take this opportunity to thank you all for the considerable commitment and energy you have applied in 2009. I am truly grateful for the significant contribution you have made to our practice, this research, and to the OT profession.
Using media to critique policy and justice

In the focus group and following on from the reading, we discussed instances of occupational injuries in society and the trends that are changing patterns of participation in occupation. It was raised how the recent riots in the detention centre on Christmas Island were reported to have occurred when ‘two Afghan men using a pool table refused to give it up and taunted waiting Tamils’. It was discussed that this predicament for asylum-seekers in mandatory detention illustrates an array of human rights violations, not the least the right to freedom of movement and the right to make choices about whom to associate with. It was imagined that a person’s right to health and well being would be further challenged in a detention centre environment where there wouldn’t be many ways to occupy your time. Other occupational issues mentioned in the group included the way in which dominant digital technologies affect child development and shared family occupations; the impact of the global financial crisis on people who are unemployed or on the pension; and how the harmful occupations related to ‘violence in Melbourne streets’ and binge drinking had been prominently profiled in the media, in turn restricting participation in occupation for others. This in turn lead to group reflection about the role that the media plays in shaping public perception and political agendas.

In the realm of health, we talked about how high profile persons have publicly shared their experience of breast cancer to a compassionate public audience. This “social movement” has contributed to the expansion of specialist oncology services in major health networks, and yet highlighted service inequalities for those people affected by chronic or progressive conditions with a lesser media profile. “MD, MD, PD all those they don’t get the same level of funding, support, research”. Therapists also critiqued government policy and response to the Victorian bushfires for potentially failing to consider the needs of vulnerable groups. The government have gone and just said well you will have to put that in your fire plan, and make sure you have someone who can help you get out. … I mean some very elderly, disabled, vulnerable people must live in all of the fire-prone areas and what do they do about evacuation?” In our group we focused on making connections across policy, occupation and justice. I do not think this is an easy thing to do. Interestingly, ite (2008) reassures that human rights are not politically neutral; it is not possible for health professionals to occupy a full range of ideological positions or to have no position at all on a certain issue. What other political commitments could you or should you make in your occupational therapy practice?
Tensions in how to practice for diversity

In the focus group, we debated how we should practice towards inclusion of people of diverse cultures and backgrounds. Some therapists suggested 'I think it is an exposure sort of thing. If you don't come across vulnerable populations regularly enough, then you don't have any idea of what to do when that happens.' Others suggested that acquiring a knowledge and understanding of the issues affecting marginalised groups could help therapists to more readily identity, and recognise clients' occupational injustices, as this case illustrated, ‘housing is a really big issue for him and sometimes indigenous populations can take shorter tracks with housing... so I suppose it is having an awareness of those options’. Yet therapists expressed their disappointment in the way in which applying group stereotypes might further marginalise people, that is something that quite upsets me... that we quickly link people in to they are from background or they are from this area’. It was pondered if this tendency to characterise or classify people according to groups be like a scientific approach, similar to how medicine objectifies the human body ‘you can put a group and say this is how we are going to treat this population, it's the same frame of mind as they say this is how we are going to treat this injury... this is how to fix it’.

Therapists felt practice with diverse peoples 'all comes back to being person-centred', and so avoided making generalisations about the client by rather focusing on the individual 'I don't really look too in depth of where they come in from that point of view, but just get them to explain their thoughts and feelings.' Interestingly, therapists even pondered if thinking about the person as part of a group is at odds with the occupational therapy theory and philosophy learned at university. It goes against what we have been taught at uni, which is to look at people's individual meaning and their everyday occupational lives. Maybe that is the reason why we don't look at things from a population base frequently or regularly because we are always looking at an individual, what one experiences or wants is completely different from another individual.’ Whilst it is an inherent belief that occupational therapists focus on the personal meaning of occupation, I do not believe this emphasis on the individual in our education should preclude us from making the link to the typical experience of marginalised groups. By paying attention only to individual accounts of disadvantage (which the client may or may not be aware of) we can overlook forms of structural disadvantage impacting on the client, and lead also to occupational injustices being enacted later with others. What do you think?
Our actions: Empowerment in an organisation

In our focus groups we have consistently talked about the professional challenge to practice at a population health level, 'I don't think as OTs we know about this stuff at a public health, world level'. Nonetheless, even in a medical-oriented context, we have influenced the health and well-being of the population, by making changes to the organisation. For instance, therapists altered the whole ward environment to be more like real life by inviting members of the community into the hospital, if we are not allowing them the opportunity to get out, then we just sort of need to be thinking of how do we get people in'. In order to do this occupational enrichment, therapists relinquished aspects of their practice and rather acted in a consultative role or as a 'driving force' of occupation-based enablement. Therapists also worked towards occupational justice at an organisational level by identifying opportunities to be more inclusive of people who may otherwise have not had their occupational needs met by the service 'we are actually trying to get more rheumatology patients through.... In terms of the hard condition we are not going to fit too much, so we will be focusing on all those other (occupational) things'.

Importantly, therapists plan to educate and support other occupational therapy colleagues to take on an enabling occupation approach, 'now it is just part of my thought process I guess and now it is part of the way I teach the next person' and have started writing policy and procedures emphasizing in support of this so occupation is not an add-on or anything, it is part of the routine'.

Therapists hoped this action might empower colleagues who are relating to practice areas that typically would adopt an impairment reduction focus, 'so the person who is doing the initial assessment is confident and not just wandering around with their head spinning, they suddenly have got things to talk about'. I was most taken that therapists' actions were underpinned by a concern for power and justice, as shown by this therapist talking about starting group supervision process, 'I was thinking maybe we will just start in the new year but then I thought maybe we just need to have a meeting where we talk about how it is going to work, so they (supervisors) decide rather than me just telling them how it is going to work, because I think that will be much more important'. Well done for making this mark on population health! Can you think of other ways to impact beyond your immediate patch of practice?
Our actions: Foregrounding the person

In daily occupational therapy practice, therapists have naturally and more consciously taken action to foreground the needs and rights of their clients. Therapists reflected how reading past progress notes could enable them to become reacquainted with a client’s occupational profile, especially following a time lapse between sessions. They actually sat down for two minutes read through the previous notes and made sure it is right in my head of what I had explained to them in the past. This reading preparation could help therapists to anticipate the human and occupational needs of the person, as is vital for client-centred practice. It is actually gathering the person’s full picture in your mind before they come in the door; whenever I don’t do it I will know their name and I will have a quick squiz at their condition... and all those things will start coming back to me whilst we are talking. But if it’s (read) before they actually walk in the door then I know exactly who this person is, what things they were talking about last time, what they wanted to work on. Contrary, one therapist exemplified how human rights practice was able to unfold when by ‘luck of chance’ they and other colleagues did not have access to, nor were influenced by, preconceived ideas in the progress notes. This enabled the therapist to openly advocate for a family’s capability to support their own father to die at home.

