The
"Culture of Practice"
of
Ministry of Education, Special Education
Occupational Therapists
and
Physiotherapists

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A thesis submitted in partial fulfilment of the requirements for the degree of
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Attestation 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 qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed ……

Dated ……..

Acknowledgments

Ethical approval for this ethnography (Application Number: 03/176) was granted by the Auckland University of Technology Ethics Committee (AUTEC) on November 18th 2003.

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Abstract

Occupational therapists and physiotherapists have increasingly moved into mainstream school-based practice in Aotearoa/NZ over the last ten years, however little is known about what underpins their practice worldview in today's climate of inclusive education. This ethnography addressed the question: *what is the culture of practice of occupational therapists and physiotherapists in the Ministry of Education, Special Education*? In search of participants' emic perspectives of their culture, the ethnographic lens was used to inform the design of this study, which is situated theoretically within interpretive constructionism.

Thirteen experienced Ministry of Education, Special Education occupational therapists and physiotherapists participated in this study. Semi-structured, face-to-face interviewing was used with eight therapists and a second email interview format was used with a further five therapists. Data were supplemented by complete-member-researcher observations in the field, as well as journal notes and written archival material from the organisation. Data analysis followed an ethnographic evaluative framework (Katz, 2001, 2002) and a cultural constructs framework, drawn from literature pertaining to ethnography and culture.

The findings in this study reveal that the culture of practice of Ministry of Education, Special Education therapists is emergent. This culture is strongly embedded in organisational culture as well as the Aotearoa/NZ Government's mission towards building an inclusive society. Findings from this study also reveal that contrary to the expectation that therapists may step into the organisation and be "fit to practice" in the education sector, this is indeed not the case. Therapists must be enculturated and supported in order to develop their understandings of the education system and what this demands of their school-based practices. Even given the support of therapy-specific induction, supervision and mentoring, the transition into the education model is huge. Because of

this, findings strongly point to the need for the organisation to support therapists' enculturation by offering formal, therapy-specific induction programmes.

For the group in this study, theirs is a culture of inclusion, collaboration, consultation, teaming and inclusive practice. Furthermore, it is a culture that values students *being* students, with passionate aspirations towards fostering and enabling student learning and participation in schooling. To effect such change related to notions of inclusive education, the higher order task of the culture and, therefore the group's practice, is one of brokering inclusion as agents for societal change. Within this, there is recognition that new entrant Ministry of Education, Special Education (MoE-SE) therapists must shift their traditional practice understandings and 'ways of being' when working in the education sector to unshackle biomedical model perspectives. They must shift their worldview of school-based therapy.

Through this study, occupational therapists and physiotherapists are offered an exemplar of what this shift might look like. It also provides a practice exemplar of what it is like to practice in a different paradigm and of environmental practice. Lastly, the findings from this study challenge the occupational therapy and physiotherapy professions, practitioners and lecturers alike, to shift beyond entrenched biomedical perspectives and to take up the staff of occupational practice. Moreover, they challenge the professions to be true to the pursuit of activity and participation outcomes for the clients, whom they all serve. This study therefore provides a tool to help ease transition. It also provides a clear way to articulate the extent of the shift from biomedical model to occupational practice in school-based practice.

Further research is required related to capturing the students' voice in relation to Ministry of Education, Special Education therapy services and how they experience the culture. The range of potential studies remains great, given the paucity of local research related to school-based therapy practice and inclusive education. Studies into teachers' and parents' experiences are warranted, as are studies which explore the experiences of Māori therapists and Māori clients. It may be interesting to compare therapists' cultures

across practice contexts, such as the special schools, and between health and education sectors. It may be helpful to look at whether therapists do find it useful to have MoE-SE practice explained in cultural terms. An outcomes-based study would help provide practice-based evidence for what works and what doesn't. Other studies might address issues such as: when inclusion is achieved, what does it achieve educationally and socially or is harm done when therapy services shift away from dealing with impairment and what is the long-term personal outcome to the student when this occurs. Lastly, a study that addressed whether embracing the culture of practice actually makes a difference in the long term for students would be valuable.

Preamble to the Thesis

It is early 1985. I've worked for one year in a paediatric health setting with several experienced therapists as role models. I am waiting for the therapy assistant to bring Max to me from the physiotherapy gym. Five year old Max has cerebral palsy and is in a wheelchair. He goes to the onsite special school and has daily physiotherapy for one hour. I see him for occupational therapy; half an hour three times a week to work on hand skills, pencil control and letter formation and visual perception. We also work with activities that will help him integrate sensory and motor abilities. Everyone seems happy for me to do this and it should help Max with his schoolwork. "There is so much to choose from in the toy cupboard" I think to myself, as I pull out the hand function kit. Before Max arrives, I set up the small therapy room with the height adjustable table and a range of hand function activities: playdough, beads, crayons, paper, pegs, blocks, and several puzzles. "This will surely improve his hand skills and writing abilities" I think, "after all we've been seeing each other three times a week since he was four. He needs therapy!"

It is now 1989. I am now working in a hospital setting. Seven year old James has arrived with his mother for his weekly occupational therapy session. Just this morning another therapist had commented, "Thank goodness the neurologist referred James" and I had replied, "I just don't know how he copes at school with his severe motor planning issues". Today I am going to assess James on suspended equipment. His teacher has been asking for a therapy report; she says it is just so difficult to manage James and wants me to tell her what to do. I am sure I can help, but it's still early days and I have told the teacher the assessment will occur over at least three to four sessions, then I would like to visit the school to see what he does there. "Hmm", I reflect to myself, "hope the Charge Occupational Therapist lets me do the school visit. It was difficult enough to convince her last time I needed to go to a school." "Remember, we're not a community service," she had said. "But how am I going to see what he was like in the classroom?" I

had thought indignantly at the time. James' mum has done a great job in bringing him in to therapy. I hope she has not had too much trouble getting time off work to bring him. "Wonder what she does with wee Emma when they come? Maybe she goes to childcare? Oh, must remember to order that new bolster swing" I think as James walks in, "he'd love that. And I must talk with the physio again. We still seem to be doing the same sorts of things in treatment. What a pain. I thought we had agreed to work on different goals."

April 1998. I am four months back in Aotearoa/New Zealand. I am sitting in an office with two educational psychologists. I am ready to find work, but feel that the health sector has changed so much in the eight years I have been overseas. A friend of a friend suggested I might like to work in the education sector in regular schools with Specialist Education Services (SES). "Only regular schools?" I had asked, "I didn't know you could do that here. Things have changed!" I am listening to the people in front of me describe what has happened to special education whilst I have been away. They talk about a policy called *SE 2000;* they talk about a vision for inclusion. "Wow that's got to be a challenge" I say, finding myself becoming excited and really liking the idea of children being able to go to their local schools regardless of disability. I hadn't realised I held this viewpoint. A month later I am in the job. I am a lone occupational therapist in a team of educationalists covering the whole of central, west, and north Auckland. I have joined the SES ranks. I have an office, a desk, a phone and a diary and I have access to a work car, sometimes. My client group is located in schools all over Auckland. I have a generic job profile that doesn't tell me *how* I should *do* occupational therapy in this practice context. "We don't just work with the students" I had heard my Team Leader say, "we also work systemically." "What did that mean?" I thought.

Some of my therapist friends in the health sector think I am mad. Others are angry that this is the way it is going to be in the education sector; some because they believe services should not be split between health and education sectors, others because they feel there was little consultation with therapists about the changes and they don't trust the

"SES lot" to know what to do with children with disabilities ... *and* "they [SES] steal our therapy ideas". I don't know if this is so. I've been out of the country and I have never worked in the education sector like this before. "Wow" I think to myself, "this will be interesting, I'll need to rethink how I work if I am going to be of benefit to the students in their schools."

It is now late 1999. I am no longer a lone occupational therapist in the Ministry of Education, Special Education (MoE-SE). I find I have become a strong advocate for inclusion, perhaps too strong. We are now three occupational therapists in the region. There is still not a physiotherapist in post. I suspect it is just too hard for physiotherapists to fathom coming in and working the way we do. We do need one on board though. I feel like our team is missing a player. I often talk to another SES physiotherapist in another District Office about this. She seems to have got her head around the way we work. We always have such inspiring talks. It's good to have that support. Once, we presented at a therapist inservice. I got the feeling that non-SES therapists thought we at SES were "doing it all wrong"; that we were "not doing treatment" and "consulting" was a suboptimal way of working with children and young people or rather students. The negativity towards the way we practice surprised me; it also worried me. I was intrigued by this. What was it that made us think and do things differently at SES? Why did those on the outside of the organisation, from my own profession, find our way of practice hard to accept?

Over a year has gone by. I still have an office, a desk, a phone, and a diary. I seem to travel a lot … and talk a lot in my practice context. My treatment spaces are the classrooms and learning environs, places where students engage in school occupations. My clients are not just the students, but also the families, *whānau and* school staff … even whole school systems. In the beginning I had brought my own toys, activities and resources into the office. I had felt so under-resourced when I started this job, but my toys sit still in their boxes; I rarely use them. From time to time I have asked my Team

Leader for resources, but I seem to buy very few. I find I don't need them, that they are often not relevant to the students' learning objectives or their being at school.

I am sitting with two other occupational therapists in the Board room. Bringing me back to task, one of the other occupational therapists asks me, "so, what do you do when a student doesn't want you to see them in class, or when a teacher expects you to take Johnny out of class to work on his hand skills separately from handwriting?" We are discussing how we work in the regular schools and why we do in this organisation. "Funny," I had reflected to myself as we talked, shared and visioned our practice together, "we think alike and do very similar things, but we're not in the same offices. All this has been so new to each of us; we've all had years of previous experience doing occupational therapy a certain way and yet, now, what we do and say in this job seems very different than before. And here we are arriving at the same way of thinking as each other. ***What's that about?"***

So began my inquiry into the culture of practice of Ministry of Education, Special Education therapists.

Today, I note that I hold a personal and professional belief that children and young people, regardless of disability and difference, have the right to belong and be educated in regular schools alongside their peers. I note that this belief permeates, shapes, and drives my practice within MoE-SE. It appears to infiltrate what I think and what I do, and it colours the lens through which I view my practice and that of others. I know, too, that I share this belief or outlook with my MoE-SE colleagues, especially with the occupational therapists and physiotherapists. It is *something* that we share in common, a shared something that we collectively value and hold dear to the heart of how we practice in our particular setting. It is also a view we seem to nurture and strive for with a passion to instil in other people.

This thesis presents my research journey from its small beginnings, to the end point of arriving at the findings and discussion; the text of this ethnography. Having come to the end of this journey, I find myself at a point which, according to Rock (2001), others find themselves:

> … one begins to notice odd gaps, deficiencies, things not covered as well as they might have been, questions not asked, responses not made to questions by respondents. One begins to carp a little at the stupidity and myopia of that earlier incarnation of oneself, the person who had flattered himself or herself to be analytically in control of everything but was actually purblind. It may not be too late to return to the field to retrieve some of the losses, but it is inevitable that one will proceed to writing with a consciousness that one does not know everything, there was neglect, that omissions will have either to be glossed over or, better, openly admitted. (Rock, 2001, p. 36).

Akin to Rock's (2001) statements above, such has been the journey of this research. It began with growing insight that the notion of culture was worthy of study in a subgroup of therapists. I journeyed as researcher, presuming myself "analytically in control" as Rock so aptly put it, gathering masses of descriptive data like a tornado, to find scraps of consequence in the rubble from which to piece together the whole. I feel I am ready to begin this ethnography, finding that I am now at its end. I must heed Rock's words and accept that not all will be known. There will be omissions and neglect and I must leave behind that which remains unknown. It is time to acknowledge and offer up for scrutiny, that which has consciously and rigorously been uncovered in this study.

Chapter One: Introduction & Context of the Study

Introduction

This ethnography explores the question: *what is the culture of practice of occupational therapists and physiotherapists in the Ministry of Education, Special Education*? It seeks to explore and articulate emic perspectives of the shared *culture of practice* of a particular group of Aotearoa/New Zealand (Aotearoa/NZ) occupational therapists and physiotherapists, hereafter referred to as *therapists*, situated within their specific practice context or work setting. By culture of practice, I mean the therapists' communally shared practice-related attitudes, beliefs, values and patterns of behaviour [ethos]. The practice context I refer to is the New Zealand Ministry of Education, Special Education (MoE-SE), part of the Ministry of Education, also known by the name *Group Special Education* (GSE), formerly *Specialist Education Services* (SES). This study encompasses the culture that began to develop when the therapists were first employed by SES, including its integration into the Ministry of Education (MoE) in 2002 (Specialist Education Services & Ministry of Education, 2001a, 2001b; Ministry of Education, 2002d). I am a member of this therapist community.

This chapter introduces the study and explains the impetus for conducting it. The notion of group culture is woven through description of the fieldwork setting and the ethnographic lens through which I have studied the group. Because the therapists' culture is fashioned around several interrelated components, readers will note that this first chapter also overviews the fieldwork site in some detail. This is done to sufficiently inform readers of the complexity of the therapists' work setting and to contextualise the study, including the impact of Government legislation on the group's practice and therefore culture.

My approach in this study was informed by ethnography which allowed me to look inwardly at the group, whilst participating in the practice context. My key concern was to gain participants' emic or insider perspectives and stories. Accordingly, I interviewed twelve therapists and was interviewed myself, analysing, in total, thirteen transcripts alongside fieldnotes. This provided rich data from which to interpret and construct the therapists' culture of practice.

Why this Research?

My reflections on the notion of 'culture of practice' earnestly began when I started working for SES, accelerated through participation in post-graduate studies. This led to the realisation that I wanted to explore the cultural undercurrent to my practice, believing it to be an essential aspect of MoE-SE therapists' practice in the education sector. I sensed that there was something we all shared in common, an ethos which perhaps contributed to forming *who* we were and *why* we were as therapists. In addition I wanted to know if this was a culture (values, beliefs, norms) that we, as a group had spun. Was it bound and woven into the daily patterns of our practice? Was it embedded within the organisation's culture? Not only did I want to explore such notions, I also wanted to capture it in text, so that others might see our culturally-flavoured ways of being MoE-SE therapists.

The idea that a contextualised culture of practice exists in groups of therapists in relation to their work place has long intrigued me, my awareness heightened by experiences of moving between both health and education sectors over several years of practice. In each setting I observed my own culture metamorphose into distinct sets of beliefs and ways of behaving, depending on the particular practice context or workplace, and on trends in practice. I also observed similar transformations in my colleagues, culminating in our holding shared beliefs and patterns of behaviour that reflected the work context. Each context seemed to have a basis for practice, distinct to the group, understood by those within and, sometimes, questioned or misunderstood by those on the outside. One

presupposition I have therefore in this study, is that MoE-SE therapists' culture of practice is learned, shared and shaped in relation to their work context.

The intent of this study is to:

1. Explore, understand and articulate MoE-SE therapists' shared culture of practice from an emic perspective.
2. Culturally inform and guide MoE-SE therapists by presenting a work that will allow the group to critically examine and consolidate their emerging culture.
3. Contribute to the induction of new MoE-SE therapists.
4. Raise organisational awareness by informing MoE-SE management and staff about the shared attitudes, values and beliefs that underpin the practice of occupational therapists and physiotherapists.
5. Share the culture with non-MoE-SE therapists and others who wish to work in regular schools.

Situating Culture in the Context of Practice

He aha te mea nui o te ao?
He tangata! He tangata! He tangata!
What is the most important thing in the world?
It is people! It is people! It is people!

(Māori Proverb: http://www.korero.maori.nz/forlearners/proverbs.html)

This study is concerned with the culture of practice of a specific group of people. Because of this, I attend to *culture* as the body of knowledge that will couch the findings of this study. People are dependent on culture to guide their behaviour and organise their experiences.

Culture, broadly defined, is learned social behaviour; a "way of life of a particular group of people" (Germain, 2000, p. 237). Without culture, people or societies could not function (Crotty, 1998). Conceptualised as a set of ideas, concepts and knowledge (Jones, Blair, Hartery, & Jones, 2000), elements of culture function as a framework for interpreting experience and guiding behaviour in everyday life. Culture therefore encompasses shared meanings, beliefs and values, through which members of a group, community or

society interact and communicate. This also includes shared attitudes, norms, rules for behaving, as well as symbols and objects which reflect these things.

In attempting to explore and understand MoE-SE therapists' culture, however, I am mindful that cultural understanding is never complete (Dickie, 2004), nor does anything remain the same. To this end, my cultural interest is not so much to learn that this particular group of people have a different culture to other groups. Rather, it is to become aware that they *do* have norms or shared ideas and patterns of behaviour, perhaps even a values and belief system that is not universal. I therefore construe culture as encompassing any taken for granted ideas, attitudes, values and beliefs that the therapists may collectively hold, reflected in their practice patterns of behaviour. In other words, a culture which underpins a MoE-SE way of life, situated in their work context, since practice occurs in that context.

By work context, I mean the MoE-SE work context in its broadest sense, including the organisation, as well as the numerous regular school community sites where MoE-SE therapists provide services to students. Thus, since the therapists' practice is situated in this context, I also include organisational culture. Organisational culture includes *how* things are done within the organisation, as well as its expectations, values, social patterns and artefacts, such as its ways of thinking, speaking and interacting. It also includes things that are taken for granted and the shared meanings people assign to their surroundings (Hawkins & Shohet, 2000). These are some of the cultural dimensions I seek to uncover in this study.

The Practice Context

The therapists in this study live their practice lives within the context of their work setting (MoE-SE). Therefore, it is useful to understand some of the history of special education in Aotearoa/NZ, including the philosophical shift that has allowed students with special

education needs to attend regular schools. This philosophical shift resulted in therapists being directly employed by the Ministry of Education (MoE).

Since this study seeks to uncover one particular group of therapists' culture, some description of the principles embedded in the special education legislative framework and the employing organisation is also warranted to situate the study in Aotearoa/NZ perspectives. In addition, the practice context in which this study is situated is convoluted because of the complexities inherent in the employing organisation and the different school communities and students whom the therapists serve. This context includes, not only the Aotearoa/NZ special education legislative framework (MoE, 2003d, 2004a), but also the interface between the health and education sectors (Ministry of Education & Health Funding Authority, 1999; MoE & HFA: Disability Support Services, 1999), Government schooling strategies (MoE, 2005c) and the Government's drive towards building an inclusive schooling society (MoE, 2005d). The complexity of these interrelated factors inform my presupposition that the group's culture of practice is bound to the underlying principle and expectation of inclusion of *all* students within the education sector.

In terms of practice, MoE-SE therapists are employed to provide educationally-relevant therapy services to students with special education needs or disabilities, hereafter referred to as *students*, who attend school in the regular education sector. These students are aged between five and twenty-one years; all have met set special education eligibility criteria according to special education policy. In general, the aim of educationally-relevant therapy services is to explain and enhance student performance and participation in the school context (Bundy 1995, 2002; Hanft & Place, 1996; Karnish, Bruder & Rainforth, 1995 MoE, 1998, 1999). In addition, MoE-SE therapists work with students in a range of locations and spaces. Student need is typically defined as it relates to naturally occurring, daily educational tasks and activities, and participation at school involves scholastic activities as well as moving around the school and being able to manage one's self-care (Coster, Deeney, Haltiwanger & Haley, 1998). Thus, for

example, if a student has difficulty with physical access to the toilet facility, assessment and problem solving would occur in that environment to remove the barrier. Alternately, if a student had difficulty with handwriting, the natural setting would be any lesson involving written communication where the student may be observed writing and where any barriers to functional performance may be identified including any intervention strategies. Similarly, student need may be addressed during physical education, in the playground, at the school pool, or even during assembly.

The Right to Access State Schools

The Education Act Amendment 1989 (NZ Government) allows *all* students the right to attend state schools regardless of their learning ability or nature of disability. Under Section 8 of the Act, people who have special education needs, whether from a disability or otherwise, now have the same rights to enrol and receive education in state schools, as people who do not. The term state school is synonymous with regular or local school and includes any rural or urban primary, intermediate, or secondary school in the compulsory school sector. Such schools, hereafter referred to as *regular schools*, are learning environments where students with special education needs are taught within general education classrooms alongside their typically developing peers. Such schools are also referred to as mainstream or inclusive schools. A regular school is situated in the vicinity or school zone where the student lives, hence they are deemed local-to-home. Fundamentally, any child has right of access to their local school.

Historically, special education was seen as a separate entity in the schooling system, based on the assumption that students with disabilities or special needs required a separate and different approach to education from their peers who did not have disabilities (MacArthur, Kelly & Higgins, 2005). Prior to 1998, the norm was for students with special education needs or a disability to attend segregated, special school facilities (Davies, 2000; Davies & Pragnell, 1999). Some students were schooled in institutions; others did not attend school at all. Under such circumstances therapy services tended to focus on a student's disability and impairments. Nowadays, whilst many families and *whānau* (Māori word for family and extended family) continue to opt to place their child in

special school facilities, many more students are attending their local schools, with higher academic and social learning outcomes and community involvement reported (Ballard, 2004; MacArthur, Kelly & Higgs, 2005).

Special Education in Aotearoa/New Zealand

In Aotearoa/NZ, special education adheres to education priorities and policy guidelines set by the Ministry of Education (MoE, 2003c, 2003d). These guidelines, originally known as *Special Education 2000* (SE 2000), sit within the Government's wider legislative framework which includes the Treaty of Waitangi (*Te Tiriti o Waitangi:* 1840), the Education Act 1989, the Human Rights Act 1993, the Privacy Act 1993, the National Education Guidelines, the New Zealand Curriculum (MoE, 1993; 2005a) and *Te Whaariki:* Guidelines for Developmentally Appropriate Programmes in Early Childhood Services, and the New Zealand Disability Strategy (Ministry of Disability Issues, 2001). The education agenda states key principles and objectives upon which the current special education policy framework has been founded, reviewed, and modified over the past decade (Ballard, 2004; Fraser, Mitchell, 1999; Moltzen & Ryba, 2005). The Government's aim is to achieve a "world class inclusive education system that provides learning opportunities of equal quality to all children and school students" (MoE, 2003d, p. 1). In other words, all students participate and are included in schooling (MoE, 2005c).

SE 2000 (see Appendix 1) was launched in 1996 (Davies, 2000; Davies & Pragnell, 1999; MoE, 1996, 1999, 2002a, 2002b; Wylie, 2000) with the intent of aligning *special* education and *regular* education (cited in Education Management Policy document for the Associate Minister of Education, 2002, p. 2). This policy reflects global societal changes in relation to issues of equity, equality and respect for individuals (Mentis, Quinn & Ryba, 2005). SE 2000 has challenged both education and therapy views on practice and service provision for students. Firstly, through greater expectation that all students achieve learning outcomes. Secondly, through requiring full participation of students with special education needs in the schooling system as citizens of Aotearoa/NZ (MoE, 2005c). In addition, SE 2000 aligns with the New Zealand Disability Strategy (Ministry of Disability Issues, 2001) to encourage and educate for a non-disabling society.

Collectively, such legislation signals the Government's stance that any student with a special education need is an *active learner* and a *full participant* of their school community and society. The expectation and rights of students to access regular school with entitlement to full inclusion is cemented by the Human Rights Act 1993 (New Zealand Government) and the Disability Strategy (MoDI, 2001). Under the Human Rights Act 1993, Section 57, schools may not refuse or fail to admit any student with a disability, nor may access to any benefits or services provided by the school be denied or restricted. The Disability Strategy, in turn, ensures the rights and provision of the best education for disabled people[1]. Thus, all children and young people will "have equal opportunities to learn and develop in their local, regular educational centres" (MoDI, 2001, p. 11). Moreover, they have the right to quality education that meets their specific and individual learning needs (Education Review Office, 2003).

Schools are therefore duty-bound, both legally and ethically, to meet the schooling entitlements of students with disabilities or special needs. They must cater for a diverse student population regardless of the student's age, gender, ethnicity, ability and learning capacity (Education Review Office, 2003; MoE, 2002a, 2002b, 2002c, 2003c, 2003d, 2004a). For these reasons, it becomes paramount that any occupational group who works with students in schools fully understands the special education policy framework and the educational context (Brandenburger-Shasby, 2005; Rapport, 1995; Vaughan-Jones, 2001). Indeed, this is essential, regardless of one's professional background or practice context, because the policy articulates a number of core guiding principles for practice.

A portion of the policy is cited below in some detail because its provisions are wide ranging and it sets the scene for therapists to effectively work in the education sector. The Ministry of Education states that:

> The aim of the Government's special education policy is to improve learning opportunities for all students with special education needs - at their local school or wherever they attend school. Students with special education needs include learners with disabilities, learning difficulties, communication or behaviour difficulties, sensory or physical

[1] Note that the terminology *disabled people* is that used in the Disability Strategy.

> impairments. Special education is about providing these students with the support they need to access learning - whether it is therapy, transport, changes to the learning programme or environment, specific teaching strategies, and/or specialized equipment or materials … The policy affirms the right of every student to learn in accordance with the principles and values of the National Education Guidelines, which include the National Education Goals, the Foundation Curriculum Policy Statements, the National Curriculum Statements and the National Administration Guidelines, as well as the Special Education Policy Guidelines … Affirming the right of every student to learn requires organisational structures to change to meet the needs of diverse groups of learners. This right embraces values, beliefs and attitudes about justice, equality, freedom and human dignity. (MoE, 2002a, p. 5)

In the above excerpt, key messages reside which signal guiding principles for the provision of educationally-relevant therapy service provision in Aotearoa/NZ schools. This policy aims to address human rights and issues of social justice by attempting to minimise disablement and exclusion in the education system and address issues of rights and equity. Emphasis is placed on the *rights* of *all* students to *learn* and to *access learning opportunities*. Thus, policy values and affirms learning and access to learning; the inherent belief is that all children and young people *are* learners regardless of their "special" needs. The expectation is that all students will be supported to learn in the schooling system. Inherently, this signals the need for change at a personal and professional level, as well as change in organisational structures to align with the necessary attitudes and patterns of behaviour that would fulfil this expectation.

Given that the special education policy framework is *the* platform from which services are expected to spring, therapists and indeed all workers and services in the education sector are required to emulate the principles reflected in the policy, in particular the call for inclusion philosophy. For instance, the vision of MoE-SE is to *maximise children's wellbeing, inclusion, learning and achievement while embracing their uniqueness, creativity and participation*. This sits within the Ministry's overall mission to "*raise achievement and minimise disparity in education"* (MoE, 2004c). This overarching worldview forms the basis of both a political and organisational values system which augments the central roots of the policy framework, with its focus on equitable access, rights to quality education and partnership with families/*whānau* (MoE, 2003d). MoE-SE workers must therefore develop attitudes and practices which reflect this system and

work to ensure the rights of all students. For occupational therapists and physiotherapists, these notions are operationalised through a protocol which therapists in both education and health sectors are expected to follow (Ministry of Education & Health Funding Authority, 1999).

The Occupational Therapy - Physiotherapy 'Operational Protocol'

Since 1998, MoE-SE therapists have practiced solely in the context of the education sector under an education paradigm, guided by a legislative framework which includes three operational protocols (MoE & HFA, 1999; MoE & HFA, DSS, 1999; MoE & Accident Compensation Corporation, 2000), specific to the provision of education-related therapy service provision. Of primary importance is the *Operational Protocol for Occupational Therapy and Physiotherapy Services for Students with Physical Disabilities* (MoE & HFA, 1999), which provides guidelines for managing and delineating services between the education sector and the health sector.

This protocol requires education sector therapists to provide services that are steeped in an understanding of education-based perspectives. This means services are, in the main, provided during school hours and within school premises or a student's given learning environment and occur within the context of the New Zealand Curriculum Framework *Te Anga Marautanga o Aotearoa* (MoE, 1993, 2002a, 2005a), hereafter referred to as the NZ Curriculum. Both occupational therapy and physiotherapy services are expected to focus on removing, reducing or overcoming barriers to learning achievement in line with special education policy guidelines. In addition, therapists must focus on assisting others to meet individual students' learning achievement objectives and outcomes, supporting students in the context of their learning environments, where the classroom teacher plays the central role (MoE, 1998, 1999), ensuring therapy services centre around and draw from collaboratively identified student goals via the *Individual Education Plan* (IEP) process (MoE, 1998); and engaging in teamwork which involves the student as appropriate and includes parents, family/*whānau*, school staff and other relevant service providers.

Also under this protocol, therapy services are expected to be cost-effective, ethically sound and based on current effective practice research evidence (MoE & HFA, 1999). Lastly, therapists are charged with seamlessly meeting individual students' learning and developmental needs throughout the span of their entire school life. This includes ensuring that students have equitable access to special education resources. Partnerships with families/*whānau* take parental choice and student needs into account. Consideration of cultural factors when planning programmes is also mandated (MoE, 1998, 1999, 2002a, 2004a, 2004c, 2005c, 2005d), in particular partnerships with Māori (MoE, 2003a, 2003b). The effect of this protocol has led to the distancing of biomedical perspectives in the education sector.

Distancing Medical Model Perspectives

The employment of MoE-SE occupational therapists and physiotherapists brought the opportunity for therapists to be fully immersed in the education sector as education, rather than health employees. Immersion in the sector led to the adoption of the education model. Metaphorically, this meant the cutting of ties with the health sector and distancing the medical model (Caswell, 1998).

Historically, students are typically referred to therapists for assessment and intervention because of their difficulties or dysfunction in underlying performance components (Borcherding, 2000; Bundy, 1995, 2002; Case-Smith, 2002; Case-Smith & Rogers, 2005; Dunn, 1990; Hanft & Place, 1996; Kramer & Hinojosa, 1999). For example, the student may have had difficulty with fine and gross motor skills which impact on handwriting or physical education activities, or on self-care skills such as dressing, or on sitting posture.

In traditional practice, therapy services in special education are largely influenced by the medical model discourse (Neilson, 2005; Slee, 1998). This discourse places emphasis on diagnostic evaluation of impairments and deficits and subsequent amelioration or remediation of any underlying difficulty, dysfunction or performance component, for example sensory, motor, psychological, perceptual, or musculoskeletal components (Caswell, 1998; Hanft & Place, 1996; Llewellyn & Maher, 1993). Therapists typically work

in a one-to-one capacity with students (Hanft & Place, 1996; Swinth & Hanft, 2002) and assessment and interventions emphasise health status and symptoms, with rehabilitation outcomes in mind (Hanft & Place, 1996; Kielhofner, 2005). Thus, the primary focus is biomedical remediation of impairments. The educational-relevance of therapy may be limited, neglected or absent.

In contrast, the education model views students as people who can learn curriculum (Mentis, Quinn & Ryba, 2005). Emphasis is placed on learning readiness and learning achievement. Services therefore aim to support participation in schooling and classroom instruction and are provided by educators and related service providers, such as therapists (Hanft & Place, 1996). Outcomes of therapy under the education model include, for instance, assisting the student to benefit from participation in education, supporting the student's physical access to the curriculum, and removing or reducing environmental barriers such as those in school buildings, as well as, people-related barriers (MoE & HFA, 1999).

Shifts in the Practice of Therapy in Education Settings

In Aotearoa/NZ the education policy clearly signals therapists to shift the emphasis of their therapy to one of primarily supporting and facilitating students' function within the context of their learning, as members of school-focused service teams (MoE-SE, 2005a). MoE-SE teams comprise members who are Speech-Language Therapists, Advisors on Deaf Children, Educational Psychologists, Special Education Advisors, Support Workers, *Kaitakawaenga* (Māori cultural advisors) and Pasifika Cultural Advisors (MoE, 2004c; MoE-SE, 2005a). Furthermore, education sector therapy services are now ring-fenced by policy, available only to students who are eligible under three of the special education policy schemes (MoE, 2004a, 2004b, 2005b; 2006). These are:- *Ongoing and Reviewable Resourcing Scheme* (ORRS) (MoE, 2004b), *Supplementary Learning Support* (SLS) (MoE, 2006) and *Moderate Physical Contract* (MPC) (MoE, 2005b) (refer Appendix 2 for more information). Students must meet specific eligibility criteria to

access the specialist services and resources available through any one of these 'gated' funding schemes.

Therapy services are viewed as a specialist service and a resource for students and schools. In line with policy, the focus of MoE-SE therapy services has shifted to focus on achieving the best fit between the person, the school-related activity or task and the environment[2]. The MoE-SE therapist is one member of a collaborating interdisciplinary team of education specialists (MoE, 2002a, 2002d, 2002e, 2004b, 2004c, 2005b; MoE-SE, 2002, 2005) who, together with schools, provide education-related services to students. This is done within the context of student needs in relation to learning achievement, school participation and their given learning environments. Thus, MoE-SE therapists team with others to determine solutions to problems and support the achievement of student goals driven by the IEP process (MoE-SE, 1998). It is important to note that in the MoE-SE context, the term *client* refers not only to the student, but also the students' parents, caregivers, family/*whānau* and various school personnel (MoE-SE, 2005a), such as teachers and teacher's aides.

Working in the education sector has necessitated MoE-SE therapists adopt a range of approaches, including collaborative consultation[3] (Dettmer, Thurston & Dyck, 2002) and the ecological[4] approach (Dunn, Brown & McGuigan, 1994; Gibson, 1970) in line with policy and organisational guidelines (MoE, 1998; MoE, 2004c; MoE-SE, 2005a). Students' development, function, access and learning achievement is therefore addressed in the context of the curriculum, the school setting and the school community whilst keeping socio-cultural and socio-political issues in mind (MoE, 2004c; Simmons

[2] Environment is perceived in its broadest sense to include characteristics of not only the physical environment, but also the technological, socio-cultural, spiritual and political environments.

[3] By *collaborative*, I mean practices whereby persons with diverse expertise, perspectives and experiences work together as equal partners to design combined approaches to interventions which effectively remove barriers to students' learning (Kemmis & Dunn, 1996). The expected outcome is a change in the school environment and the development of strategies which will enable students to succeed at school, despite any limitations imposed by impairment and the environment, or both (Bundy, 1995; Giangreco, Edelman & Dennis, 1991). *Consultation* refers to practices whereby therapists use their expertise to focus their efforts on working collaboratively with the consultee. Consultees, for example, a teacher, teacher's aide, Principal or parent, are responsible for the outcome for the individual student (Dunn, 2000).

[4] The *ecological* approach views student behaviour as being determined by the interaction of the individual with all components of the environment (Dunn, Brown & McGuigan, 1994; Law, 1991; Law, Cooper, Strong, Stewart, Rigby & Letts, 1996; Gibson, 1970).