Being open to and prioritising the client perspective (and in this case that of the family) is critical if the positive potential for human rights practice is to be realised; as was noted by this family in their expression of gratitude: ‘he was so grateful for us for listening to his problems and for getting his Dad home... he said his Dad picked the Melbourne Cup winner and all those other sort of personal things that he would never have had the chance to do in a hospital’. Therapists also shared some ideas for future actions that would further convey this respect for client dignity and choice, such as organising specialised equipment for the ward so people do not have to be ‘bed washed’ and bed nursed for the last one, two, three, four weeks of their life, and by inviting clients to participate and make decisions when shopping for items to be used on the ward. This foregrounding of the client brings me to what I think is the essence of this research. Occupational therapists work for human rights as an outcome of practice (by enabling people to participate in diverse and meaningful occupations that are vital for health, wellbeing and justice) and just as importantly, as a process of practice (by practising in a way that is occupation-focused, empowerment-oriented and most importantly, just). It is our moral duty to help our clients realise their humanity, and in doing so, we can realise ours.
Appendix E: Example of NVIVO Word export

“The push to meet the hospital goals, the hospital way”

<Internals!Focus Group 1 Transcript> - § 6 references coded [9.91% Coverage]

Reference 1 - 1.21% Coverage

Wanting to be part of a group to practice in more of an occupation-focused way (1, 2)

Noticing an occupation focus is not always the goal of therapy, rather it happens as an end of practice (1, 2)

Finding practice to have more of a physical base, rather than an occupational focus (1, 2)

Personally from my stream it is quite difficult, and that is one of the point of being part of this group, it’s very physical based I guess you could say so that was one of the reasons I wanted to join in this group to see how we could alter that more physical intervention, rather having an occupational focus. But we still do in the end always relate back to the goal of how someone is going to achieve what they want to, it’s just not always the clear goal from the get go. I would say that it’s other goal is the end result but along the way it is may not to looked at as often.

Reference 2 - 1.67% Coverage

Wanting to believe that practice focuses on what clients want to do, but having to meet hospital needs (1, 3)

Finding that what occupations the client wants to do beyond getting home is not much of a focus in OT (1, 3)

I think it’s true in, I mean, I know particular in hand therapies it’s physical but it’s difficult in lots of other settings as well. I like to think that we are focusing on what people do and what they want to do, but we are also work within the hospital system where we have to, we are constrained by what they need us to do and in given timeframes so that sort of has an impact on how much we could. If I went to team meeting and said ‘actually what we are going to do tomorrow is going shopping because this person really wants to’ or whatever, they would laugh at me (laugh). In acute, it’s not realistic. I think I still like to hold on in the back of my head somewhere, thinking about what the patients likes to do, wants to do, needs to do and then you’ve got what the hospital wants them to do.

Reference 3 - 2.48% Coverage
Finding OTs do bring routinely practice bring back to personal care and safety, rather than enabling the full range of occupations (1, 4)
Finding OT groups are not necessarily based on occupations that are important to clients (1, 4)
Finding that even in the community OT focuses on the physical side rather than an occupational focus (1, 4)

So what types of things do you do, if not shopping? (laugh)

Oh that they want to do? Not very many things at all really; truthfully. I means in acute it’s about getting them home and you know whatever they want to be able to do in order to get home. So for some people it’s enough that they can walk to the toilet and back, and get on and to get on off the toilet, depending on what sort of level they are at.

Even in sub-acute though it’s very difficult to tow the line with everything that more than what’s required for safe discharge, because of the same pressures of the hospital system, and we do bring it back to self care, being able to get your meals, and maybe a little bit of community, and we might do a touch on leisure, and we have groups but it’s not specific to what they are saying is important with their occupations.

Even as a community OT but you do find that you don’t tend to do as many of those occupational things. A lot of it is physical - rails or ramps or equipment - and it would be nice perhaps to be able to do those more cooking things or more personal care focus or community access and that type of thing. But there is just not time to do that type of thing.

Reference 4 - 1.86% Coverage
Finding that OT stops once safety goals have been achieved (1, 17)

I think that we can perhaps can look at the safe discharge if you sort of pull back from that slightly, and think well actually the occupation of being able to go to the toilet and get on and off it safely is a valuable occupation. So you know it is not that they are at odds with each other, it’s just that the way in which you view them.

You stop once you reach those goals, is where the medical model stops you.

But you can in a way you are launching someone off into that safe environment so they can get to the loo and get back again into their chair safely. Which gives them the opportunity to take their occupations on, whether it is the occupation of reflecting. You can’t see the whole process, which is frustrating.
The hard part is that you can’t see that, but you are enabling the process.

If it's client centred, they are the important ones that we have to move through*.

Reference 5 - 1.94% Coverage

Noticing that resources towards medical interventions are not necessarily centred to what the client wants (1, 22)

I will give you an example from mental health. The main issue, is medication compliance, a lot of people who come into the hospital are involuntary. So that means they are at risk of themselves or others and unable to be treated in the community, so all the resources of the whole unit are dedicated towards finding out which medication is best for this person, all nursing are making sure they take them at particular time, trying to convince them that it actually works. Think about the enormous resources that it takes in order to treat this person with a mental illness, who doesn’t want to take any medications. If we directed all those resources towards finding housing, employment and all the things that they want and need to do; if we channel all those resources towards that, would we perhaps have a different outcome?

That is just my question, a different tact for how we can approach health care. A re-channeling of energies.

Reference 6 - 0.74% Coverage

Finding that therapeutic use of activity is a positive step for practice, though it is not typically meaningful to the client (1, 36)

That is why coming in here and trying to think of various ways of doing it. We have got a new therapist who does more functional, but they are still functional in the sense of trying to open and close a jar, trying to use putty in different ways. Things like that. Realistically that is not usually something that is important; using putty in different way.