Carlsson, 1999). To practice ecologically, MoE therapists have presumed that they must consult, collaborate and see students engaging in their naturally occurring curricula, within their naturally occurring school activities, settings and social structures or relationships, in order to effectively enable participation and learning.

Focus on curriculum and enabling school participation

Addressing curriculum tasks, activities and key competencies are fundamental to MoE-SE therapy practice in schools. As stated, enabling[5] students' roles, such as learner, participator, peer, and friend, and school participation and occupational performance in school-related activities and tasks have become the concern of MoE-SE therapists' practice. In the 'enabling' role, MoE-SE therapists seek to help individuals and schools be involved in solving their own problems. This is also in line with policy dictums and encompasses the NZ Curriculum (MoE, 1993). Key scholastic subjects or learning areas and skills and competencies of the NZ Curriculum therefore become primary focus areas for MoE-SE therapists when working in schools. All curriculum topics include skills such as communicating, socialising, writing, reading, thinking and problem solving, for example, as well as the physical skills used to access the curriculum or manage daily self-care activities and play skills (MoE, 1999).

MoE-SE therapists are also concerned with enabling contextualised occupations, in line with the move to evaluate and address issues of function in naturalistic settings rather than in clinical settings (Hanft & Place, 1996; Hocking, 2003). This is particularly so for the MoE-SE occupational therapists given that occupation[6] is the domain of concern of this profession (Christiansen, & Baum, 1997; Hocking, 2001; Townsend, et al., 1997). Whilst both professions are concerned with the things students may want and need to at school, in the main, functional movement and managing one's body effectively and efficiently falls within the legitimate domain of physiotherapy (Bennett & Karnes, 1998;

[5] The term *enabling* refers to the process of "facilitating, guiding, coaching, educating, prompting, listening, reflecting, encouraging, or otherwise collaborating with people" (Townsend et al., 1997, p. 180).

[6] In the occupational therapy literature *occupation* is defined as "groups of activities and task of everyday life, named and organized, and given value and meaning by individuals and culture …" (Townsend, et al., 1997, p. 181), including looking after oneself (self-care), enjoying life (leisure), and contributing to the social and economic structure of communities (productivity: play/work/school/paid and unpaid vocation).

Ketelaar, 1999; Wilhelm, 1993). Occupational therapy, in turn, is primarily concerned with student roles and school-related occupational performance or carrying out meaningful occupations at school (Case-Smith & Rogers, 2005; Coster, 1998; Dunn, 2000). They are also concerned with removing physical access barriers through property modifications submissions (MoE, 2005e).

Choosing a Methodology

I selected to use ethnography as the lens (Lawlor, 2003) through which to explore and articulate the group's culture because it is a research approach used to study and learn about individuals, groups of people, communities and societies as they go about their daily activities in their natural settings (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001; Bochner & Ellis, 2002; Brewer, 2000; Crotty, 1998; Davies, 1999; de Laine, 1997; Denzin, 1997; Denzin & Lincoln, 2000; Fetterman, 1998; Germain, 2000; Hammersley & Atkinson, 1995; Johnson, 1990; Katz, 2001, 2002). It also allowed me to take up a complete-member researcher role. Because I am a member of the group, it could be argued that I already have an emic perspective of the therapists' practice-related attitudes, beliefs, values and patterns of behaviour. However, the intent of the study is to critically distil these cultural concepts through the rigour of the qualitative research process, so that they may be clearly articulated. In keeping with ethnography methodology, I used the reflexive processes of self-reference and self-disclosure (Davies, 1999; Germain, 2000) to address any pre-suppositions throughout the research process. These processes are expanded upon in the methodology chapter.

Through the ethnographic gaze, my aim as researcher was to gain the emic (insider) perspective of the group in relation to their culture, also my culture, using a range of data gathering methods. Interviewing was used as the primary method, alongside immersion in the fieldwork site, journal notes and collection of archival material. Participants were from multiple MoE-SE District Offices, providing a representative sample from around the country, which served to increase the study's credibility. Content and thematic analysis,

based on a cultural constructs framework drawn from anthropological and sociological interpretations of culture (Bates & Fratkin, 1999; Cockerham, 1995; Haviland, 1999; Jones et al., 2000; Miller, 1999) was applied to the data. Constructs included, for example, enculturation, social structure and cultural fit. Interpretive analysis was, in turn, guided by an ethnographic evaluative framework, following Katz (2001, 2002) and Fine, (2003) to reach text that would articulate the emic perspective of the group's culture.

Summary and Overview of the Thesis

The focus of this qualitative study is the emic exploration of the culture of practice of MoE-SE occupational therapists and physiotherapists including clear articulation of the culture in text. I anticipate that findings from this study will culturally inform the practice of not only MoE-SE therapists, but that of all therapists who work with school-aged students in regular school settings in Aotearoa/NZ. In addition, findings are intended to contribute to the induction and therefore enculturation of therapists into MoE-SE, and in turn findings will inform the organisation. Findings are also intended to help therapists reflect on their school-based practice and the extent to which their practice supports the achievement of inclusion. Lastly, because this study looks at culture, it is unique in that it seeks to find the heart (philosophical underpinnings) of MoE-SE therapists practice.

This chapter has introduced the study and described the legislative and organisational background. In addition, several of the MoE-SE therapists' practice influencers have been described, as well as key concepts and terms introduced in order to situate the study. The intent of the study has been stated, including its relevance to the therapists' practice context.

Chapter 2 summarises relevant literature which serves to inform this study. Chapter 3 will present the methodology, design and methods of the study, including the philosophical approach which underpins it. Chapters 4 through 6 present the findings of this study. Lastly, Chapter 7 brings it all together in the discussion, where I provide a

synopsis of the findings and discuss the implications and recommendations from this study, including its strengths and weaknesses, and any future considerations.

Chapter Two: Review of the Literature

Introduction

> "Words simultaneously reflect and reinforce our attitudes and perceptions; words shape our world" (Snow, 2004b, p. 1).

In this chapter I present the literature which added depth to my insights for exploring the culture of practice of MoE-SE therapists. Much of the literature comes from experts in the field and this in part has served my acceptance of it being trustworthy. In addition I have selected and judged the literature from a subjective stance, on the basis of what colleagues draw from in the MoE-SE practice context. This literature tends to be aligned to what fits with the context as well as what causes the wider MoE-SE therapy group to critically reflect on their practice.

I begin by discussing culture and cultural constructs; the central perspective of this study. I then focus on some of the literature which has contributed to informing and shaping the provision of educationally-relevant occupational therapy and physiotherapy services in regular schools in Aotearoa/NZ, referred to as school-based practice. Such literature adds depth to what has already been raised in Chapter 1 and draws from MoE research which granted, may be construed as biased, because it comes from within the organisation. I also include some key points from the general literature regarding what is currently espoused about therapy practice with students who have special education needs. Lastly, I include a brief discussion on inclusive education discourse, ending by touching on disability discourse because this has also impacted therapists' thinking about school-based practice in educational settings.

No studies of the culture of practice of therapists were located in the literature, however over the last decade, or so, there has been a steady rise in literature related to school-based therapy practice (Bundy, 1995, 2002; Brandenburger-Shasby, 2005; Case-Smith, 2002; Caswell, 1998; Dunn, 1992; Doubt & McColl, 2003; Hanft & Place, 1996; MacDonald, Caswell & Penman, 2001; Marshall, Hocking & Wilson, 2006; Tutty &

Hocking, 2004). The literature pertaining to therapy practice in schools mostly originates from outside of Aotearoa/NZ primarily in western countries, beginning in the 1980s in the United States of America and Canada, followed by the United Kingdom.

Much of the school-based literature is philosophical (Snow, 2004a, 2004b) and descriptive (Bundy, Case-Smith & Rogers, 2005; Hanft & Place, 1996; Prater, 2003; Swinth & Hanft, 2002), with the focus primarily on the changing role and functions of therapists in schools. More literature is available in the field of occupational therapy, rather than physiotherapy. Latterly, in the field of occupational therapy, a series of rigorous qualitative studies have emerged locally, related to school-based practice (Marshall, Hocking & Wilson, 2006; Tutty & Hocking, 2004; Vaughan-Jones & Penman, 2004). Others are yet to be published (A. Hasselbusch, personal communication, June 1 2006).

Notions of Culture

"Culture is tricky" (Dickie, 2004, p. 169), coming to consciousness only when people are confronted with difference. Indeed, culture itself seems to be an elusive notion that is difficult to define (Jones et al., 2000). Cultures are often strangely intangible and paradoxical to those on the 'outside'. Yet conversely, for those immersed in it, culture is often invisible and taken for granted. In groups of people culture can be the glue, or common thread, that binds them, whether loosely or tightly, or the roots from which the group grows, becoming the foundation of their collective worldview (Hawkins & Shohet, 2000). There are many ways of looking at culture, therefore, including culture as civilisations, culture as worldview, culture as symbols and culture as a stabilising mechanism (Wikipedia, 2006).

There are local layers to culture. Sub-cultures exist within societies, with groups of people having distinct sets of behaviours and beliefs which differentiate them from a larger culture of which they are part (Wikipedia, 2006). Other cultural layers include corporate or organisational cultures, institutional therapeutic cultures, and professional

cultures which are founded on setting-based ways of viewing and interpreting the world and experience (Gubrium & Holstein, 1995; Wikipedia). Small groups also have local cultures, or sub-cultures (Gubrium & Holstein), as is presumed by me in relation to the group in this study. Thus a further presumption I have is that MoE-SE therapists' culture of practice is likely to be organisationally embedded. This is because the culture will reflect organisationally salient priorities and agendas, as well as the culture of their professional backgrounds.

Culture tends not to be something people think about in their daily lives, except perhaps when they are faced with language or behaviours that are difficult to grasp and which seem to come from an "*other*" culture (Dickie, p. 170). For instance, a health sector therapist (from an other culture) coming into the education sector would find himself or herself confronted with customs, language and policies imbued with education perspectives and terminology, rather than medical terminology or health-based perspectives, all of which would be different and perhaps, difficult to grasp or understand.

Culture may be considered from two perspectives: the cognitive perspective and the ecological perspective (Fetterman, 1998; Germain, 2000). Both these perspectives are considered applicable to the focus of this study because of their relevance to therapists' enculturation in the education system. The cognitive or ideational perspective views culture as a cognitive system made up of "whatever one needs to know" (Germain, p. 242) in order to function acceptably in a culture. The latter perspective, ecological or materialistic, includes customs, patterns of behaviour and 'way of life' (Fetterman). The ecological perspective views culture as an "adaptive system of learned beliefs and behaviours" (Germain, p. 241) which helps groups or societies adjust to their environments.

From these perspectives, it would be reasonable for me to presume that MoE-SE therapists' *knowing* would be limited, or even absent, when they first arrive at their new practice context; strangers in a new land, so to speak. It would also be reasonable

perhaps to presume that newly employed therapists' understandings of the culture, as well as the cultural dynamics of the organisation, would likely be limited. This would impact on their ability to acceptably translate special education policy into practice, in keeping with the 'ways of being' of the education, rather than health, sector. Coming to the education sector and MoE-SE would most likely have required some form of cultural learning and cultural adaptation on the therapists' part.

Culture comprises ideas, beliefs, knowledge and patterns of observable behaviour that characterise a particular group (Fetterman, 1998). It is located in the minds of people and expressed in their language or semantic system (Germain, 2000) and through their values system. Values may be defined as sets of general beliefs, opinions and attitudes, regarded as important, worthy and significant by a person in relation to what he or she deems is 'right' and 'good' in life (Mitcham, 2003). One's beliefs translate into what one accepts as 'truths' in the world. As individuals and members of organisations, groups and society, therapists possess both professional and personal values and beliefs or truths. These are expressed in their worldviews, actions, principles, practice priorities and standards.

Culture is learned through the process of enculturation (Bates, 1999; Cockerham, 1995; Haviland, 1999; Miller, 1999), passed down through generations via formal and informal education and socialisation (Kielhofner, 1985). One must learn the concepts, beliefs, knowledge, language, symbols and patterns of behaviour that reflect a way of life. Given that culture is learned, it also seems reasonable for me to presume in this study that a process of enculturation has occurred for MoE-SE therapists, which allows MoE-SE therapists to acquire the necessary cultural knowledge to function as a member of the therapist group, as well as a member of the wider MoE-SE team.

Enculturation facilitates cultural fit, the process whereby the individual or society adapts and changes to achieve stability, continuity and survival in a given environment (Cockerham, 1995). To this end, culture is deliberately transmitted from generation to

generation through the process of socialisation. The society or the group coaches and prepares its members to act in ways consistent with approved norms and values, including knowledge, roles, skills and socially appropriate emotions related to gender, age, status and the culture. In other words, socialisation renders a person "fit for living in the company of others" (Cockerham, p.74).

Some believe that culture is relative (Cockerham, 1995; Haviland, 1999; Howard, 1993; Miller, 1999), bound within moral dimensions. Others do not subscribe to cultural relativism, particularly when it comes to issues of fundamentalism. From the perspective of cultural relativism, it can be argued that what is right for one group is not necessarily right for another. However, whether the culture of practice that I uncover in this study is right for all therapists practicing in the education sector is not the focus of this study. This study seeks only to gain an emic perspective of the MoE-SE therapist group's practice-related attitudes, values, beliefs and patterns of behaviour in order to present some of these characteristics via text. However, to "truly understand others, one must apply the concept of cultural relativism" (Howard, p. 5), that is to judge and interpret the behaviour and beliefs of others in terms of *their* traditions and experiences in *their* environment. Informed by this perspective, my intention in this study is not to take cultural relativism to the extreme to assert that if it is 'right for the group, it *is* right' and therefore can not be judged from the outside. This is not the purpose of the study. Rather my interpretations and text seek only to reveal and illuminate the group's emic perspective of their culture on the basis of their traditions and experiences in their environment. Thus this study seeks to determine a goodness of fit in relation to the Aotearoa/NZ context.

Culture and Environment

Culture is shaped by the environment, and in turn culture and its sub-cultures, shape and interpret the physical and social environment (Kielhofner, 1995). Understanding environment, including political, spiritual, technological, social and cultural aspects of 'environment' from a macro perspective is paramount because issues of environment are of concern to therapists' practice in schools (MoE, 2005e; MoE-HFA, 1999; MoE-HFA: Disability Support Services, 1999). This is a position strongly held by the occupational

therapy profession in Canada (Law, 1992; Law, Cooper, Strong, Stewart, Rigby, & Letts, 1996; Law, et al., 1997; Letts, Law, Rigby, Cooper, Stewart, & Strong, 1994; Fearing & Clark, 2000) as well as others. Social, attitudinal and institutional (organisation and political) barriers are also seen as significant environmental barriers (Law, Haight, Milroy, Willms, Stewart, & Rosenbaum, 1999; Richardson, 2002).

Environment is also context for occupational performance (Dunn, Brown, & McGuigan, 1994; Townsend, et al., 1997) and participation (WHO, 2001). In the context of this study, occupational performance relates to students' choice and engagement in meaningful self-care, play and school-related tasks and activities, contextualised by the school environment (Townsend, et al., 1997). Focus on occupational performance (Baum & Law, 1997) assists students to become actively engaged in their schooling life activities, in turn enabling students to achieve goals related to what they need and want to do in an educational context. Moreover, trends in healthcare services, translatable to the education sector, call for therapists to focus on activity and participation outcomes. The World Health Organization's (WHO) *International Classification of Functioning, Disability and Health* (ICF) (WHO, 2001, 2002) includes description of participation in terms of restrictions to individuals' experience when participating in educational, self-care, communication, social, vocational and civic occupations. Environment is also context for friendships and relationships at school where "cultural and social aspects of the school and the values and practices of teachers play a critical role" (MacArthur, 2002, p. 17).

The environment may be conceptualised as providing,or affording opportunities within it (*affordances*) (Gibson, 1970), as well as having expectations and making demands of the individual (*press*) (Lawton, 1980). In the school context the press is for learning achievement, participation and development, embodied within the below mantra stated on MoE letterhead:

Te Ihi, Te Mana, Te Matauranga
Beyond what I imagined I could be

Gibson coined the term 'affordances' to describe "what the environment offers, provides or furnishes the organism, either for good or ill" (p. 127). Hence in the education sector,

the environment may afford negative and positive opportunities for performance, as well as provide potentials for behaviours. The environment may also offer the individual and groups certain freedoms to choose and act (Gibson; Kielhofner, 1995). For instance, one could say that the special education policy and the MoE-SE work environment affords occupational therapists and physiotherapists certain opportunities and challenges for new and modified ways of working and thinking, resulting in either positive or negative consequences, depending on how the individual chooses to act. Similarly, people in the school environment, such as Principals, teachers or therapists, may afford students negative or positive opportunities to belong and be included in the school community.

Accordingly, the environment presses for certain types of behaviour (Lawton, 1980). Environmental press refers to the way the physical and human environment tends to shape behaviour by expecting and demanding responses from the individual, such that the individual 'feels' the press of the environment. In other words, the environment recruits or requires particular behaviours from the individual related to when, where, and what sequences of behaviour are called for. For example, the education sector work environment is likely to press for certain ways of thinking and behaving which align with the vision and principles of the special education policy and organisational culture. Thus, in this study, it would be reasonable to presuppose that MoE-SE therapists are expected to behave in a particular way that reflects what is right for the organisation and its policies. One might expect that participants are more likely to express organisational notions in a study that seeks to explore their culture of practice.

Naturally, each organisation that provides education-related services to schools will have its own organisational culture and each therapy discipline will also bring to the organisation its own professional culture. Each school setting will also have its own culture. Therefore, the participants in this study will be dealing with more than one culture; perhaps even many cultures, or variations of culture, within the education sector as they go about their work. However, I presuppose that the participants in this study will

share a common philosophical base and understandings which stem from the educational paradigm.

Cultures also evolve social roles and structures (Haviland, 1999; Kielhofner, 1995). Because of this, what one does may be understood in terms of the context in which the performance takes place. One's way of being is therefore culturally recognisable; behaviours become named, rule-bound sequences of action (Law et al., 1997). Social roles may be defined as socially agreed upon sets of behaviours and functions, for which there is a code of norms. When one achieves these behaviours, one is said to be role competent. There may be no 'true' universal standards for behaviour, however, although some absolutes may exist in the culture of practice explored in this study.

Accordingly, individuals tend to skilfully negotiate or construct their own meaningful choices against a background of social, economic and familial forces which both constrain individual actions and are created by individual actions (Jackson, 1998). This fits with notions of interpretive constructionism (Crotty, 1998), environmental affordances (Gibson, 1970) and press (Lawton, 1980). One cannot force an individual to fit the existing world, however what one does and engages in regarding activities and roles, and how one behaves and acts are all contingent upon the environmental context. Informed by these findings from the literature adds to my presupposition that the MoE-SE therapists' practice context will contribute to a large extent to their social structure, as well as shape and inform *how* they practice.

Organisational Culture (Ethos)

Organisational culture is a collective of the organisation's traditions, norms, values, and beliefs, including its policies and procedures. Organisational culture is also symbolic, permeating all levels of the organisation, recognisable through its high and low profile symbols (Hawkins & Shohet, 2000). For example, the MoE-SE logo and policies are reflected in the physical environs through public relations material, official note paper and posters, as well as in the language used to express the core business of MoE-SE.

There are levels to organisational culture (Hawkins, 1997; Hawkins & Shohet; Schein, 1985), each level being influenced by the one beneath. At the lowest level, organisational culture encompasses *motivational roots*, or the fundamental goals and objectives that drive the organisation's choices, along with the emotional base or patterns of feeling that shape organisational meaning. Above this level sits the *organisational mindset* or *collective worldview*, that is, how the people within the organisation see the world and frame experiences. Above this sits the most observable level of organisational culture, that is, the observable *behaviours* of the workers. These behaviours reflect the organisation's patterns of relating and behaving, that is, the *cultural norms*. At this level are organisational artefacts which, for example, include the various rituals such as meetings, training programmes, symbols, art, and buildings. Artefacts also include mission and vision statements, policies, and so on.

Conceptualising the work context as levels of organisational culture serves a useful guide for selecting the types of organisational data to be gathered from the field, such as: the vision statement, policies and procedures, public relations material, official documents, training presentations and induction processes, physical settings, language and work relationships. An organisational levels framework also lends impetus for exploring how organisational culture informs and impacts the therapist subgroup's culture of practice in the education system.

Therapy in Education

The bulk of literature pertaining to therapy in education emerged in the 1980s outside of Aotearoa/NZ in countries like Britain and the United States of America, linked to the inclusion movement in those countries which led to therapy services being increasingly provided in the education context. In the main, therapy services in schools are reported to "both look very similar and nothing like the services that were initially provided in the late 1970s" (Block & Chandler, 2005, p. 1). "Similar", because the service provision continuum requires all forms of intervention to meet students' needs relative to having equitable educational opportunities. "Different", because services reflect changes in

school communities, such as legal mandates for inclusion of all students in regular schools (Block & Chandler, 2005).

However therapists are poorly prepared to enter working in the regular school sector, requiring additional mentoring and continuing education (Brandenburger-Shasby, 2005). Furthermore, the absence of guidelines for school-based practice is prevalent (Brandenburger-Shasby). In Aotearoa/NZ the OT/PT protocol (MoE &HFA, 1999) may possibly be likened to a guideline, however its content is sparse; what is there pertains more to delineating funding roles and responsibilities between health and education sectors rather than evidence-based practice guidelines.

Local studies have been sparse, despite SE 2000 being implemented in 1998. One independently conducted study (Caswell, 1998) examined the provision of physiotherapy in Aotearoa/NZ schools for students with physical disabilities. Using survey methodology, the views of 36 physiotherapists from special schools, attached units, special classes and mainstream schools were sought. Overall, findings from this study matched overseas research and called for "therapists to develop a unique model of service delivery" (p. 19) in the education sector that differed markedly, and broke away, from the medical model of service delivery. In addition, the following was highlighted: therapists need to understand the roles of team members, share the decision making process, develop more consultative approaches to teamwork and develop more flexible attitudes and practices in the education sector. Caswell's study also highlighted the importance of training packages to support therapists to successfully transition to working in the education sector, because the education sector context "demands a change in emphasis from the medical model to the educational needs of the student" (Caswell, p. 19), a notion supported by the wider discourse on disability (MacArthur & Kelly, 2004; Mackay, 2002; Neilson, 2005; Snow, 2004a, 2004b).

Generally, changes in special education policies (Ballard, 1999, 2004; Booth, Ainscow, Black-Hawkins, Vaughan & Shaw, 2000; Davies, 2000; ERO, 2003; Fraser, Moltzen &

Ryba, 2004; South African Department of Education, 2001; United States Department of Education, 2004), societal attitudes and the voice and expectations of people with disabilities (Kielhofner, 2005; MacArthur & Kelly, 2004; Marshall, Hocking & Wilson, 2006; Neilson, 2005; Taylor, 2004; Watson, 2002) and their families/*whānau* (Pollock Prezant & Marshak, 2006; Snow, 2004a) have informed, challenged and shaped the practice of therapy in education. Change is also occurring due to developments in professional bodies of knowledge shifting towards contextualised paradigms related to enabling function and participation (Brown, Ryan, & Esdaile, 2003; Hemmingson & Johnsson, 2005; Hocking, 2001; Whiteford & Wright-St Clair, 2005; WHO, 2001, 2002).

In the words of a parent: "we have come a long way from prior generations where parents were encouraged to view children's disabilities as pathological, and to work within an expert model where therapists know what's best for the children" (Paikoff Holzmueller, 2005, p. 585). Indeed, environmental (Law, et al., 1999) and social factors are identified as some of the most significant barriers to learning and participation (Law, et al., 1999; WHO, 2001, 2002), such that attitudes towards disability are often identified as the biggest barrier (Gething, 1993; MacArthur & Kelly, 2004; Neilson, 2005; Tait & Purdie, 2000; Taylor, 2004).

In the United States (US), practice has been challenged since the 1980s by the notion of educational relevance. Based on shifts in thinking towards inclusive education, Hanft and Place (1996) warned that therapists who persist with implementing traditional medical model perspectives would be challenged when practicing in regular school settings. The harsh reality for therapists is that unless the education environment or learning context affords educationally-relevant justification for therapy services, there is no reason to provide a service to that student in his or her educational context (Bundy, 1993, 1995). This take on service provision differs markedly to medical model perspectives, which justify intervention on the basis of ongoing improvement in performance components (amelioration of underlying deficits).

Aotearoa/NZ Perspectives

Occupational therapists and physiotherapists have provided services in educational settings in Aotearoa/NZ since the early 1950s (Caswell, 1998; Vaughan-Jones, 2001). Much reform has occurred in education since those beginnings, particularly in special education (Ballard, 2004; Davies 2000; Fraser, Moltzen & Ryba, 2005; Mitchell, 1999) with a strong swing towards inclusion in the 1990s (Mentis, Quinn & Ryba, 2005; Mitchell).

Today's therapists must recognise that the provision of therapy services for students in schools needs to shift beyond the old notions of impairment-focused, clinic-based therapy services, towards being contextualised, educationally-relevant and participation-focused (Bundy, 1995, 2002; Case-Smith & Rogers, 2005; Caswell, 1998; Hanft & Place, 1996; Swinth & Hanft, 2002). Contemporary practice requires the emphasis to be placed on enabling occupations (Coster, 1998), fostering respectful relationships, being collaborative (Paikoff Holzmueller, 2005; Pollock Prezant & Marshak, 2006) and viewing students from an ecological perspective (Dunn, 2004; Dunn, Brown & McGuigan, 1994; Mitchell, 1999). Services provided within school settings are called to focus on enhancing the student's abilities to participate in the educational process (Ballard, 2004; Case-Smith & Rogers; Fraser, Moltzen & Ryba, 2005).

As previously stated, whilst the international body of literature related to therapy in the education sector has grown steadily (Bundy, 2002; Case-Smith, 2002; Case-Smith & Rogers, 2005; Fairburn & Davidson, 1993; Hanft & Place, 1996; Kemmis & Dunn, 1996; King, et al., 1990; Mahon & Cusack, 2002; Magill, Tirrul-Jones & Magill-Evans, 1990; Michaels & Orentlicher, 2004; Niehues, Bundy, Mattingly & Lawlor, 1991), there has been a dearth of local literature to guide therapists in their practice in the education sector. This is particularly so in relation to studies which may lend form to what one might consider appropriate and necessary values and belief systems for school-based practice in regular school settings.

However, in the last five years, reports on qualitative studies have begun to surface in Aotearoa/NZ (MacDonald, Caswell & Penman, 2001; Marshall, Hocking & Wilson, 2006; Tutty & Hocking, 2004; Vaughan-Jones & Penman, 2004) as therapists begin to search for an evidence base for their practice. All of these studies used qualitative methodologies, each exploring different aspects of interest to therapists' practice with school-age students, for example, identifying indicators for integrated effective service provision for students with physical disabilities (MacDonald, Caswell & Penman, 2001), the lived experiences of teacher aides (Tutty, 2003), the narratives of students with learning disabilities (Marshall, 2005) and the place of occupational therapy in special education (Vaughan-Jones, 2001).

Alongside Caswell's (1998) earlier mentioned study, these studies provide the beginnings of a local body of knowledge that will offer guidance for therapists' practice in the education sector. Of note is the two-part research programme commissioned by the Ministry of Education. Part one, the pilot study, identified indicators for integrated effective service provision for students with physical disabilities (Appendix 3) based on an extensive literature review and interviews with 59 key informants, including students, parents, education and health professionals and advocates (MacDonald, Caswell & Penman, 2001; MoE, 2002f).

Part two of the MoE research programme is as yet unpublished (MacArthur, McDonald, Simmons Carlsson, Caswell, & Clark, 2003). It involved case-study methodology with nine school sites (special schools and regular schools), combined with observation of 18 focus students' participation at school and home and multiple semi-structured key informant interviews with each students' multidisciplinary team. The school sites included on-site and itinerant therapy services. Overall, this research project sought to define what models of integrated effective practice looked like in Aotearoa/NZ school settings and the extent to which they reflected the findings from the first study. The findings reported several factors impacted on the way services were delivered and the way in which integrated effective practice was implemented, such as time and funding

constraints, and contexts. All the participants highly valued collaboration, consultation and teamwork. Such elements were seen as important for maintaining a shared framework for integrated effective practice across school sites. However change was required to establish clear roles and boundaries in schools to support integrated effective practice and links between the IEP and class programmes. The study also found that students did not always have the opportunity to contribute their voice in their schooling. Discrimination and disabling environments were factors which also impacted on students' school participation. Of note for my study, the itinerant therapy services were reported as being committed to the concept of inclusion, but there was insufficient time to liaise and collaborate, impacted on by the amount of travel involved. Itinerant teams reported using a consultative approach focused on the functional integration of therapy goals into naturally occurring school routines. Some parents had expressed concern that their child was not receiving sufficient therapy support and the focus students were reported as being relatively well integrated in their schools.

Data from these two studies reveal something of types of the practice behaviours, attitudes, values and beliefs that inform therapists' practice in education and include many of the desirable ways of behaving that behove good and effective practice in schools, for instance, those which fit with collaborative and ecological practice, as well as promoting contextualised outcomes that are linked to adaptation and functional skills in school settings. Parents, students and agencies reported they valued relationship-based services which are highly collaborative and flexible, with a balance between addressing students' physical needs and learning needs. Respect, equity and being inclusive are also valued. The belief that attitudinal and environmental changes should be the focus of school-based services to foster inclusion of all students in schools was also supported.

Mirroring US writings, Vaughan-Jones and Penman (2004) reported findings that were consistent with the need for therapists to understand the educational system and adjust their ways of practice when moving into school-based practice in order to achieve the *best fit* within the educational context. Therapists are advised to learn the overt and

unspoken rules and regulations that preside over the education system, whilst recognising that the structure of the special education policy has a positive impact on assisting therapists to better develop their role within the education sector because of its inherent press for inclusion, learning achievement, participation and students rights.

Shifts in therapists' role in regular schools

The role of the occupational therapist and physiotherapist in Aotearoa/NZ schools is, therefore, linked to supporting students' development and functioning in the school environment. It is also clearly linked to facilitating students' access to the New Zealand Curriculum (Caswell, 1998; MoE, 2002e; MoE & ACC, 2000; MoE & HFA, 1999). Such students are those who fit within the ORRS, SLS or MPC schemes, outlined in Chapter 1.

It is interesting to note that the languaging of the MoE inclusion criteria for all these three schemes is steeped within the thinking of the biomedical model, rather than the language of participation as espoused by the special education policy and the Disability Strategy. Indeed Mitchell (1999), amongst others (MacArthur & Kelly, 2004; Nielson, 2005; Slee, 2001), signalled that whilst the intention of the special education policy was to move away from a medical paradigm, remnants of this model remain, with many components continuing to focus on students' deficits and the provision of resources to meet needs related to the deficit. Such languaging only serves to reinforce the out-dated notion that the student or individual is the problem and is a far cry from the contemporary social model of disability (WHO, 2001, 2002), which stresses health, functioning and participation, irrespective of impairment. The significance in pointing this out is that such languaging is in conflict with current international discourses pertaining to inclusive education. There is a call for the removal of the word 'special' in education (Ballard, 1999; Slee, 2001), and the disability rights discourse, whereby people with disabilities are empowered to be recognised and respected for themselves, rather than categorised as 'different' on the basis of biomedically-defined, deficit-focussed 'needs' as in the dominant medical model discourse (Neilson; WHO, 2002).

School-Based Practice

Whilst I did not locate any studies in the literature specifically describing school-based practice in Aotearoa/NZ, looking at the expanding body of literature in other western countries, such as the United States, Canada, Australia and the United Kingdom, suggests that the experiences of Aotearoa/NZ MoE-SE therapists are following 'health-to-education' transition trends in inclusive education. These trends articulate notions of educational relevance, collaborative consultation, the use of ecological and functional approaches (Ketelaar, 1999) to intervention and inclusive practice.

Furthermore, school-based practice has its focus on educational goals, supporting both academic as well as functional goals (Case-Smith & Rogers, 2005; Coster, Deeney & Haltiwanger & Haley; King, et al., 1990). Therapists are perceived as key players in integrating students who have disabilities into regular school settings (Mahon & Cusack, 2002) with expertise for enabling transition (Kardos & Prudhomme White, 2005; Michaels & Orentlicher, 2004). Thus, they must become conversant with special education legislation (Vaughan-Jones & Penman, 2004) so that they may situate their practice within it, as well as explain policy-driven practices in schools.

Prior to SE 2000, a decontextualised model of practice was commonly used by therapists in education settings. Provision of school-based services involved withdrawing students from their classes for therapy, "in a space separate from daily educational activities" (Swinth & Hanft, 2002, p. 12). Therapy was frequently delivered on a one-to-one, regular basis (Dunn, 1991), commonly referred to by therapists as 'hands-on therapy'. In this mode the therapist role may be perceived as 'the expert' (Caswell, 1998). Such practice is in keeping with early 1990s US concepts of a three-pronged, therapy service models continuum framework: *treatment – monitoring - consultation* (Dunn, 1991) (see Appendix 4). In this framework, treatment or hands-on therapy is considered a direct service model. Monitoring and consultation are indirect models. This framework has been adopted widely by Aotearoa/NZ paediatric therapists (MoE & HFA, 1999; New Zealand Association of Occupational Therapists Inc., 1998).

The intention of such a continuum is to enable therapists to design services for all children in a variety of different settings (Dunn, 1991). In Aotearoa/NZ, emphasis continues to be placed on the treatment/direct end of the continuum (MacArthur, MacDonald, Simmons Carlsson, Caswell & Clark, 2003; MacDonald, Caswell & Penman, 2001) despite contemporary perspectives on what constitutes effective service provision in schools (Bundy, 2002; Dettmer, Thurston & Dyck, 2002; Hanft & Place, 1996; Swinth & Hanft, 2002). Furthermore, service provision models have been redefined to better reflect trends in the school-based practice of today with emphasis placed on consultation and collaboration (Bundy, 2004; Dunn, 2002).