<Internals!Focus Group 2 Transcript> - § 2 references coded [2.80% Coverage]

Reference 1 - 0.41% Coverage

Finding that the hospital pushes goals onto the client rather than working with the client on what they want (2, 41)

The system needs, I found working in sub-acute you are pushed to do the things that the hospital wants you to do discharge planning, so you sort of imposing the goals onto the client, as opposed to * I think in our role you are allowed to do that, it's just a matter of engaging.
Noticing a difference between clients who are voluntary and those who are truly engaged (2, 42)
Noticing the contradiction to client-centred practice when needs and goals are not defined by the client (2, 42)
Feeling uncomfortable when clients are required to engage in OT in order to get home (2, 42)
Wondering if practice is not as effective when the client is not truly engaged in OT (2, 43)

I have that sometimes. 80% of the clients there are involuntary. Unlike where you guys are, most of them come relatively voluntarily. There is voluntary and there is voluntary isn’t there, Most of them are relatively voluntary

Via ambulance (Laugh)

The involuntary status of the mental health act changes the game a little bit. The doctors are asking me to do an assessment with someone who needs to go home, in terms of are they going to be able to be safe to cook a meal and not starve because no-one is going to come and see them for a few days. They don’t want to do it; they just want to go home. The ‘doctor says this is part of your precondition for going home’, and they begrudgingly and they are really pissed off. They do it and 80-90% of the time they are okay, but I always feel uncomfortable about that. This whole thing about in our practice guidelines when we are trained, peoples’ free will is very important. Working in a hospital, we work we walk very closely to the edges of that free will and in mental health we cross over those lines all the time. I find it quite hard to marry the best practice idea, in a sense people really should be coming to us as occupational therapists with ideas of what they would like to do and then we are enabling them, as opposed to us dragging ideas out of them to try and provide therapy for them. I struggle with some of those ideals in the profession and the reality of what we are trying to do. By trying to force it a little bit, which is sometimes what I feel like I am doing, am I then perhaps only doing it half way, or the disenabling if you like.

<Internals!Focus Group 3 Transcript> - § 2 references coded [7.71% Coverage]

Reference 1 - 3.95% Coverage

Finding it daunting to know how to report back at the ward round when OT focus is not compatible with hospital goals (3, 2)
Feeling at odds that the client is asked to do things that they don’t want to do (3, 2)

Something that strikes me I was thinking today, I am working with a man at the moment, he has been in hospital for a while and his psychiatric treatment has kind of failed and there are lots of political issues
around that and I have been given the task of giving him some “occupational enablement”. They didn’t say as much but basically they want me to put him on a rehab program to get him more active blah, blah, blah. The question about enablement that comes up for me is who’s enablement is it. The hospital wants him to move on, they want him to be enabled. He does kind of want to get out of hospital, but sometimes he is too unwell to go anyway. So do you know what I mean? The pressure is coming from me to enable him but it is not coming from him to enable himself or to work with his own life or towards what he wants to do. So the challenge of then having to report back at the ward round tomorrow about what I have been doing with him. Just feeling quite at odds with some of the principles that are in here (EOII) I know I talked about that last time but I am still grappling with it, I constantly feel like, he doesn’t really want to do these things. I don’t want to be writing up a list of things that he should be doing today, because it is my list of what I think he should be doing, as opposed to his list of what he would like to be doing. Maybe he is happy tapping on the window every half an hour and asking the nursing staff to open his door, do you know what I mean?

Have you had some sessions with him?

Had a couple, and uh, so I suppose it is hard if they are not big talkers either. Even though he was a university student not too long ago, his language is not overly, he doesn’t really want to talk about things so we are kind of at a loss as to what to do, We sat in his room and looked out the window, and ‘oh look at those books over there.

Trying to get someone out of a hospital bed and do something, but if they aren’t physically ready for it

That’s right, but it feels like a treatment failure, on our part as therapists as well. The team is going, ‘I want you to move this patient along’. It is, I find it a tension.

Reference 2 - 3.76% Coverage

Noticing how some clients need space before OT can help them to rebuild their life (3, 8) *LIKE WHEN OT IS NOT A PRIORITY

Noticing that hospital expectations that clients start doing things do not take account of what it is like to be unwell (3, 10)

I have been asked by our team, we have got a lady who had GB* 6 months ago, and has been in hospital since and in ICU for about 4-5 months and her recovery is incredibly slow and she can wiggle her thumbs and her fourth finger and that is about it. Having problems with breathing aswell at that is why I became involved. I was asked in the team meeting if I could in a way rebuild this lady’s life for her. Get my magic wand out shall I? What am I supposed to do? We have spoken to her about reading, or having a page turner or something like that but she is ‘Oh well there are lots of books that I have read
and some of the books I have got at home I wouldn’t mind reading but there is nobody to go and get them - because she lives quite a distance away - and I don’t really want to read books that I have read already’. She has a very active life on the ward there are always. There are always physios standing her up and pumping things down into her lungs, and doctors coming along and attacking her to do various things *. So she has an extremely busy life and sometimes when I go and see her because I go and do a little bit of hand therapy to give her a bit of massage and to have a chat really, and to give her a bit of social interaction that doesn’t involve ‘how are you feeling? Where is the pain?” and all the usual stuff and she just goes ‘oh thank goodness there is a little bit of peace and quiet’. She is just bombarded by all these people all the time.

But they want you to find something for her to do

Yeah, absolutely. They have been down the route of having talked about somebody bringing clothes in for her and she is ‘no I am fine without clothes’. The way she is living now is so at odds with the way she was living before. She was living on her own, and a very independent lady in her early 70s but you wouldn’t know it. Very active, lots of friends, goes to the theatre, goes to concerts, very into music; very, very active.

It is very easy to see it from her position through

She is locked in, it’s amazing

She is unwell

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Reference 1 - 1.28% Coverage

Finding that doing the leg work to support people making the transition to residential care counts for nothing as the system makes the call of where they go (4, 44)

Finding the quickest and easiest solution is forced onto the client if they are occupying an acute bed (4, 44)

Probably. I think that article and what they are doing in the United States with that particular case that has happened and the rest of it. Still here in Australia we have got too many different people all trying to organise this under 65s getting out of nursing home program. There seems to be heaps of different programs. That’s what happens the government finds a little bit of money, and everyone goes off and does something completely different. It needs to have some more one governing body or something, because when a person is sitting on an acute ward the quickest and easiest option out is straight to a
nursing home, and unfortunately that is what happens and that is where they end up.

<Internals!Focus Group 5 Transcript> - § 1 reference coded [0.47% Coverage]

Reference 1 - 0.47% Coverage

Believing that whilst enabling occupation may be helpful, it is not always meaningful (5, 47)

And I would say what we do, some of it enables occupation, but it's not, I don't think it's that meaningful. I mean your gardening, your cooking, maybe that's meaningful, but someone is grateful that they get out of their chair but is that necessarily meaningful?

<Internals!Focus Group 6 Transcript> - § 1 reference coded [1.09% Coverage]

Reference 1 - 1.09% Coverage

Seeing the tragedy when discharge policy rushes or places limitations on client choice for residential care (6, 17)

That is the tragic part of the having to be placed from the hospital system, the constraints that have been put on now that you lose all that choice of going to the place that you want to, that is most suitable to your needs and all the rest of it because the hospital puts in place such tight policies around the criteria that you meet if you stay in hospital to wait for the bed basically and you know they would move them to the waiting wards where they are going to have very limited input by any therapy staff. That is something at a hospital level I think where the decisions have been made, rather than anything locally.