Informed by MoE policy (MoE, 2003d; MoE & HFA, 1999) and contemporary notions about practice (Bundy, 2002; Case-Smith & Rogers, 2005; Caswell, 1998; Hanft & Place, 1996; Swinth & Place, 2002) and inclusive education (Ballard, 1999; MacArthur & Kelly, 2004; Fraser, Moltzen & Ryba, 2005), best practice points to students being primarily at school to learn and participate in education. Therefore therapy services need to be educationally-relevant (Bundy, 1995; Caswell, 1998; Giangreco, 1998; Hanft & Place, 1996; Swinth & Place, 2002). Such thinking challenges the decontextualised model of practice, since withdrawal of the student means removal from the very thing that he or she is at school for.

Service provision

The provision of school-based therapy services presses for good interprofessional practice behaviours (Dettmer, Thurston & Dyck, 2002). Key capabilities of interprofessional teamwork (Jones, 2005) centre around team members achieving the following:

- working together in an integrated way to develop a common purpose,
- effectively and efficiently utilising the various expertise of team members to provide quality services to clients,
- commitment to a common purpose and goals,
- mutual respect,

- valuing difference,
- effective communication,
- adaptation to change,
- team development, and
- professional identity.

In addition, therapists need to learn to speak the same language as their education counterparts; to be responsive to, and espouse, the "mission, culture and philosophies of public education" (Block & Chandler, 2005, p. 1). Accordingly, understanding the education system (Vaughan-Jones & Penman, 2004) and provision of relevant and evidence-based interventions to students in school becomes paramount (Block & Chandler; Giangreco, 1995).

In school contexts both direct and consultative services are perceived as effective approaches to service provision (Thress-Suchy, 1999). Over the past five years, however, international support for consultation services has increased (Bundy, 2003, 2004; Case Smith & Rogers, 2005; Dudgeon & Greenberg, 1998; Hanft & Place, 1996; Kemmis & Dunn, 1996; Swinth & Hanft, 2002). Use of direct services is challenged by the need to justify such services in relation to how effectively they address IEP goals and objectives (Swinth & Handley-More, 2003). The shift into the education sector has led to the adoption of collaborative and consultative practices which emphasise the ecological viewpoint. Collaborative teams are advocated (Benson, 1993; Dettmer, Thurston & Dyck, 2002; Waldrom, et al., 2002).

Collaborative practice is said to occur when persons with diverse expertise, perspectives and experiences work together as equal partners to design combined approaches to intervention to effectively remove barriers to learning (Kemmis & Dunn, 1996). The expected outcome of collaborative practice is a change in the school environment and the development of strategies which enable the student to succeed at school despite the limitations imposed by impairment and the environment, or both (Bundy, 1995;

Giangreco, Edelman & Dennis, 1991). Consultation may be the more difficult service provision model to administer (Bundy, 1995, 2002, 2004), however, proponents of collaborative consultation state that it is an extraordinarily powerful model in schools (Bundy, 2004; Dettmer, Thurston & Dyck, 2002; Hanft & Place, 1996).

"Consultation enables students to succeed in the environment *despite* their limitations" (Bundy, 2002, p. 321). In consultative practice, therapists use their expertise to focus their efforts on working collaboratively with the consultee, who is responsible for the outcome of the individual student (Dunn, 2000) and school system. Accordingly, consultation may be in the form of case consultation where the student's needs are the focus; colleague consultation such as that with a teacher, parent or teacher's aide in the school setting or with a MoE-SE colleague, and system consultation whereby the aim is to "improve how the system works so that all children benefit" (Dunn, 2000, p. 113). Moreover, consultation requires therapists to not only have theoretical and technical knowledge, but, as importantly, interpersonal skills such as strong communication and negotiation skills, the ability to work in partnership, leadership skills and the ability to acknowledge and accept diversity. They must also possess diversity readiness, or the ability to work in diverse communities, taking into account cultural influences, resource systems and ecological practices (Dudgeon & Greenberg, 1998) to deal with diverse student needs, multiple relationships and a variety of school communities, each with its own culture. Consultation therefore could be said to be more dependent on interpersonal competencies, people-related and communication skills rather than technical skills.

Contemporary perspectives on school-based practice argue that using client-centred and collaborative consultation is one of the most valuable and effective models of service provision in schools (Bundy, 2002, 2004; Dettmer, Thurston & Dyck, 2002). This is because consultation focuses on assisting people to develop strategies for solving their own problems. Collaborative consultation allows the following to occur: effective use of team members, supporting inclusion, fostering the sharing and building of skills in other

professions, and enhancing resources for problem solving in the school context (Hanft & Place, 1996).

Teachers are reported to value therapy strategies being integrated into the classroom as well as information sharing and collaboration with therapists about what would be effective for their students (Thress-Suchy, et al., 1999; Dunn, 1990). In contrast, parents have been found to adhere to the notion that more direct hands-on therapy is better for their child (Giangreco, Edelman, MacFarland & Luiselli, 1997). Ineffectiveness of services was often being linked to not having enough therapy services by teachers and parents alike (Thress-Suchy, et al.). However, this notion of 'more is better' is shifting (Snow, 2004a, 2004b).

An interactive process collaborative consultation allows teams of people with diverse expertise to generate resourceful solutions to mutually identified and defined problems (Hanft & Place, 1996). In support of the utilisation of collaborative processes, Bundy (1995) suggested that monitoring/indirect services should be used with caution because therapists need to possess "good teaching skills" (p. 79) in order for this model to work well in schools. Furthermore, whilst direct service delivery may be the most familiar model to many therapists, it has several limitations in the school context because of its disruptive effect on students' learning and participation (Bundy, 1995, 2002, 2004). Direct service, however, is still relevant when skill acquisition is necessary (Bundy, 2004) and as Dunn (2000) pointed out in later writings, it is desirably best provided in the child's natural setting.

The literature also reports difficulties in the provision of school-based therapy services. For instance, limited time to collaborate and provide services, recommendations not being followed by school staff, feeling uncomfortable in the classroom, and school personnel not being supportive (Prigg, 2002). Other difficulties include, therapists not having a sound understanding of the laws and policies that shape therapy services (Rapport, 1995), lack of knowledge and understanding of the education system and a

lack of others understanding the therapist's role in education (Vaughan-Jones & Penman, 2004). The extent of how well a therapist is able to shift from a biomedical or health paradigm to an education paradigm is also a challenge for many therapists, including their ability to move beyond providing one-to-one, pull-out services (Hanft & Pace, 1996; Swinth & Hanft, 2002). Therapists are also challenged by feeling that they may be constrained into only providing consultation services (Swinth & Hanft, 2002). A further challenge is related to the tension between what therapists believe they should be doing and what they actually do in practice, for instance being able to see that their role needs to be different in school-based practice (Niehues, Bundy, Mattingly & Lawlor, 1991). Niehues and colleagues stress the importance of matching the therapists' roles to the settings in which they practice.

Educational relevance

Therapy services are considered a related service in schools because under the education paradigm students are viewed as learners, rather than individuals characterised by ill-health, injury or impairment (Block & Chandler, 2005; Brandenburger-Shasby, 2005; Hanft & Place, 1996). Unlike the health sector, the focal point of school-based assessment and intervention has shifted away from a rehabilitation perspective (Giangreco, 1995) to one of educational relevance (Bundy, 1993; Jenkinson, Hyde & Ahmad, 2002; Llewellyn & Maher, 1993) and participation (Hanft & Place, 1996; Swinth & Hanft, 2002).

The press of the education model is for integration of therapy into the classroom (Prater, 2003) and learning activities (Case-Smith & Rogers, 2005; Giangreco, Edelman & Dennis, 1991; Thress-Suchy, 1999). The goal is student participation and achievement at school in order to reach individual potential, despite impairment limitations. In addition, the press is for intervention to focus on imparting knowledge (Bundy, 2004; Thress-Suchy, 1999).

The shift into educational relevance therefore takes the viewpoint that students with special education needs are deemed 'only-as-special-as-necessary' (Giangreco, 1995)

when making decisions about a student's need for service. Such thinking presses for the provision of educationally-relevant therapy rather than services designed on the basis of the student's impairment or disability. Thus, "the issue is not which mode of service provision … but rather which mode or combination of modes matches the function being served" (Giangreco p. 61), that is the student's learning, functional performance and participation needs based on objectives identified from the IEP process (MoE, 1998).

Contextualised and ecological practice

Therapists need to understand contexts of practice and how shifting contexts calls for changes in their practice behaviours (Caswell, 1998; Fearing & Clark, 2000; Law, et al., 1996, 1999; Vaughan-Jones & Penman, 2004). The education context expects and demands therapists to comprehend the press of the environment on their roles and their behaviour, and therefore their service provision. Thus, if therapists want to understand who they are in the education environment, which is framed within Government policy, they will need to fully understand the context which they have selected to work within. This will foster understanding of how the education context influences their roles and practice in the education sector (Caswell; Niehues, et al., 1992; Rapport, 1995).

The ecological perspective views student behaviour as being determined by the interaction of the individual and the environment (Dudgeon & Greenberg, 1998; Dunn, Brown, & McGuigan, 1994; Gibson, 1997; Law, et al., 1996; Letts, et al., 1994; MoE-SE, 2005a), whether environment is at the macro level (for example school politics; education policy) or micro level (for example class community). Thus, my presumption is that environment is a pivotal component of MoE-SE therapists' practice, starting with the micro level of classroom environments (Griswold, 1994; Orr & Schkade, 1997).

The purpose of therapy in the school system is therefore related to the student's education, it is not for therapeutic benefit alone. Assessment is expected to focus on student readiness, academic achievement, curriculum and school community participation. A central focus is identifying, reducing and removing barriers to learning, rather than on patient health status and symptoms. Students' efforts are supported within

their given academic environments if, and only when, necessary and only if they meet the eligibility criteria for specialist support services as mandated by legislated special education policies (Case-Smith & Rogers, 2005; Hanft & Place, 1996; Fraser, Moltzen & Ryba, 2005; SA DoE, 2001; US DoE, 2004).

Inclusive practice

In the education sector 'inclusion' or 'inclusive education' is defined as a process which serves to increase all students' participation in not only learning, but also in curricula, school culture and the school community (Ballard, 2004; Booth, et al., 2000; MacArthur, Kelly & Higgins, 2005). General consensus is that inclusive practice involves a "process of reducing barriers to learning for all children" (Ballard, p. 4). Inclusion is facilitated by asking not *whether* to include a child, but rather *how* to include a child (Service Leaders, Inclusive Services, 2001). Through inclusive practices, therapists have the opportunity to support schools to be inclusive and to enable student participation (Doubt & McColl, 2003). Accordingly, the end result of inclusive practice is a student whom the school and the people in the school fully value as a learner, peer and active participant in school life and the school community (MacArthur, Kelly & Higgins, 2005). The student is an integral member of his or her class and school community, learning and participating alongside his or her peers, like any other student, viewed as a person and learner first. Inclusive practice seeks to achieve this end through a range of collaborative and consultative processes alongside the modification of teaching, learning and assessment approaches. According to some, doing so allows the diverse needs of all students to be met (Booth et al., 2002; Mentis, Quinn & Ryba, 2005).

Inclusive Education

The term *inclusion* is widely used in western countries, however universal consensus on what it is, or is not, in relation to education has not been reached (Ballard, 1999, 2004; MacArthur, Kelly & Higgins, 2005; Slee, 1998, 2001). In Aotearoa/NZ inclusion is defined as "a principle, an attitude and a set of processes which affirm the right of every student to learn in accordance with the principles and values of the National Education Goals and

the NZ Curriculum Framework" (MoE, 2002a, p. 27). Accordingly, inclusive education is strongly linked with changes in education policy, school culture and leadership, and teaching practices (Booth, et al., 2000; MacArthur & Kelly, 2004; Mentis, Quinn & Ryba, 2005). Inclusion is, therefore, a keystone in the Aotearoa/NZ Government's education policy, as it is in the United Kingdom (Booth, et al., 2000), and other countries (South Africa, DoE, 2001; US DoE, 2004). As stated in Chapter 1, this policy espouses several principles which uphold the provision of special education, including themes related to the right to access education, equity, partnership, choice, and access to culturally appropriate education (MoE, 2003d). According to Booth and colleagues (2000), inclusion in education involves two processes: firstly, increasing student participation in the local school culture, curriculum and community, and secondly, that of reducing exclusion of the student from the aforementioned components.

Whilst these may be the ideals of inclusive education, it may not be the reality for all students. There will be schools where achieving inclusion is unattained. There will also be students for whom inclusion may simply not work. Furthermore, whilst inclusion may be the policy framework, the key issue is how one interprets and implements it (Lindsay, 2003). To this end, Lindsay calls for a dual approach that addresses both the rights of children, as well as the effectiveness of their education. This approach must encompasses rigorous research to inform both policy and practice using research that steps beyond examples of 'good practice' to "focus on experiences and outcomes and [to] attempt to identify *causal* relationships" (Lindsay, p. 10).

Another MoE pilot study which looked at enhancing effective practice in special education (EPPSE) (MoE, 2005f), involving 21 schools, found that "children learn best when a school has a culture of inclusion, a strong school-home partnership, and access to specialist support" (Feltham, 2004, p. 4). Fundamental to effective practices was a culture of inclusion. This needs to be modelled in schools at all levels from senior management to teaching and non-teaching staff. Furthermore, parent and

families/*whānau* value the collaborative approach to decision making for their children (MoE, 2005f).

In addition, the Aotearoa/NZ Disability Strategy (MoDI, 2001) adds support to the call for inclusion since it clearly outlines the Government's framework for shifting this country's societal worldview towards one of inclusion of people with disability. As government employees, therapists who work for MoE-SE are bound by special education policy *and* the objectives of the Disability Strategy (ERO, 2003; MoE-SE, 2005a), in particular the following objectives:

- The building of a non-disabling society that ensures the rights of disabled people,
- The provision of quality education and long-term individually-focused support systems for disabled people which value families, *whānau* and others who provide ongoing support to people with disabilities, and
- Enabling disabled children and youth to lead full and active lives in their communities (MoH, 2001; MoE, 2002a, 2004a).

SE 2000 therefore "reflects a paradigm shift" (Mentis, Quinn & Ryba, 2005, p. 74) in Aotearoa/NZ from a biomedical perspective towards a societal model which purports notions of equity and respect for children and young people as learners. As in the case of special education policies in other countries (Booth et al., 2000; SA DoE, 2001; U.S. Education Department, 2004), SE 2000 requires whole school ecologies to adapt their learning contexts, their school cultures, communities, policies, curricula, and teaching and learning practices (Mentis, Quinn & Ryba, 2005). Accordingly, schools must develop the necessary attitudes and skills for the provision of inclusive education, for instance, inclusive values and beliefs, inclusive policies, collaboration and consultation, and inclusive practices. For example, the valuing of all students as learners and participants in schooling, acknowledging that all students have the right to attend and be educated in their local schools, respecting difference and diversity, empowering learners through developing their strengths, and seeing inclusion in education as a part of an inclusive society (Booth et al. 2000; Mentis, Quinn & Ryba, 2005). Furthermore, teaching and

assessment approaches are designed to fit the learning programme to the student rather than the student to the programme (Booth et al.; Mentis, Quinn & Ryba). Thus, if and when inclusion is achieved, there is a good fit between the student, the environment and the activity, or programme. However, what it not yet evident is what this 'goodness of fit' means. Does it mean the child learns and progresses in learning or, if this is not the aim for some children, is goodness of fit more focused on 'fit', rather than educational progress?

Inclusion is a complex concept which continues to evolve. In addition, inclusion, or inclusive education, is based on personal values and beliefs, educational structures, policies, processes and practices (MacArthur, Kelly & Higgins, 2005). Achievement of inclusion in society and school communities will require people to overcome exclusive, disabling and segregationist practices (Ballard, 1999; Booth, et al. 2000; Mitchell, 1999). This places it within the domain of social justice discourse (Slee, 2001). Simply placing a student with special education needs in the regular school setting, however, does not signal the achievement of inclusion (MacArthur, Kelly & Higgins).

Disability Discourses – Impact on Therapists' Thinking

"Inclusive education is not a technical problem, it is cultural politics" (Slee, 2001, p. 173, emphasis added). Accordingly, Slee warns against the dangers of language use and inherent meanings in words:

> Traditional special educators demonstrate a remarkable resilience through linguistic dexterity. While they use a contemporary lexicon of inclusion, the cosmetic amendments to practices and procedures reflect assumptions about pathological defect and normality based upon a disposition of calibration and exclusion. (p. 167)
>
> A stipulative language requires that we consider the terms we use. Inclusion has been used to refer to unconditional access by some while it refers to a sliding scale of partial participation for others. This degree of latitude is unacceptable. … The engagement with language has profound implications for policy. (Notes, p. 175)

Whilst there is continuation of the place of special education within education thinking and practice, policy will continue to categorise and label students as *special*, that is as

different and *other*, thereby perpetuating the elusiveness of inclusive society, a point in case under disability rights discourse (Nielson, 2005; Snow, 2004a, 2004b).

As reported by MacArthur and Kelly (2005), children and young people with disabilities are often "seen as different from other children and in need of special education" (Ballard, 2004, p. 1). Whilst this viewpoint persists there is just cause for the argument that inclusion will remain difficult to achieve (Snow, 2004b). Accordingly, there is debate over the removal of the notion of *special* within the context of education (Slee, 2001; Snow, 2004). Ballard argued that the continued existence of *special* education has the effect of acting as a barrier to achieving inclusive education; however, there is also no certainty that current meanings of inclusion will achieve the ideal either. In his discussion of education research and teacher education, Slee (2001) suggested that the starting point be one of confronting the political, rather than technical, nature of one's work. Influence of policy, such as the Disability Strategy (2001), therefore, appears to be crucial in achieving the goal of inclusion within Aotearoa/NZ, as is people being clear on what they mean by inclusive education (Slee, 2001) and, thereby, inclusive practice.

Nonetheless, whilst this debate continues, leaders within occupational therapy have urged therapists to look to the current disability discourses for guidance (Kielhofner, 2005) for both their technical and cultural implementation of school-based practice. Ponder the words of Snow (2004b), a parent and advocate of disability rights and strong proponent of society needing to recognise that disability is a natural phenomenon of the human experience:

> We may have changed the locations where people with disabilities spend their time, but **today's social policies still reflect the attitude that the "problem" of disability is within the person** … a continuum of services exist: from treatments designed to "fix" or "help" those who (it's thought) may one day achieve some measure of an "able-bodied" standard, to programs which "protect" those who won't, and everything in between. (Snow, p. 2, emphasis original)

One should not be surprised that the key discourse for today's practice addresses issues of *rights* for people with disabilities (Nielson, 2005). It is perhaps time we woke to this. Under the rights discourse, themes are related to issues of identity (Watson, 2002), as

well as self-reliance, independence and consumer rights (Kielhofner; MacArthur & Kelly, 2004; Nielson; Taylor, 2004), and social justice. Furthermore, the disability rights discourse fights for equality of citizenship (rights and belonging) and against discrimination, exclusion and oppression of people with disabilities (Nielson, 2005). According to Nielson, this discourse "is challenging old attitudes and assumptions and empowering people with disabilities to be recognised and respected for themselves" (p. 19). As such, these are perhaps the loudest voices that therapists working in education should listen to.

Summary

This chapter has reviewed aspects of the literature in order to illuminate key constructs of culture that are relevant to conducting this study. I did not locate any studies such as mine in the literature.

Key pertinent concepts to the practice of therapists in the education sector were, however, uncovered and these provide a foundational knowledge base for an ethnography which seeks to explore the culture of practice of a group of therapists who work with students in regular school settings. Overall, the literature provided insights into the nature of culture and informed the cultural narrative of the study's findings and text. It also provided insights into the nature and evolution of school-based practice in Aotearoa/NZ, as well as perspectives on inclusive education which inform both policy and practice. Such understandings serve to situate cultural findings in the context of organisational embeddedness. Lastly, insights from disability discourses and trends in practice added greater insight into reasons why school-based therapy practice needs to shift and this is illuminated by the findings of this study presented in Chapters 4 through 7. However, the literature does not include any studies such as mine, and therefore is missing researched perspectives about the value and belief systems which underpin therapists' practice: their culture of practice, that is, the ethos.

The next chapter addresses the philosophical approach which underpins this study, including the study design, participant selection and methods of data gathering and analysis. Application of rigour to the research process and methods is also outlined.

Chapter Three: Methodology & Methods of Ethnography

Introduction

This chapter describes the methodology (ethnography) and methods of the study. Ethnography is construed as methodology, method and text (Fetterman, 1998; Germain, 2000) with culture being its central concern (Atkinson, Coffey, Delamont, Lofland & Lofland, 2001; Bochner & Ellis, 2002; Brewer, 2000; Crotty, 1998; Davies, 1999; de Laine, 1997; Denzin, 1997; Denzin & Lincoln, 2000; Hammersley & Atkinson, 1995; Johnson, 1990).

In this chapter, I outline the epistemology and theoretical stance taken to inform the research process and method. I present the ethnographic lens through which this study is focused, relative to the intention of presenting the emic perspective of the group's organisationally situated culture of practice. The researcher is also situated within the context of this study and I describe the participant group. The fieldwork site is explained, as well as the range of ethnographic methods used to gather data. Lastly, the process of data analysis is explained and I end with a brief discussion of the text of ethnography.

Epistemological and Theoretical Perspectives for the Study

In qualitative research, one's epistomological stance demonstrates how the researcher will interact with the participants; findings being created as a result of this process (Polit & Hungler, 1997). Epistomology (theory of knowledge) is embodied in the theoretical or rather hypothetical perspective of a study (Crotty, 1998) and provides context for the research process.

This study is situated within the epistemology of *interpretive constructionism*. The interpretivist approach "looks for culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67). Constructionism looks at the way humans

understand and explain *how we know what we know*, that is how they construct meaning. Central to constructionism is the assumption that *meaning is constructed*, not discovered. Truth is not out there waiting for us to find it (the objectivist viewpoint). The particular view I took in this study is that people actively construct meaning from the world, their interactions with each other and with the objects in the world, referred to here as *meaning-making*. Accordingly, "there is no meaning without mind" (Crotty, p. 9). That is, meaning-making does not occur without the interaction of the subject (person) with the object (inanimate article or artefact) or other persons. Meaning-making interactions between persons and objects give foundation, scope, and validity to how we know what we know. Reference to persons in the context of this study includes the participants and their clients (students, families, school personnel for example). Objects on the other hand, include a range of things such as therapists' tools of practice (car, diary, therapy resources), as well as the physical space of offices and schools and paper objects, such as policies and guidelines (see examples highlighted in Chapter 1).

The use of the interpretive approach allowed me to uncover some of the culturally derived, historically situated meanings of participants' social life-world, situated within the context of their work setting. In addition, the use of constructionism allowed me to explore the group's "way of looking at the world and making sense of it" (Crotty, 1998, p. 8). It is important to note here that the use of interpretive constructionism offered me *one way* to explore participants' meanings or understandings and interpret the data in this study. I emphasise the words 'one way' because followers of constructionism posit that different people construct meaning in different ways, even in relation to the same phenomenon (Crotty, 1998). Thus, this study is *my construction*; others will construct their own meanings.

One pre-study assumption I had was that the therapists (participants) have constructed ways of understanding and explaining how they know what they know to fit with the worldview of the education sector. Now, using the ethnographic lens of interpretive constructionism I apply a different and more rigorous way of looking anew at the group's

constructed meanings, thereby re-building my own understandings of these meanings. As the researcher, I specifically focused the ethnographic lens on the group's *culturally-constructed meanings* arising from their interactions with others and objects in their particular practice world. I sought to come to a place of understanding through the interpretive process. Interpretation, therefore, encompassed therapists' meanings attached to social symbols such as language and objects (Crotty, 1998; Polit & Hungler, 1997), for example, spoken and written language, such as the text of the special education policy or symbolic representation of the MoE-SE vision statement. Thus, from this relativist post-modern position (Ballinger, 2004) my aim was to illuminate the group's insider taken-for-granted or common-sense meanings and present this within cultural constructs. This may include cultural constructs such as enculturation, social structure (relationships), values, beliefs and patterns of behaviour.

Methodology

Ethnography, originating in anthropology (Brewer, 2000; Denzin, 1997; Howard, 1993; Keesing & Strathern, 1998) is widely used in sociology (Crotty, 1998). At the core of ethnography lies the assumption that groups of people eventually evolve a culture that serves to guide members' view of the world and their patterns of behaviour (Polit & Hungler, 1997). Culture helps people function in the world; without it "we could not function" (Crotty, p. 53).

Ethnographers may study broadly defined cultures, for example an entire Pacific people's village community. Alternately, they may study narrowly defined cultures resulting in mini-ethnography (Germain, 2000), as is the case with my study. Because of this, one of the critical components of ethnography is immersion of the researcher in the study group, culture or community and the setting (Brewer; Fetterman, 1997), typically referred to as the fieldwork site (Germain).

Since its conception in the 1900s, ethnography has passed through many phases and interpretations (Atkinson, et al., 2001; Denzin, 1997), ranging from traditional

ethnography where the outsider researcher undertakes lengthy fieldwork immersion in a community; to post-modern ethnography where the voice of the writer (researcher) comes alive beside the voices of others (participants) as they interact with one another (Denzin; Reed-Danahey, 2001); to ethnographic texts written by 'complete-member researchers' (Ellis & Bochner, 2000, p. 740) where researchers explore the group of which they are a member, as is the case in this study. However, its central concern remains the gaining of the emic perspective of how members of a group see and make sense of their world (Atkinson et al.; Brewer, 2000; Crotty, 1998; Davies, 1999; de Laine, 1997; Denzin; Fetterman, 1998; Germain, 2000; Katz, 2001, 2002).

Furthermore, ethnography is recognised as worthy methodology in the field of occupational therapy (Griswold, 1994; Lawlor, 2003; Neville-Jan, 2003; Townsend, Langille & Ripley, 2003), alongside growing awareness that culture resides within professional groups and therefore impacts on practice. To quote Dr Iwama (2006):

> If we accept a broader definition of culture as 'shared experiences' giving rise to 'shared systems of meanings' then we can see that even occupational therapy – its ideology, structure, content and approaches are culturally and contextually bound … can be viewed as a particular culture of cultural group.

The contemporary view on ethnography is therefore one where the meaning of ethnography may no longer be taken for granted (Atkinson et al., 2001; Denzin, 1997). Writers of ethnographic text are cautioned not to presume to present objective, non-contested accounts of others' experiences, given that those they study "have their own understandings of how they want to be represented" (Denzin, 1997, p. xiii). Nevertheless, the ethnographer's tasks must remain focused on uncovering the typical ways of thinking, feeling and behaving that correspond to the group, or culture of a given community, and formulate these findings into a useful representation. This role is imbued with connecting emic meanings with the group's observable and contextualised interactions with objects and the real world (Denzin).

The Researcher's Role

This study sits within complete-member researcher ethnography (Ellis & Bochner, 2000) because I am a member of the group. As a research instrument (Germain, 2000), I am

written into the method of the study. My role in this study was one of overt *participant-as-observer* (Germain). I use this term to denote that I have a dual role: that of researcher (*researcher-self*) and that of a member of the group (*participant-self*). As the researcher, I stepped outside of my practice community to take on the role of critical inquirer, observer, listener and learner. This dual role was made known to all the particiants, as well as others in the fieldwork site, such as my colleagues and managers, who were informed both verbally and in writing to dissipate any potential tension arising from the dual roles. In keeping with contemporary ethnography, my uptake of the participant-as-observer role acknowledged and used my existing background as a MoE-SE therapist and my professional life history as a member of the group (Brewer, 2000; Ellis & Bochner, 2000; Reed-Danahay, 2001). Deployment of my own history emphasised my situatedness within the group, as well as my temporal connection to the group's history. Furthermore, it offered the element of researcher immersion in the fieldwork site to an extent.

Whether a researcher should be an 'insider' or 'outsider' of a community is debated within ethnography in relation to reliability of the data (Atkinson, et al., 2001; Crotty, 1998), linked to the tension between objectivist and subjectivist positions (Reed-Danahay, 2001). Objectivists hold that judgment should not be biased by personal values and beliefs, therefore, complete-member researchers are unable to be objective in their analysis or reflection because of their cultural predisposition. In contrast, subjectivists posit that one's values are inevitable and indeed desirable in qualitative research (Crotty; Ellis & Bochner, 2000; Polit & Hungler, 1997); therefore, the researcher's view is best construed as always biased. Accordingly, one's "view from nowhere [is] in fact always a view from somewhere in particular" (Spencer, 2001, p. 444).

Indeed, qualitative research is never value-free because even outsider-researchers are enculturated with their own attitudes beliefs and values. There is always a view from somewhere in particular in the research process and it is better to acknowledge than ignore this (Spencer, 2001); this was so for my study. I acknowledged my full immersion

and commitment to the group (Ellis & Bochner, 2000) I studied. Because of this I "held" the view that I was culturally predisposed and subjective in my view; being that it was a view from somewhere in particular. However, I construed this view to be from the inside *and* from the outside, because, in one sense, being in the researcher mode required me to look from the outside whilst being on the inside. Thus, my stance was that my beliefs and values as a MoE-SE therapist were not only inevitable, but also desirable in the study. Because of this, my reflections and interpretations are voiced in the text from the conscious stance of researcher and also as a member of the group.

In point of fact, risk of too much subjectivity in qualitative methodologies is false. Davies (1999) stated that "we cannot research something with which we have no contact, from which we are completely isolated" (p. 3). Moreover, the place of personal approaches is defended and supported in contemporary ethnography (Reed-Danahay, 2001); the ethnographer whose voice is present in the work and text is applauded. My connection to the group and the fieldwork site was important in this ethnography.

Being a complete-member researcher was advantageous to the study because of my intimate knowledge of the group, their practice and the fieldwork site. This afforded possibilities for contextualised analysis of the culture on its own terms and according to its own standards; a process referred to by cultural anthropologists as cultural relativism (Cockerham, 1995; Haviland, 1999). For example, risk of misinterpreting cultural meaning from behaviour was reduced because of my local understanding of the organisation's written and spoken language and symbols. This enabled me to more readily decipher what lay behind the data and the group's social structure. Social structure, refers to the relationships that hold a group or society together through their sense of common identity and social organisation, consisting of both their symbols and shared ideas about social life (Cockerham; Haviland).

As a member, I was able to navigate and avoid any potential pitfalls and misinterpretations that outsiders may commonly make. Any misunderstandings of

cultural humour or language were reduced, such as *MoE-ese*, a term I use to denote the participants' 'in-house speak/text' and that of the organisation. I was 'in-the-know' regarding any common-sensical, taken for granted meanings behind MoE-ese and corresponding patterns of behaviour. Conversely, however, whilst my immersion was construed as advantageous, I was also mindful that the risk of misinterpretating data was possible from my assuming understanding through my familiarity with the group's social structure. Supervision and the application of reflexivity and rigour through participant checks were helpful processes to minimise this potential risk throughout the study. These processes also served to reduce any potential risk from preconceived ideas to the integrity of my data analysis. Conscious attention was paid to questioning my intepretations so that there was clarity in the text of my own emic, taken for granteds and those expressed by the participant group.

Supervision contributed to keeping my researcher-self from being shaped by any conventional meanings my participant-self may have learnt to associate with the objects and social interactions in the practice world of MoE-SE. To uncover my own values, beliefs and presuppositions, I was interviewed by a colleague early on in the study using the same questions I put to the participants. My transcript was added to the participants voices and used as part of the data set for analysis. In this way, I was able to see that I too took my culture for granted seeing it, in layman's terms, as the "way we do things round here". I also discovered that I too had difficulty articulating my values which were hidden within the stories I chose to share with the interviewer.

Thus, as researcher I sought to look with fresh eyes at the group through the process of critical inquiry and reflexivity; the process of critically thinking about what one is doing and why (Ballinger, 2004; Brewer, 2000; Davis, Watson & Cunningham-Burley, 2000). Reflexivity is used in ethnography to continually manage the integrity of one's thinking throughout a study. The reflexive process of turning back on oneself or the "process of self-reference" (Davies, 1999, p. 4), alongside supervision, allowed me to be cognisant of my own influence and effect on the study and to acknowledge and make my own position

and assumptions explicit (Ballinger). In addition, it allowed me to be aware of the ways the study would be affected by the people in the study and by the process of my carrying out the research, which, in turn, provided stimulus for interpretation (Ballinger). Lastly, it allowed me to go beyond or behind participants' words and my own presuppositions to construct what was going on through the interpretive process.

The Fieldwork Site

Fieldwork is the most characteristic element of ethnographic research (Fetterman, 1998); the fieldwork site being the context which the researcher is closely associated with and participates in (Brewer, 2000). Chapter 1 introduced the fieldwork site as the therapists' practice context in some depth because it set the scene for the context of the study. The added description that follows serves to further explain this context, grounding it as a place and space where the group's culture resides.

The Organisational Context

MoE-SE is a subdivision of the Ministry of Education. As part of the Government, the Ministry of Education states that its influence on education outcomes is indirect, being neither provider nor director of education. Rather, it (Ministry) states that its role is facilitative, as illustrated below:

> Education enables people to gain knowledge, skills, and attitudes so they can participate fully, socially and economically, in the community. Our [Ministry of Education] role is facilitative rather than directive. We empower through our leadership, management of the infrastructure, problem solving ability, and assistance of those at risk of underachievement. What we do influences the motivation and focus of the sector … We need to foster a policy environment that enables educators to operate effectively and learners to participate and achieve. We need to ensure we are creating a system that can respond quickly and effectively to wider social and economic impacts and the needs of different communities, society, and employers. (MoE, 2005d)

Despite the emphasis given to the facilitative role, with the integration of SES into the Ministry, MoE-SE is in reality a service provider division of the Ministry, charged with strengthening the Ministry's overall special education direction and providing services to students in schools, at a national and regional level (MoE-SE, 2005a). Thus, in relation

to special education, MoE-SE is the Ministry's first point of contact for schools, providing coordination, advice and support for funding and services, as well as working with schools and *iwi* (Māori tribes) to provide integrated services for Māori. Paradoxically, MoE-SE is often confused as being 'the Ministry', that is the policy maker and policy enforcer (personal observation). However, this perception is inaccurate. The Ministry of Education (the Government) writes and legislates the policies; MoE-SE employees work according to the policies and legislation.

Physical space and artefacts

As Ministry employees, MoE-SE therapists are spread across sixteen District Offices, clustered into four regions. Northern, Central North, and Central South are on the North Island, the Southern region covers the South Island. Therapists work either full-time or part-time, with therapy position full-time equivalences (FTE) dictated, in part, by the number of students funded for special education through each District Office.