<Internals!Focus Group 8 Transcript> - § 1 reference coded [1.63% Coverage]

Reference 1 - 1.63% Coverage

Suggesting that enabling meaningful occupation may not happen if not related to the medical diagnosis (8, 22)

Do you think we always address those things? Things that aren't necessarily related to their diagnosis, or admission or their health per se, although everything is interdependent. For example, we have talked about social isolation before, if someone is needing to connect to their friends and family, or they needed employment.

Not as we should

Probably not if it is not related to their admission. I go into leisure a bit, but not normally in the sense of
how can we promote you to be more engaged in what you want to be able do, but more as a sense of you need social, here is a planned activity group or senior citizens or any of those sorts of connections. Less on that individual leisure.

<Internals\L Interview> - § 1 references coded [16.70% Coverage]

Reference 1 - 11.74% Coverage

Seeing how a push for efficiency can be helpful for clients in some instances (L, 3)
Comparing how internationally there seems to be greater emphasis on preparation for discharge (L, 4)

Well they’re rolling it out across Austin so they’ve done a couple of wards I think I’m sort of in the second wave of a couple of the wards so it was involvement via the ward I work on even though I am kind of only peripheral to the ward so it was a bit strange sort of standing back and We just looked at the process, the we chose is how because I was working with one of the nurses is how the information about discharge planning gets from the ward around to everybody else on the team and whether there was an easier way of making that process happen so that either the nurse in charge had to go around every ward round and spend many hours going around the ward rounds or whether there was an easier way of doing it and we’re trying out the patients dart board so you can see different coloured dots for every patient and then you’ve got the allied health and other input at the top and then you change the colour of the dot depending on whether there’s a referral whether you’ve seen them or whether there’s no further action and we’re trying to get the doctors to put dots in the discharge column as well and it’s just a, no discharge plans currently which is fair enough because not everybody has them currently, discharge them in approximately a week and then discharge in the next few days so we’re not pinning them down to you’ve got to write a date on there and it’s got to true from the moment they come in but it just gives people an idea of when somebody might be going and that allows the nurses to get the pharmacy stuff set up, to talk to the family and if necessary talk to the patient so they can arrange a vehicle to take them home and stuff like that. Because there’s a big push in the hospital and it makes sense really and it makes sense for the clients as well I think there’s a big push in the hospital for people to go home before ten o’clock because it means that the bed is free for somebody else to come into and from a person going home point of view it means they’re home fairly early in the day and they have got a bit of a chance to just sit around and stare around the place and thing oh what do I do now and also to try and get stuff sorted out so if a carer needs to come in later on in the day, so if carers need to come in or if relatives are going to come in a bit later on or something I think it gives the clients more of a kind of structure to their day that they’re a bit more assured of when they will be going home so I think it has it’s positive things rather than being dropped off at five o’clock and thinking oh I haven’t got any milk!
It's not because that's a corporate goal that DHS hands down and so it's one of those kind of faceless corporate goals but actually by looking at the reality of what happens when you arrive home at five o'clock in the evening or at ten o'clock or eleven o'clock in the morning then I think I'd rather arrive home at eleven o'clock in the morning if I've got things to get my head around.

Yeah there is a transit lounge and they're trying to use that more but a lot of ours do go home with relatives or with somebody else and obviously with that there is an element to that that you have to wait until your relative is free before you can be taken home as well but yeah we're just looking at giving the rest of the team a bit of a chance of knowing what it was the doctors were thinking and also a bit of discipline for the doctors who can get very focused on the treatment and what's going with this person and whatever and only think about discharge when everything else has been settled and sorted out kind of thing. Whereas I went into the hospital in the UK and almost the question they asked me or the paperwork they gave me before I was admitted before they let me sit in the bed or showed me where the bed was or put me into the ward even was how are you getting home then so there is that impetus to you know to know how it's going to happen, whether you do need a social work referral or whether some care does need to be restarted you know who needs to be told when you're going home so all those things are kind of in place before you're allowed in!
Appendix F: Example of NVIVO Excel export - Category and theme development

Category Development One

<table>
<thead>
<tr>
<th>Name</th>
<th>Category</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling frustrated with the system and powerless to change it</td>
<td>An unjust system</td>
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</tr>
<tr>
<td>Sensing inconsistencies with basic human values</td>
<td>An unjust system</td>
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<tr>
<td>The lucky client - Service inequalities</td>
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<td>Enabling occupation may not be meaningful in itself, but creates opportunities later on</td>
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</tr>
<tr>
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<tr>
<td>Needs and wants are different things - Choosing not to enable occupation</td>
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<tr>
<td>Deciding to withdraw services - Influences on professional decision-making</td>
<td>Blindspots &amp; complicity</td>
<td>1</td>
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<tr>
<td>Questioning if all OTs naturally care for justice</td>
<td>Foundations for justice</td>
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<tr>
<td>Debating if OT belongs in the hospital, and seeing a future in the community</td>
<td>Future vision for OT, Medical model</td>
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<tr>
<td>Overwhelmed by the challenge to the profession - Power of medical model</td>
<td>Future vision for OT, Medical model</td>
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<tr>
<td>Believing and hoping there is a shift towards human rights in health care and feeling optimistic it will favour OT</td>
<td>Future vision for OT, Medical model</td>
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<tr>
<td>Caring brings joy, however practice is not always caring</td>
<td>Human connections</td>
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<td>Tensions in applying group characteristics</td>
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<td>Illness has a ripple effect - The need for a broader approach</td>
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<td>Focusing on structural change</td>
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<td>Occupational injustices in Western countries - How they may or may not be obvious</td>
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<td>Practice boundaries - Working near and crossing over</td>
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<td>Querying the rules and practices of documentation</td>
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<td>The legal system acts as tie-breaker</td>
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<td>Thinking about the human right to make choices and have them supported</td>
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<td>The lucky OT - Noticing differences in EO across occupational therapy practice areas</td>
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<td>Utopian visions of OT - The human right to occupation &amp; occupation-focused occupational therapy</td>
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<td>Finding theory helpful and inspiring, wanting to move it into practice</td>
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<td>Being inspired by practice actions and hopeful for a bright future</td>
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<td>Trying to imagine what a client's life is like, yet knowing it is unimaginable</td>
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<td>Valuing OT role as client advocate, but seeing it as a skill mastered by social work</td>
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<td>Exploring client needs beyond those listed on the referral</td>
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<td>Making the jump - Skills for human relating</td>
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<td>Finding it easy to slip into the medical way of doing things, and yet trying to fight it</td>
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<td>Implications of bypassing the client</td>
<td>Limitations to client-centred practice</td>
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<td>Casting judgment yet trying not to push a view- Implications for client-centred practice</td>
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<td>When practice is black and white it can be challenging - Constraints on client-centred practice</td>
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<td>Challenges to client self-advocacy - The nature of dependence</td>
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<td>Perspectives of health - Noticing discrepancies between an occupational therapy view and that of medicine</td>
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<td>The politics of collaboration</td>
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<td>Timing practice well</td>
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<td>Having the moral courage to advocate for what is important to OT</td>
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<td>Management does not always understand or translate</td>
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<td>Feeling like a small fish in a big pond - Positions of influence</td>
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<td>Wanting to prove the effectiveness of OT, yet troubled by a perceived lack of evidence</td>
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<td>Feeling powerless and being constrained to focus on quality of life</td>
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<td>Finding it hard to get a foot in the door for funding when scientific knowledge and research is prioritised</td>
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<td>The value afforded to OT - EO as a side issue</td>
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<td>The complexity of occupation and enablement may be invisible to others</td>
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<td>Seeing the worthiness of OT, and the need to give it a better public profile</td>
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<td>The OT will sort it out - OT is synonymous with safety</td>
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<td>The ease and inherent risks of enabling occupation</td>
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<td>Getting passionate about occupational injustices</td>
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<td>Changing practice is hard, it takes time and persistence</td>
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<td>The benefit of a profession organised around a particular vision</td>
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<td>Desire for less clinical, and occupationally enriched spaces</td>
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<td>Supportive environments foster inclusive community attitudes</td>
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<td>Advancing human rights by profiling an occupational perspective</td>
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<td>Helping carers to understand and make choices about caring</td>
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<td>OT makes the link - A translational profession</td>
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<td>Being willing and open to do things creates space to enable occupation and justice</td>
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<td>Building collaborative relationships and drawing upon support of allies</td>
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<td>Working smarter not harder, Picking the battles in order to minimise the drain</td>
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<td>Reclaiming time to talk with the client - Avoiding the rush and working smarter not harder</td>
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<td>Coaching to help the client come alive</td>
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<td>Clients are enablers - The power of story-telling and making connections</td>
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<td>Giving the team greater responsibility</td>
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<td>Learning to push harder for help with the client</td>
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<td>Powerful practice stories</td>
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<td>Supervision &amp; reflection can provide a link to a human rights approach</td>
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<td>A breath of fresh air - The therapeutic value of getting out of the hospital</td>
<td>Transformative human rights</td>
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<td>Seeing the true client at home - Valuing the home as a context of practice</td>
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<td>Planning for practice helps brings focus to the person</td>
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<td>Shunning structure - Seeing it as a hindrance for working with the person</td>
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<td>Meeting the client with a fresh slate allows for transformative human rights</td>
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<td>Miscellaneous - Needs deeper discussion with therapists and my reflection</td>
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<td>Knowledge for practice</td>
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<td>Therapist's efforts to care are not always felt by the client</td>
<td>Practice consequences &amp; guilt</td>
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<td>Struggling with understanding the research issues</td>
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<td>Reflections on the research activities</td>
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<td>Learning through the research</td>
<td>Research processes</td>
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<td>Enabling occupation and justice minus the finishing touches</td>
<td>Complicity in human rights issues</td>
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<td>Having to choose and prioritise which clients to see</td>
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<td>Valuing practice that pays respect and dignity to the client</td>
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<td>The enjoyment derived from caring</td>
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</table>
Changing practice is hard, it takes time and persistence
Desire for less clinical, and occupationally enriched spaces
Trying to imagine what a client's life is like, yet knowing it is unimaginable
Concerns for vulnerable people
Exploring client needs beyond those listed on the referral
Making the jump - Skills for human relating
Getting passionate about occupational injustices
When OT is not a priority - The client's focus is on life and survival
Sensitivity to the politics of collaboration
Having the moral courage to advocate for what is important to OT
Being willing and open to do things creates space to enable occupation and justice
Bypassing the client
Referral goals may not match the priorities of the client, therefore restricting client engagement
The push to meet hospital goals, the hospital way
Concerns about job security thus practicing according to funding
When practice is black and white it can be challenging
Challenges to client self-advocacy - The nature of dependence
Perspectives of health - Noticing discrepancies between an occupational therapy view and that of medicine
Feeling frustrated with the system and powerless to change it
Feeling like a small fish in a big pond - Positions of influence
Wanting to prove the effectiveness of OT, yet troubled by a perceived lack of evidence
Feeling powerless and being constrained to focus on quality of life
Finding it hard to get a foot in the door for funding when scientific knowledge and research is prioritised
The value afforded to OT - EO as a side issue
The complexity of occupation and enablement may be invisible to others
Seeing the worthiness of OT, and the need to give it a better public profile
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<td>The ease and inherent risks of enabling occupation</td>
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<td>Learning to push harder for help with the client</td>
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<td>An emphasis on enabling being and becoming, not just the doing</td>
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<td>A breath of fresh air - The therapeutic value of getting out of the hospital</td>
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<td>Humanising and empowering the client</td>
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<td>Seeing the client as a person, and building a human relationship with them</td>
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<td>Helping carers to understand and make choices about caring</td>
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<td>Clients having to take responsibility - Enabling justice, enabling self advocacy</td>
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<td>Coaching to help the client come alive</td>
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<td>Clients are enablers - The power of story-telling and making connections</td>
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<td>Research processes</td>
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**Theme Development One**

- **Advancing the occupational view**
  - Advancing human rights by profiling an occupational perspective
  - Coaching to help the client come alive
  - Helping carers to understand and make choices about caring
  - Learning to push harder for help with the client
  - OT makes the link - A translational profession

- **Humanising the client for transformative praxis**
  - A breath of fresh air - The therapeutic value of getting out of the hospital
  - An emphasis on enabling being and becoming, not just the doing
  - Desire for less clinical, and occupationally enriched spaces
  - Meeting the client with a fresh slate allows for transformative human rights
  - Planning for practice helps brings focus to the person
  - Reclaiming time to talk with the client - Avoiding the rush
  - Seeing the client as a person, and building a human relationship with them
  - Seeing the true client at home - Valuing the home as a context of practice
  - Shunning structure - Seeing it as a hindrance for working with the person

- **Methodology**
  - Learning through the research
Reflections on the research activities