MoE-SE therapists are office-based workers who travel to multiple school settings to provide itinerant services for students. Thus their caseloads comprise a range of students geographically scattered in schools within the district and often encompassing a mix of urban and rural schools, depending on the location of the District Office. For example, my District Office "patch" covers the central Auckland area, but includes Waiheke Island and Great Barrier Island. Therapists must therefore allow time in their schedules to travel to schools to provide itinerant educationally-relevant therapy services. Vast distances are covered at times to provide services for one student, sometimes travel is via boat or aeroplane and an overnight stay is required.

Unlike their counterparts in the health sector, MoE-SE therapists do not access traditional therapy environments and tools of practice such as dedicated treatment rooms and treatment resources. Instead, MoE-SE treatment rooms are the typical student learning environments. Such spaces encompass those where students participate and learn, including, but not restricted to, classrooms, playgrounds, school halls, corridors and offices and sometimes staff tearooms. Learning environments may also include the

home setting or a community setting, if that is where the student is receiving education (MoE, 2004a). In addition, MoE-SE therapists may attend students' health-based clinic appointments according to identified need. Subsequently, MoE-SE therapists' intervention tools, resources and equipment are objects and materials peculiar to the world of academia, learning and school environments. These include, for example, the curriculum topics and the correspondent cognitive and physical performance skills and abilities (MoE, 1993; MoE, 2005a), as well as school-based objects such as furniture (desks and chairs), whiteboards, books, pencils, rulers, calculators, a Bunsen burner and a ball, to name a few.

Research Process and Methods

In this next section I describe the research process and methods, beginning with the gaining of ethical approval. This is followed by a description of participant recruitment and selection. Lastly, I describe the data gathering techniques and how the data were analysed.

Ethical Approval

Ethical approval for the study was gained from the Auckland University of Technology Ethics Committee (AUTEC) (Appendix 5a, b, c). Key ethical principles considered in the study's design included doing no harm, informed consent and voluntary participation, avoiding deceit, confidentiality and anonymity, as set out in the *Participant Information Sheet* (Appendix 6) and *Consent Form* (Appendix 7). Researcher inter-subjectivity and any consequences for future research (Hammersley & Atkinson, 1995; Tolich & Davidson, 1999) were also addressed. In addition, as part of the ethics approval process, I consulted the MoE-SE *Pouarahi-A-Takiwa* (District Māori Advisor) when considering inclusion of Māori and the research project's obligations to *Te Tiriti o Waitangi* (Treaty of Waitangi). The ethics approval process also included assurance that all parties (participants, clients, schools and colleagues) would be protected by stating that this study was not about any student, family/*whānau*, school, nor any other agency (see Appendices 5, 6, 7).

Whilst awaiting ethical approval, I sought permission from the MoE-SE *Professional Practice* division to call for expressions of interest from occupational therapists and physiotherapists across the regions; planning to do so only once AUTEC approval was granted. At the organisational level, this step was important in order to inform management and staff of the study's intentions. Contact with the Manager of Professional Practice was made via email communication, an accepted modus operandi within the organisation. Approval was granted and copied to my local District Management Team, as well as all MoE-SE District Offices. I also placed advertisements calling for expressions of interest in two public sources (see Appendix 8). This drew three external enquiries from therapists who were not eligible to participate because they were not employed by MoE-SE and therefore did not meet the inclusion criteria (see Appendix 9).

Participant Recruitment

Ethnography requires that cultural informants (participants) are able to provide rich data (Germain, 2000) to gain the insider perspective of culture (Atkinson, et al., 2001; Brewer, 2000; Fetterman, 1998). To this end, I sought experienced MoE-SE therapists from across the country (refer to the study's inclusion criteria in Appendix 9, 11) and applied purposive sampling to capture participants who would be able and willing to "tell it like it is" (Germain, p. 249). Inclusion criteria were drawn up in a *Participant Response Form* (Appendix 10) and this checklist allowed me to ascertain whether participants met inclusion criteria. The Response Form also captured participants' profession, contact details, District Office and whether they visited urban and rural schools, or both. Only MoE-SE occupational therapists and physiotherapists who met the inclusion criteria were interviewed in this study.

I used the organisation's internal email network to call for volunteer participants. This was circulated to all MoE-SE occupational therapists and physiotherapists, accompanied by the following attachments:- Participant Information Sheet, Consent Form, Participant Response Form and a formal *Participant Invitation Letter* (Appendix 11). This email was cascaded by a Regional OT/PT Lead Practitioner via the MoE-SE *National Occupational*

Therapy and Physiotherapy LISTserve, a key nationwide communications network for information sharing and dissemination within MoE-SE therapists' daily practice. However, in hindsight, I realised that the timing of the call for volunteers fell at the end of the fourth school term prior to the summer school holidays. This meant that many MoE-SE therapists did not have sufficient time to consider participation in the study, therefore, the invitation was resent by one of the Professional Practice Advisor's two months later, at the beginning of term one in the following year. Doing so ensured that all the therapists would have equitable access and sufficient time to consider participating in the study. All respondents were thanked by myself, either via email or verbally either face-to-face or by telephone, on receipt of their Participant Response Form. Following the selection process, I contacted each therapist via email or telephone to acknowledge their interest and to accept or decline their participation in the study.

The Participants (Therapists)

In total, seventeen therapists (included the first six) returned the Participant Response Form, nine were occupational therapists and eight were physiotherapists. Of the seventeen volunteers, three therapists later declined for personal reasons, two did not reply. The remaining twelve were interviewed: six occupational therapists and six physiotherapists. My own interview brought the total number of therapists to thirteen. Of the thirteen therapists, eight participants had face-to-face interviews and five answered an e-mail based interview questionnaire. Participants' identities are protected through the use of pseudonyms throughout the thesis, including giving my transcript a pseudonym to reduce any potential risk of it being given additional weight by readers because it could be identified as mine.

Group composition

The thirteen therapists in this study came from ten, out of the sixteen MoE-SE District Offices, with the majority from North Island offices. Each therapist self-identified as Pakeha, New Zealand European, or European. There were no Māori or Pasifika therapists because, excluding myself, none are currently employed within MoE-SE. All the therapists worked in regular schools with students who are eligible for special

education funding support via the *Ongoing and Reviewable Resourcing Scheme* (MoE, 2004b). Eleven therapists also worked with students who met the eligibility criteria for the *Moderate Physical Contract* (MoE, 2005b) and the *Supplementary Learning Support* (MoE, 2006) schemes. All of the therapists were seasoned practitioners and had prior experience of working in the education sector and health sector. All provided services to students who attended urban schools; six also provided services in rural school settings and a small number held leadership roles within the organisation.

At the time of the study, the group's average length of employment with MoE-SE, including the period when MoE-SE was SES, was seven years, with a range of four to nine years. They had spent on average approximately 21 years working with children and young people, with a range of eight to 36 years. Their average practice experience was 30 years, with a range of 16 to 40 years. Most of the therapists were employed part-time, ranging from 0.4 FTE to 0.9 FTE positions. In total they comprised 6.3 FTE of the overall occupational therapy and physiotherapy MoE-SE workforce; respectively, 3.6 FTE occupational therapy positions and 2.6 FTE physiotherapy positions. This corresponded to approximately one eighth of the total number of FTE occupational therapists and physiotherapists employed within the organisation at the time of the study.

Participant anonymity and confidentiality

Participant confidentiality was ensured through pseudonyms and individual coding on all transcripts and fieldnotes. All data were stored in a secure locked area separate from working documents. No material or information was divulged or made public, nor known to anyone except to my supervisors. Participants were also requested not to divulge any information that would identify their co-workers, students or family/*whānau* during their interviews. On the odd occasion this did occur in an interview, I removed any identifying details from the typed interview transcript. For example, when a colleague was named, I replaced the name with their profession, as in [*psychologist*] or [*teacher*]. If a school was named, it was substituted by the word [*school*]. Alternately, I left the identifying word as a blank space, or marked as [*X*], in cases where this would not interrupt the flow and sense of the transcript. The majority of the audiotaped interview transcripts were typed up by a

typist who signed a *Confidentiality Agreement* (Appendix 12). I cross-checked all transcripts against the audiotapes for accuracy.

Ensuring safe researcher-participant relationships

As I was a member of the participants' community, many of the therapists in this study had prior awareness of my intention to conduct the study. My intention was that no participant would be left in an unsafe emotional, relationship, or practice state as a result of my role as researcher. Whilst I anticipated that the study would not pose any risks to the participants or that any participant would experience any adverse consequences, physical or psychological, I took precautionary steps to recognise and avoid any such potential risks by ensuring that all parties were well informed. For instance, I considered the risk of triggering previously unacknowledged emotions in therapists related to their practice ideas, values and beliefs and any risk associated with my ongoing contact with the therapists. These risks were discussed in my supervision. Therapists were also given explicit written and verbal assurances around confidentiality, voluntary participation and their right to withdraw with no adverse consequences. In addition, I made every endeavour to separate the information gained from the research and the fieldwork site observations by carefully and consciously processing the data. I also consciously endeavoured to ensure future relationships with my colleagues would not be compromised and participants were informed that I was available to offer support, however this was neither required during, nor after, the study.

Data Gathering Methods

Combining data gathering methods (research triangulation) was central to the reliability and validity (Boyd, 2000; Fetterman, 1998) of this study because ethnography is not a particular method of data collection, but a style of research distinguished by objectives which focus on gaining emic understanding of the social meanings and activities of people in a given setting (Brewer, 2000). Data are often gained from observation and ethnographic inquiry, therefore methods are often generated in the field (Brewer; deLaine, 1997; Fetterman, 1998; Fontana & Frey, 2000).

In this study I used a variety of techniques to collect the data, relying on a cultural constructs frame of analysis to infer tacit meanings shared by the group (Appendix 13). The primary data gathering method was semi-structured participant interviews (Cohen, Manion & Morrison, 2000; Fontana & Frey, 2000) which I used to gather rich data, drawing on culturally flavoured questions and explanations to gain insights and generate text to describe the group's shared cultural worldview. Two forms of participant interviewing were used in this study:- eight semi-structured, face-to-face, audiotaped interviews, plus a short email questionnaire with the five remaining participants. Other data gathering methods included my incidental fieldsite observations and experiences, reflexive journaling as well as data checks with participants and with 'experts-in-the-field'.

Participant interviewing

In the text of this ethnography, the face-to-face interviews are referred to as dialogues or *kōrero* (conversation) because the process I engaged in was more interactive and exploratory, as between two members of the same group. My aim, through dialoguing, was to capture participants' perspectives (meanings) in relation to their practice ideas, beliefs, values and behaviours. Interviews were guided by a pre-formulated Interview Guide (Appendix 14), the questions informed by my own past experiences and readings in the field. For example, I asked participants what they believed were the most important attitudes, values and beliefs to have in the MoE-SE work setting and how they knew they were practicing inclusion in the setting. I also asked them to describe the most important aspects of behaving as a MoE-SE therapist as well as an example of successful practice.

All of the eight face-to-face interviews occurred in a prenegotiated place on a date and time of the therapist's choice, all consented to being interviewed and our *kōrero* being audiotaped. Four interviews took place at therapists' District Offices, three were conducted at my District Office and one at my residence. The nature of participant involvement and the potential risks were revisited prior to each interview and the granting of informed consent. Each interview began with my stating the purpose of the study and my interest in getting at the *how* and *why* of MoE-SE therapists.

The email interview was added later in the study, after returning to AUTEC for further ethics approval (Appendix 5c) to utilise this method of data gathering. This method of data gathering sat well within the practice behaviours of the therapists, given the pivotal role technological communication systems played within the organisation. A short, six point questionnaire (Appendix 15) was sent out to the remaining five participants with the Consent Form and Information Sheet attached. Participants had the option of responding to the questionnaire via return email or via fax and they were also offered the opportunity to email me with any questions or concerns. All Consent Forms were returned via fax.

In contrast to the face-to-face verbal interviews, which identified much of the *what* of the therapists practice, my intention with the email interview was to capture more of the group's *how*-related processes and stories, based on some of the emergent themes from the face-to-face interviews. For instance, distinctive themes centred on inclusive practice, valuing relationships, teamwork and enculturation were emerging. I therefore wanted to verify and further illuminate these notions with the five remaining participants, guided by the work of Katz (2001) who stated that the recognition of "luminous data often light[s] the path to causal inference" (p. 443). In particular, the email interview sought to capture more specific data which would verify and further illuminate the *how* of the culture. How questions guide discussions to allow the researcher to trace how networks of social relations and processes of interactions work, thereby allowing one to see some explanatory breakthrough in what might shape culture (Katz, 2001, 2002).

Shifting the focus to *how* questions invited the therapists to offer historicised, temporally formatted responses that were useful for strengthening my interpretive explanations (Katz, 2001). I asked such things as:- "How do you practice inclusion? How do you team, form relationships and collaborate in schools?" and "How do you share and pass on knowledge about how to practice as a MoE-SE therapist to new therapists?" Data gained from these questions assisted me to more clearly tease out some of the processes and meanings behind how the therapists did things, in turn providing me with deeper understanding of the reasons for *why* in the final analysis.

Adding the remaining five participants served to further enhance the credibility of the study's findings through representing a greater number of voices, as well as increasing the geographic spread of participants across the country. In addition, illuminating the *how* of practice served to broaden and strengthen the data and emergent cultural themes, thus affording a thicker description of the group's culture of practice. Data captured from these voices were then further enhanced by my membership of the group, likened to immersion in the field.

Fieldwork observation

Fieldwork is situated in the notion of 'being there' to observe, to ask naïve or insightful questions and to record what is seen and heard. During fieldwork I used several techniques to gather data, including observation, past experiences from my professional life history as a MoE-SE employee and reflexive journaling. These data sources served as the 'lived-in' cultural backdrop against which the participant transcripts could be foregrounded. By lived-in I mean my own experiences and meanings of the culture and the fieldwork site. My fieldwork experiences occurred as I went about my day-to-day practice. This allowed my researcher-self to sample vignettes of practice, including those of therapists and colleagues and my own, across the fieldsite and across different points in time. I captured some of the more poignant experiences through journaling.

Fieldwork also gave me access to the many discourses, written artefacts, subjective experiences, archival data and objects therapists routinely interacted with, as well as the office environment. For example, policies such as those introduced in Chapter 1 and numerous PowerPoint presentations MoE-SE therapists are routinely used to educate others about their role and their work, beneath which lay potential for uncovering notions of their culture. During fieldwork I was also able to re-visit and re-look at any emerging themes arising from the study. I was positioned to observe practice in action and to check my thinking with colleagues as the study progressed. The fieldwork site therefore offered me abundant opportunities to observe and reflect upon the group's social structure, as well as to engage with the range of artefacts that potentially symbolised the therapists' culture of practice. Any poignant aspects were in turn captured in my journal.

Journaling

The research journal comprised of a notebook and a loose paper file which held all kinds of arbitrary notes, ranging from scribbles on bits of paper, to collections of email conversation print-outs and notes from supervision insights, thoughts and ideas. In fact, the research journal contained anything that I had thought of in relation to the study, whether during an interaction, after an interview, during an inservice or team meeting or at the point of falling asleep at night. The below text illustrates one such experience which offered data for reflexive interpretation in this study:

> Regional GSE Conference - great opportunity to be together. Listened to loads of speakers weave many facets of culture through their presentations. Don't think I had noticed this so much before – must be wired by my study! Exciting to see organisational expression of who we are - useful for study. CEO spoke of the GSE vision and where this sat within the greater MoE mission - "how well were we doing?" Covered who we collectively are, where we are going and why - filled with GSE attitudes, values, beliefs: belief in student and parent participation and acceptance; valuing learning opportunities for <u>all</u> students; valuing the voice of students and their families. Our belief in building inclusive schools. Said we needed to share in the Ministry's quest to raise achievement and reduce disparity. Spoke of the passion and commitment underpinning our work - need to ensure link to learning outcomes. The organisation's culture = my culture. Will get copy of powerpoint. (April, 2005)

During the study I revisited my notes and reflexively drew from them, especially during the data analysis phase. I also used them to generate discussion with my supervisors and colleagues. Use of journal content also facilitated the process of monitoring the match between my research question, the selected group and their context (Hammersley & Atkinson, 1995). This offered a further means for enhancing the credibility and transferability of the study through triangulation.

Data checks

Further research triangulation was achieved through two additional processes:- participant checks and experts-in-the-field checks. These processes allowed me to check the quality, comprehensiveness and confirmability of the data and ethnographic text. Although debated by some in ethnography (Barbour, 2001; Nolan & Behi, 1995), participant checks are one of the most crucial techniques for establishing the credibility of a qualitative study (deLaine, 1997; Hammersley & Atkinson, 1995). Participant validation in this study supports its claim of authenticity.

Participant checks required therapists to check their transcripts for accuracy and make amendments. Transcripts were sent to the participants with a covering letter (Appendix 16) and self-addressed envelope. They were informed that I would assume they were happy with the content of their transcript if I did not hear back from them. All participants sent their transcripts back over a period of four weeks. No participant chose to have their transcripts removed or changed, one made minor changes, two later shared their excitement about the dialogue in their transcript.