Struggling with understanding the research issues

**OTs are the enablers - Positive self-talk and belief in the profession**
- Being inspired by practice actions and hopeful for a bright future
- Being willing and open to do things creates space to enable occupation and justice
- Changing practice is hard, it takes time and persistence
- Concerns for vulnerable people
- Exploring client needs beyond those listed on the referral
- Feeling proud and important
- Finding theory helpful and inspiring, wanting to move it into practice
- Getting passionate about occupational injustices
- Having the moral courage to advocate for what is important to OT
- Making the jump - Skills for human relating
- Sensitivities to the politics of collaboration
- Shifting to occupation-focus is difficult but with commitment it can become routine
- Trying to imagine what a client's life is like, yet knowing it is unimaginable

**Sustaining the professional self - Tools for human rights practice**
- Building collaborative relationships and drawing upon support of allies
- Choosing the words of enabling occupation
- Clients are enablers - The power of story-telling and making connections
- Clients having to take responsibility - Enabling justice, enabling self advocacy
- Giving the team greater responsibility
- Powerful practice stories
- Recording data about enabling occupation as a starting point for improving practice
- Seeing the worthiness of OT, and the need to give it a better public profile
- Supervision & reflection can provide a link to a human rights approach
- Working smarter not harder, Picking the battles in order to minimise the drain

**The bipolar OT - Complicity and criticality for human rights and occupational issues**
- Casting judgment yet trying not to push a view
- Deciding to withdraw services - Influences on professional decision-making
- Enabling occupation and justice minus the finishing touches
- Having to choose and prioritise which clients to see
- Lack of referral on
- Needs and wants are different things - Choosing not to enable occupation
- Querying the rules and practices of documentation
- The legal system acts as tie-breaker
- The reality of risk
- When practice is not client-centred

**The institutional vice**
- Bypassing the client
- Challenges to client self-advocacy - The nature of dependence
- Concerns about job security thus practicing according to funding
- Feeling frustrated with the system and powerless to change it
- Feeling like a small fish in a big pond - Positions of influence
- Feeling powerless and being constrained to focus on quality of life
- Finding it hard to get a foot in the door for funding when scientific knowledge and research is prioritised
- Having to negotiate unrealistic expectations that clients can be fixed
- Losing track of the client
- Management does not always understand or translate
- Perspectives of health - Noticing discrepancies between an occupational therapy view and that of medicine
- Referral goals may not match the priorities of the client, therefore restricting client engagement
- Tensions around duty of care and feeling concerned about the legal consequences of professional decisions
- The complexity of occupation and enablement may be invisible to others
- The ease and inherent risks of enabling occupation
- The lucky client - Service inequalities
- The OT will sort it out - OT is synonymous with safety
- The push to meet hospital goals, the hospital way
- The value afforded to OT - EO as a side issue
Wanting to prove the effectiveness of OT, yet troubled by a perceived lack of evidence
When practice is black and white it can be challenging

**Utopian visions, dystopian realities**
Aspirational and pragmatic understandings of human rights
Believing a justice approach is not characteristic of OT in Australia
Caring is effective but having to justify it as work
Contemplating the theory of occupational justice
Debating if OT belongs in the hospital, and seeing a future in the community
Illness has a ripple effect - The need for a broader approach
Lack of connection between OT theory and practice
Occupational injustices in Western countries - How they may or may not be obvious
OTs are special at enabling client choice
Overwhelmed by the challenge to the profession - Power of medical model
Questioning if all OTs naturally care for justice
Rooting for the client, and lamenting the likely restriction in their life choices
Shades of grey in determining the client's competency to choose
Tensions in applying group characteristics
The benefit of a profession organised around a particular vision
The lucky client - Service inequalities
The lucky OT - Noticing differences in EO across occupational therapy practice areas
Thinking about the human right to make choices and have them supported
Utopian visions of OT - The human right to occupation & occupation-focused occupational therapy
Valuing OT role as client advocate, but seeing it as a skill mastered by social work
When OT is not a priority - The client's focus is on life and survival

**Theme Development Two**

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<td>Believing and hoping there is a shift towards human rights in health care and feeling optimistic it will favour OT, with education a key part</td>
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<td>Contemplating the theory of occupational justice</td>
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<td>Debating if OT belongs in the hospital, and seeing a future in the community</td>
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<td>Disconnection among the ranks</td>
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The push to meet hospital goals, the hospital way

**OT sidelined to the operandi of the institution**
Challenges to client self-advocacy - The nature of dependence
Concerns about job security thus practicing according to funding
Feeling frustrated with the system and powerless to change it
Feeling like a small fish in a big pond - Positions of influence
Feeling powerless and being constrained to focus on quality of life
Finding it easy to slip into the medical way of doing things, and yet trying to fight it
Finding it hard to get a foot in the door for funding when scientific knowledge and research is prioritised
Overwhelmed by the challenge to the profession - Power of medical model
Perspectives of health - Noticing discrepancies between an occupational therapy view and that of medicine
Referral goals may not match the priorities of the client, therefore restricting client engagement
Rooting for the client, and lamenting the likely restriction in their life choices
Management does not always understand or translate
Tensions around duty of care and feeling concerned about the legal consequences of professional decisions
The complexity of occupation and enablement may be invisible to others
The ease and inherent risks of enabling occupation
The legal system acts as tie-breaker
The OT will sort it out - OT is synonymous with safety
The push to meet hospital goals, the hospital way
The value afforded to OT - EO as a side issue
Wanting to prove the effectiveness of OT, yet troubled by a perceived lack of evidence
When practice is black and white it can be challenging
The lucky OT - Noticing differences in EO across occupational therapy practice areas
The lucky client - Service inequalities
Therapist's efforts to care are not always felt by the client
Bypassing the client
Having to personally live with the guilt and consequences of professional decisions
Losing track of the client
Having to accept clients can't be fixed, and negotiate unrealistic expectations of OT
When OT is not a priority - The client's focus is on life and survival

**Agents of change**
Being willing and open to do things creates space to enable occupation and justice
Embracing the personal self in professional practice
Trying to imagine what a client's life is like, yet knowing it is unimaginable
Feeling proud and important
Questions of politics, power and neutrality
Valuing OT role as client advocate, but seeing it as a skill mastered by social work
Seeing the worthiness of OT, and the need to give it a better public profile
Sensitivities to the politics of collaboration
Exploring client needs beyond those listed on the referral
OTs are special at enabling client choice
Working smarter not harder, Picking the battles in order to minimise the drain

**Humanising the client for transformative praxis**
A breath of fresh air - The therapeutic value of getting out of the hospital
An emphasis on enabling being and becoming, not just the doing
Clients are enablers - The power of story-telling and making connections
Clients having to take responsibility - Enabling justice, enabling self advocacy
Coaching to help the client come alive
Enriching hospital spaces
Meeting the client with a fresh slate allows for transformative human rights
Planning can hinder practice and help bring focus to the person
Reclaiming time to talk with the client - Avoiding the rush
Seeing the true client at home - Valuing the home as a context of practice
Shunning structure - Seeing it as a hindrance for working with the person

**Advancing an occupational view acts as a platform for occupational justice**
Choosing the words of enabling occupation
OT makes the link - A translational profession
Pushing harder and going further for the client
Advancing human rights by profiling an occupational perspective
Better seeing injustices and fighting to change them
Learning to accept client choice

**Building a more inclusive occupational therapy**
Building collaborative relationships and drawing upon support of allies
Focusing on structural change
Giving the team greater responsibility
Helping carers to understand and make choices about caring
Illness has a ripple effect - The need for a broader approach
Opening access to OT
Recapturing breadth in occupation-focus
Stretching the role of OT
Learning to bend the rules
Having to accept clients can't be fixed, and negotiate unrealistic expectations of OT

**Forums that foster learning about, and practice of occupational justice**
Finding theory helpful and inspiring, wanting to move it into practice
Getting up with the theory
Linking the theory to the everyday
Powerful practice stories
Supervision & reflection can provide a link to a human rights approach
The need to engage across all of OT
Knowledge for practice

**Experiences of changing practice**
Being inspired by practice actions and hopeful for a bright future
Changing practice is hard, it takes time and persistence
Getting the timing right when engaging others
Ideas to keep the research alive
Shifting to occupation-focus is difficult but with commitment it can become routine
Struggling with understanding the research issues
Power of learning as a group, motivation for change
Querying the rules and practices of documentation
Getting passionate about occupational injustices

**Critique of the research processes**
Critique of the research processes
Critiquing levels of participation
Focus groups gave chance to stop, think, and share ideas
Liking the structure of focus groups
Noticing sameness and differences among the group
Personal reflections on the research activities

**Miscellaneous or has significant leftover content**
Concerns for vulnerable people
Practice boundaries - Working near and crossing over
Supportive environments foster inclusive community attitudes
Caring is enjoyable, but not always done
Trying to get around the system
Caring is effective but having to justify it as work
Being willing and open to do things creates space to enable occupation and justice
Questions of politics, power and neutrality
Making the jump - Skills for human relating
Casting judgment yet trying not to push a view
Appendix G: Co-researcher Information and Consent Form

Co-researcher Information Form

Project Title: Exploring occupational therapy practice and taking action to enable occupational justice

Principal Investigator: Professor Gail Whiteford

What is the research about?

This project aims to investigate and affect the application of theory and philosophy in the development of occupational therapy practice. In particular, this study will explore how the recently revised text *Enabling Occupation II: Advancing an occupational therapy vision for health, well-being and justice through occupation* (Townsend & Polatajko, 2007) can be applied to, and influence, occupational therapy practice.

This research stems from challenges within occupational therapy to broaden its focus, towards enabling individual and social change. Whilst occupational therapists have been encouraged to be more political and to reflect greater global perspective and ecological
concern, it is less clear how occupational therapists do this in everyday practice. This study aims to lessen this gap between philosophy, theory, and practice.

Using qualitative research processes, this project will explore three main questions: (1) How do occupational therapists understand and enact social, ecological and humanitarian issues in practice; (2) What conditions constrain or support occupational therapists in enabling occupational justice; and (3) What actions can occupational therapists take in order to practice ethically and wisely?

**Who is conducting this research?**

Danika Galvin is a student researcher, and this project is part of the Doctor of Philosophy she is undertaking with Charles Sturt University. Professor Gail Whiteford from Charles Sturt University is supervising the research, and thus takes overall responsibility for the project. This research is affiliated with a larger national and international project that is being undertaken by researchers from the School of Community Health at Charles Sturt University, and which has received approval from the Charles Sturt University Ethics in Human Research Committee.

The linked study involves a variety of other occupational therapist groups in Australia, France, and Canada, who are also exploring the clinical utility of the revised Canadian Model of
Occupational Performance and Engagement (CMOP-E) in occupational therapy practice, using the text by Townsend and Polatajko (2007) as stimulus material. The generalised findings from these studies will be pooled so that we can develop a more comprehensive understanding of occupational therapy practice in Australia and worldwide.

Do I have to take part in the research?

You are under no obligation to take part in the research; participation is entirely voluntary. If you do take part you may withdraw from the study at any time without giving a reason for doing so. Please be aware however, that if you decide to withdraw from the study any information that you contributed up until the time of your withdrawal will remain included in the research.

What benefit will I obtain from participating in the research?

In choosing to participate, you will be making a commitment of considerable time and energy to the research process. Nonetheless, your involvement in this research may provide a means for your professional development, and help you to develop skills for reflecting on your own professional practice, and for making changes to enhance your practice accordingly.

This research project will create a structured and supportive environment for exploration of occupational justice, which is an
emerging concept in occupational science and occupational therapy literature. Participating in this project may help you to better understand and enact occupational justice in your everyday practice, and may assist you to enhance the quality of occupational therapy you provide, thus potentially benefitting your clients.

In addition there will be opportunity for you to claim professional development points for your involvement in the research with the Accredited Occupational Therapist (AccOT) program.

If I take part in this research what would it involve?

As it adopts a participatory action research framework, therapists who choose to be involved in this research will play an active role. The participating occupational therapists will be asked to critically reflect on how equity and justice issues are understood and enacted, and enabled or constrained, in their everyday occupational therapy practices.

Using this understanding, participating occupational therapists will collaboratively plan and implement changes to practice, in order to make improvements. They will then evaluate the effectiveness of their changes, and have the opportunity to repeat this action-reflection cycle so as to more closely align their practices with their own developing visions of practice.
Over the course of a year, each participating occupational therapist will be invited to engage in the following research activities:

- Take part in up to 3 individual interviews, lasting 30-60 minutes each and scheduled within working hours at Austin Health

- Participate in a monthly focus group for 12 months, with each focus group lasting between 60-90 minutes during working hours at Austin Health

- Read nominated chapters from Enabling Occupation II as stimulus for critical reflection and focus group discussions

- Select a de-identified client or case story as an example of practice, with preparation of this story expected to take about 15-30 minutes

- Regularly reflect on practice

- As part of the monthly focus groups, comment upon and critique the emerging findings from the study.

It is recognised that the realities and pressures of a demanding workload might mean that on some occasion’s co-researchers may not be able to complete all these research activities. Moreover, if a co-researcher is on leave, he or she may miss a focus group for that month; such absences are completely acceptable and unproblematic. It is expected that the average time required for each
co-researcher would not exceed 40 minutes per week over the 12 months duration of the research.

**What will happen to the information I provide during this research?**

The information that you provide in individual interviews, focus groups and practice stories will be analysed by the student researcher. A copy of your individual interview transcripts will be given to you if you request this. All co-researchers will have the opportunity to provide regular feedback about the research, as it progresses, and this information will be used to make decisions about further research actions.

At the conclusion of this study, Danika Galvin will be writing about the study in her PhD thesis. A copy of Danika’s completed thesis will be given to Austin Health. It is anticipated that the findings of this research will be published in peer-reviewed journals and presented at conferences. When reporting findings, individual co-researchers’ anonymity will be preserved through the use of pseudonyms and the omission of identifying information.

Only the researchers will have access to the information that you provide during the study. Electronic data will be password protected and Danika Galvin will take responsibility for storing all information in a locked cabinet. All confidential records will be stored
for seven years in a locked filing cabinet at the School of Community Health, Charles Sturt University. At the end of this period, hard copy data will be destroyed by shredder and electronic records will be deleted.

**How will my privacy, confidentiality and anonymity be maintained?**

You will not be anonymous to other co-researchers in the study. However, in order to help preserve privacy of co-researchers and the research data, you will be asked to maintain confidentiality of fellow co-researchers. This means that if you agree to participate, you will not disclose to others outside the research the names of fellow co-researchers. Prior to participating you will be asked to sign an agreement to maintain this confidentiality. As stated previously, when reporting findings of the study pseudonyms will be used and personally identifying information will not be reported.

**What happens now?**

Please contact Danika Galvin by email, to ask any questions about aspects of the research that you are unsure about. Once you understand what the research is about and what your involvement would entail, you need to decide whether or not you are willing to take part. It would be appreciated if you could email Danika Galvin of your decision by Monday 2nd March 2009. Should you be willing, you will additionally be asked to sign and return the consent form by
post to Danika Galvin, and to await contact regarding the first
meeting schedule.

This study has received ethical approval from Charles Sturt
University and the Austin Health Human Research Ethics Committee.
If you wish to contact someone, independent of the study, about
ethical issues or your rights, you may contact:

Dr Andrew Crowden
Chairperson
Austin Health Human Research Ethics Committee, Austin Health
Phone: 03 9496 2901

Executive Officer
Ethics in Human Research Committee
Charles Sturt University
Phone: 02 6338 4628

Thank you for your interest.

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Co-researcher Consent Form

Project Title: Exploring occupational therapy practice and taking action to enable occupational justice

Principal Investigator: Professor Gail Whiteford

I ...................................................... have been invited to participate in the above study which is being conducted under the direction of Professor Gail Whiteford (Principal Researcher). I understand that while the study will be under her supervision, other relevant and appropriate persons may assist or act on her behalf.

My consent is based on the understanding that the study involves the procedures as explained on pages 1-4 of this document. The study may involve risks, inconvenience and discomforts, which have been explained to me and which are listed on pages 1-4 of this document.

• I have read this ‘Co-researcher Information and Consent Form’ and understand the general purposes, methods and demands of
the study. All of my questions have been answered to my satisfaction.

• I can withdraw from this study at any time.

• I permit the researcher to make audio-tape recordings as part of this project.

• I consent to the publishing of results from this study provided my identity is not revealed.

• I hereby voluntarily consent and offer to take part in this study.

Signature (Co-researcher): Date:

Witness to signature: Date:

Signature (Researcher): Date:
Statement of Confidentiality

Project Title: Exploring occupational therapy practice and taking action to enable occupational justice

Principal Investigator: Professor Gail Whiteford

I agree to maintain the confidentiality and anonymity of co-researchers involved in the study titled, “Exploring occupational therapy practice and taking action to enable occupational justice”. I agree not to discuss specific details about the study, and most particularly, I will not reveal the identity of co-researchers in this study to anyone who is not a staff member of occupational therapy at the Austin Hospital. (General discussion about the project, its method, and broad area of content with others is encouraged.)

Signature (Co-researcher): Date:

Witness to signature: Date:

Signature (Researcher): Date:
### Appendix H: Ideas for changing practice

Focus group | Kinds of changes discussed in the focus groups. 

Applied to the registers of *thinking, saying, relating,* and *doing* of practice ([Kemmis & McTaggart, 1998](#)).

| Focus group 1 | • Thinking about placing limits on caseload in order to provide high quality occupational therapy.  
• Talking about occupational performance as more than safety and independence.  
• Relating to, and lobbying managers for more occupational spaces within the existing hospital setting.  
• Doing more occupational assessments at home, rather than home assessments. |
| Focus group 2 | • Thinking about what you would like to happen to you if you personally were placed in the client’s situation.  
• Talking to clients in a way that inspires and motivates as well as providing the realistic feedback.  
• Relating to, and educating colleagues about the scope of occupational therapy |
<table>
<thead>
<tr>
<th>Focus group 3</th>
<th>Focus group 4</th>
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<tr>
<td>• Doing assessments that enable the client to identify their own needs, beyond the medical, e.g. well-being questionnaires.</td>
<td>• Thinking about the ways you can include people who may not be competent, in decision-making.</td>
</tr>
<tr>
<td>• Thinking about the long term cost benefits of an occupational approach, in order to justify doing it.</td>
<td>• Talking about and bringing an occupational perspective to ward rounds, such as by sharing what a client does at home</td>
</tr>
<tr>
<td>• Talking to colleagues and researchers about the need for scientific inquiry and client narratives.</td>
<td>• Relating in a way that is less rushed and more compassionate for the client.</td>
</tr>
<tr>
<td>• Noticing opportunities for clients to relate with each other within or beyond occupational therapy.</td>
<td>• Doing or starting a professional development</td>
</tr>
</tbody>
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that considers human rights and injustice issues.

Focus group 5

- Thinking more critically about which clients to see, such as according to their readiness.
- Ensure clients themselves ‘have their say’ about nature of services, through writing letters etc.
- Doing a review of group programs, including client perspectives about the relevance.
- Relating and collaborating on innovative projects with students on placement.

Focus group 6

- Thinking more openly about the need to accept a referral for people in residential care.
- Saying the client’s name in documentation, rather than saying ‘patient’.
- Relating to clients post discharge about their experiences, in order to develop a higher quality service.
- Doing practice so that it is less separate to the client, such as inviting clients to presentations.
Appendix I: My self-reflection guide

- How do I feel?
- Did I dominate the discussion?
- Did I probe and follow-up on significant issues?
- Did I miss any issues raised by the co-researchers?
- How could I improve my listening skills?
- What were the main themes raised?
- Who contributed to the discussion? Who did not?
- How might each co-researcher be feeling?
- What worked well? What didn’t work well?
- How could the next focus group be improved?