Experts-in-the-field checks were accessed through a range of modes. During the write-up phase, I presented the preliminary findings to the MoE-SE Northern Region therapist group, who acknowledged the content as being true to their practice values and beliefs. This presentation enhanced and confirmed the accuracy of the findings. In addition, I used experienced MoE-SE therapists to read and comment on the draft findings chapters (Appendix 17). I also consulted with an ethnographer, from the Faculty of Applied Sciences, Auckland University of Technology to check methodological questions. Adding participant and expert checks in the research triangulation process enhanced my goal of ensuring the quality and accuracy of data. Because of this I was able to compare data derived from different phases of the fieldwork, from differing points in time in the fieldwork setting, and from different therapists (Hammersley & Atkinson, 1995).

Staying true to the participants' voices

I endeavoured to ensure that the the participants' voice and their experiences were embodied through the text because I wanted to avoid limiting the reader's access to only my interpretations; that is my constructions of other people's constructions (Spencer, 2001). However, during my *kōrero* with participants I did add what I made of the experience being described. Such instances are signalled in the text through the use of my real name (Carolyn), as illustrated in the below excerpt. Here, Yolanda and I are discussing others' perceptions of what MoE-SE therapists should be doing in schools. As we talk I draw from my own professional life history to offer my interpretation of the topic.

The particular issue we were exploring was schools' expectation of therapists to apply a 'fix-it' model to students who have impairments and we are discussing why this is so:

> **Yolanda:** Yeah I think it shapes outcomes quite a lot in that a lot of the time we are working to help people to understand why we work differently. And often that continues to be a mismatch. And every time there is somebody new the poor child has to go through that whole loop of: "Why don't they fix them? What's the therapist doing? Why don't they fix them?" I have also found that as you have worked with a school, and the team around the child understand the child, and we put in the adaptations, that there is kind of magical quality. The child makes very clear gains and then the people around the child stop with those messages of "Why don't you fix them?" and they see that they are in a very powerful position and that they can enable occupation, and they can enable participation, and that's what OT [*occupational therapy*] is about. We can be really powerful in teaching other people to let that happen. For me, actually experiencing that in GSE has changed my beliefs about therapy quite a lot.
>
> **Carolyn:** Right, yeah, because it can be hugely rewarding can't it? I find that the schools I know that have "got it", they stop perceiving the child, the student as a problem, and they start talking about how much that individual [*student*] contributes to the class, and the school community. And it's when they start talking about the student in that way - like they do any other student - I know they've got there. And I'm not sure what to label the "getting there" but the student is just now one of their community and they will bend over backwards to find a solution.
>
> **Yolanda:** Yeah. And if I had to go back to doing only remedial work, I would have, in the back of my mind "What's the message for this child about who they are?"

Potential themes that sit within this conversation include our shared belief in the inclusion of students as learners in schools despite the presence of impairments, as well as the notion that a student's impairment is secondary to what MoE-SE therapists are at schools to do. This type of researcher-participant *kōrero* played a role in my constructing interpretations, as well as confirming that they matched that of the participants. This, in turn provided a further means of reinforcing my depiction of what was culturally true for the group in their context.

Capturing the researcher's 'voice' – the participant-self

Lastly, because this study sits within complete-member researcher ethnography, I believed it was important to capture my own voice as a MoE-SE therapist. I did this at the outset of the study and was interviewed by a non-therapy colleague. Being interviewed gave me insights into what it might be like for the participants during the interview process, for example, I found some of the questions tricky to answer.

> **Interviewer:** Can you think of and describe a scenario when you felt that your work was successful, sort of what did you do that made you think or know that it was successful?
>
> **Carolyn:** Hmmm (*pauses*). Interesting question (*laughter*). Now why is that? (*Asking myself out loud in reflection)*.

Being interviewed helped to uncover and name any presuppositions. This allowed me to watch for bias during the interviews and minimise the risk of influencing participant responses to mimic my views:

> **Interviewer:** What do you think influences or hinders your work in this setting?
>
> **Carolyn:** The team that I work with influences, the different team members. So right now we are in a space where there are new members. They have a different perspective of how to work with ORRS [*Ongoing and Reviewable Resourcing Scheme*] students. That interferes with my work. I guess the attitudes that schools have towards the student influences my work, you know, like if it's a negative attitude I [*have to*] work much slower to try to get them to a point of positivity. What really hinders my work is the constraints - the minimal resourcing, the constant meetings about how we [*the organisation*] are going to do our work - which takes away from us actually doing our work, the lack of understanding around ORRS students. I think, sometimes I feel like ORRS students are just the poor cousins of the whole of special education. It's almost like "oh well we've set up a system for them, they are alright" you know "we've done the money bit and they've got their teacher aide, they're alright". And the inequity of the system, in terms of resourcing. So that sort of influences and hinders. But it doesn't stop me from doing a good job. The things that enable my work is the teaming. It makes a huge difference, that role release and that sharing and that support. The collegiate support, it's very interdisciplinary. It's wonderful.

Here, laid bare for critical examination and refute are many of my presuppositions, in other words my own values, beliefs, attitudes and my prejudices. For example, I hold the following beliefs: a school's negative attitude towards a student makes my work more difficult and slower; MoE-SE therapists' work with ORRS students is undervalued; resourcing for ORRS students is inadequate and services are inequitable. Lastly, I passionately value interdisciplinary teamwork. I now turn to describing the process of data analysis.

Data Analysis

In this study, data analysis was guided by Katz (2001; 2002) and Fine (2003) and I appraised the data using evaluative questions based on Katz. This enabled me to search

for causal, or logical, explanations by looking for a range of phenomena based on the points below:-

- data that revealed enigma, paradox and absurdity which provoke curiosity about the sociological *why*
- strategically organised data that support explanations and at the same time negate major alternate explanations
- rich and varied data that specify definitions of problems and qualify answers to the problems
- revealing phenomena which show how forces shape the group's social life, such as when moments of strong emotion are revealed by participants
- situated data (data situated within the practice context and group's social life)
- data describing how behaviour was crafted and that convey a 'being-there' or 'life-in-action' sense which point to forces that potentially shape the group's social patterns, and
- data that reveal poignant or compelling moments, which, in turn, reveal certain kinds of structure in the group's social life.

According to Katz (2001), the labour of constructing ethnographic texts, the outcome of analysis, often proceeds "in a mist of vague evaluative notions" (p. 86), a concept I strongly identified with during analysis. Moreover, as Katz stated, the data only became compelling when I attempted to construct the text. Fine (2003), in turn, offered guidance towards arriving at a text that would provide understanding of the group in context by grounding my understandings in detailed vignettes from all the data sources. Thus, my data analysis looked to providing "verbal pictures" (Fine, p. 57) as well as explanations.

Framing the Journey of Analysis

Data analysis was the most challenging phase in the research journey and, because of this, I returned to culturally-based readings (Bates & Fratkin, 1999; Cockerham, 1995; Haviland, 1999; Jones, et al., 2000; Keesing & Strathern, 1998; Miller, 1999) to recapture the cultural essence of my study. From these readings I formulated the cohesive cultural constructs framework (refer Appendix 13) which, alongside Katz's evaluative questions,

became my end guide to interpreting the data and crafting the final text of this ethnography. Using this framework progressed my understandings from the *what* and *how* of culture to the *why*. I then used participant quotes to illustrate and encapsulate the group's core cultural meanings in the text. For example, in relation to enculturation (how one learns culture) I started by looking at the pattern of important things which the therapists said they did [the *what*], such as induction. I then examined this cluster of activities more closely to explore *how* they went about their induction processes. From this platform, I constructed an interpretation of the importance and meaning of induction [the *why* of enculturation].

A particular struggle at the outset of data analysis, however, was the issue of 'from where to start my analysis' and 'how to start' because I was a member of the group. I brought my own work history and contextualised participation to the project, therefore, I could not avoid looking at the data from a position of familiarity and I needed to overtly take this into account. It seemed logical therefore to begin the initial analysis from already assumed 'familiar to us and our practice' concepts. Here I drew from two MoE-SE generated works to formulate theoretical assumptions, supported by literature related to therapy in education:- the MoE-SE-wide survey on professional practice (MoE, 2004c) which presents the collective voice of MoE-SE fieldstaff and the MoE commissioned three year study (MacArthur, McDonald, Simmons Carlsson, Caswell, & Clark, 2003; MacDonald, Caswell & Penman, 2001) which looked at effective integrated service provision for students with physical disability in the education sector (refer Appendix 3: *Indicators for Integrated Effective Practice*). I also drew from the numerous organisational policies and publications which contributed to shaping the group's practice and therefore culture.

Using these works alongside Katz and the cultural constructs framework, I began data management and analysis by applying the *a priori* concept coding method (Bailey, 1991) as a means of "first-cut analysis" (see Appendix 18). This method involved defining first-cut categories on the interview questions, for example, inclusion, inclusive practice, collaboration, working as team, working with students and working with families, practice

paradigm, things we do, how we behave, and stories of success. These categories were aligned with many of the findings reported from the MoE-SE professional practice survey and based on the interview questions.

Interview transcripts were individually analysed to uncover data that might reveal the concept by deciding the following:- whether specific groups of words in the data encompassed the concept; whether there was sufficient occurrence of each concept; whether there was sufficient weight to the concept to consider it relevant or important to providing insights into the group's shared culture of practice. Using this technique allowed me to sort and chunk raw data from the transcripts, as well as other pertinent data sources onto an Excel spreadsheet of the categories. Transcripts were colour coded for ease of identification. Sub-categories were then added as they emerged, for example under the category 'working with students' core notions of 'not fixing the student' and 'not being the expert' emerged.

In hindsight the method I used for data analysis was perhaps a lengthy process, however beginning with a priori method allowed me to find and explore basic themes in interview dialogues that were comparable across participants' transcripts, fieldwork notes and written artefacts. Recurring concepts in a priori categories could then be collapsed into new categories and relabelled as core strands of the culture. Following exhaustion of a priori categories, I progressed to the application of the cultural constructs framework to arrive, at last, at my findings. Central to all data analysis I asked the question: "does this theme or construct say something about a shared culture of practice; am I illuminating it adequately and richly through an emic perspective in text, and am I writing ethnography that people will feel like reading?"

The Text of Ethnography

Methodological description would not be complete in this thesis without addressing the text of ethnography. Text refers to the written end product of the ethnographic study. Since interpretive constructionism views truth or meaning as waxing and waning because

of people's engagement with the realities in the world, the text of this study offers one description of a group's culture of practice. Others may construct their own, and different, meanings from the text I offer. Moreover, ethnography deals with representations based on an exercise of interpretation (Katz, 2001, 2002; Spencer, 2001), in turn offering a means of producing written descriptions and explanations or constructions about the ways of life of those written about, the context, and that of the writer (researcher) (Denzin, 1997).

Denzin (1997) stated: "truth and facts are socially constructed, and people build stories around the meanings of facts. Ethnographers collect and tell … multiple versions of the truth" (p. xv). The relationship between text and context is, therefore, acknowledged in ethnography which seeks to be contextualised through offering both descriptive and non-descriptive representations (Spencer, 2001). Descriptive representations are truths which may be refuted by observation. For instance, I could write that a) the therapists <u>are</u> inclusive practitioners, or (b) <u>if</u> the therapists are inclusive practitioners or (c) therefore the therapists <u>are</u> inclusive practitioners. All three statements may be considered true descriptive representations; however, each may be refuted by observations of what the therapists actually do in the fieldwork site. Non-descriptive representations are the writer's reproductions and interpretations; such text combines both objective and subjective elements related to what the interpreter, or researcher, makes of the experience. Both types of representation are used in the text of this study.

Furthermore, the interpretation and presentation of data via any ethnographic text is subjective (Reed-Danahay, 2001). My interpretation can only be of the larger group dynamic (personal communication Dr Sharyn Graham, email conversation 13/01/05). As ethnographer I stood with those who believe in aiming to write a rich and readable ethnography; one that is open about its limitations and partiality and which acknowledges the complexity of the participants' world. Because of this, one can expect some difficulty in portrayal through the use of the written word; there can be some sacrifice of coherence or clarity (Spencer, 2001).

Rigour and Trustworthiness of the Study

This study attempted to clearly and systematically document descriptions of the research path, including the study's central assumptions. Procedures for checking and rechecking the data are documented and articulated. This audit trail serves to enhance the confirmability of the study and allows examination of procedures for data collection and analysis so that judgements about the potential for bias, or distortion, may be made (Ballinger, 2004; Trochim, 2002).

In addition, the study's trustworthiness and rigour is enhanced by clear documentation of my participant recruitment and selection processes, and use of reflexivity and supervision. I was cognisant to avoid any potential threat to validity through bias, in particular acknowledging the potential tension between the researcher-self and participant-self. The process of reflexivity heightened my awareness of potential for bias, thereby minimising the risk from my own pre-suppositions; supervision and being interviewed enhanced this state of mindfulness. Any risk of setting out to prove my own point was minimised because I followed these processes (Fetterman, 1998). Moreover, they ensured that I remained true to gaining an emic perspective of the group's culture of practice.

Because I am a member of the group and the context of this study, I was able to access a semblance of prolonged engagement in the fieldwork site, thereby providing me sufficient time in the field (de Laine, 1997) to achieve the purpose of the study, that is, to explore the group's culture of practice. To this end, my time in the field as a practitioner served to enhance the study's authenticity.

Lastly, a rigorous process of triangulation was applied in this study, described throughout the chapter. Participant checks as well as experts-in-the-field checks ensured the study's trustworthiness by establishing the findings as credible from the perspective of not only the individual participants (Trochim, 2002), but also the therapist community, whose culture of practice is articulated in this text.

Summary

This chapter has described the research journey, including the fieldwork site, methodology, methods and text of the ethnography. The theoretical stance which informed the research process was also presented, as was the role and position of the researcher in order to situate myself, both as a member of the group and the researcher within the context of this ethnography.

The next three chapters present the findings of the study.

Preamble to the Findings

The findings chapters present a view through the ethnographic lens. It is a subjectivist, yet integrated view construed from both the outside *and* the inside because I am both the researcher and a member of the group. In the next three chapters I sought to weave cultural constructs into the fabric of my interpretive processes with the aim of embroidering a text that richly represents the group's culture of practice.

The first of the findings chapters begins by presenting the notion of *arrival,* the second *enculturation*, and the last, the notion of *being inside* the culture.

In keeping with ethnographic methods, I extensively used participants' voices to illuminate the culture. This is because I wish to reveal *their worldview*, using *their words*. By "their" I mean Bonnie, Cassie, Cherie, Deb, Jackie, Leanne, Liz, Melinda, Pauline, Phillipa, Sandra, Tracey and Yolanda (all pseudonyms). Furthermore, since I am interpreting narrative data, the use of excerpts from raw data serves to highlight the the trustworthiness of the study because readers can 'see' what has informed my interpretations. I am mindful that others who read this text will also construct their own threads of interpretation. These will be shaped by the reader's own cultural lens, professional history, experiences and context and may, therefore, differ to those presented in this text.

Terminology and participants' language

In writing the text, I also drew from the group's language and fieldwork site. For instance, the terms *Ministry of Education, Special Education* (MoE-SE) and *Group Special Education* (GSE) are synonymous so I have used the terms interchangeably to reflect the way participants speak. MoE-SE is the official and public name of the organisation, whereas GSE is the in-house acronym. GSE, however, is also commonly used by outside agencies and clients alike. In addition, participant references to 'OT' in their transcripts mean 'occupational therapy'; 'the OT' and 'OTs' mean the 'occupational

therapist', or 'occupational therapists'. Similarly 'the PT', 'PTs', or 'physio' denotes 'physiotherapist'. 'Physio' can also mean 'physiotherapy' as in 'physio programme'.

I used the online Learning Media *Ngata* Dictionary, *Te Pou Taki Kōrero* (2006) to interpret Māori words used in this text. In some places I have changed the gender of the student in therapists' stories to minimise any potential risk of identification in the findings. Names of schools or services have been removed or non-identifying labels are used, for example 'School X', 'special facility', or [*community agency*]. Lastly, some minor editing of some participants' text has occurred to enable ease of reading and maintain the flow of text. For example, I have altered the tense or removed irrelevant utterances, however the utmost care has been taken to maintain the integrity of participant narratives when doing this.

Chapter Four: Journeys towards the Practice Context & Each Other

Waka.
Photo by Rei Samuels, Behaviour Support Worker, MoE-SE Auckland City.
Used with permission.

Introduction

In this study, *arrival* is heralded by participants' (therapists) journeys towards the practice context. These journeys all end at new beginnings at MoE-SE. This chapter reveals insights into the nature and essence of the journeys, illustrated through the use of three vignettes, beginning with Sandra's journey and followed by Phillipa and Bonnie's, later in the chapter.

Journeying to the practice context and subsequently each other at MoE-SE is symbolised by the above photo. The *waka* (Māori canoe) is a semblance of the great historic canoes upon which the first people and culture of Aotearoa/NZ journeyed to this *whenua* (land) and their new beginnings.

Coming Together: New Beginnings

In the main, the therapists in this study entered MoE-SE of their own volition, some knowing that they would be cast adrift from traditional ways of thinking about practice.

Indeed much of their journeys appear to be part of a process of casting themselves adrift from prior ways of knowing and doing:

> **Pauline:** I'm just thinking back now when I worked in a hospital. The therapist takes everything into their own hands and provides the treatment and there is no way around it. But the ultimate goal would be [*that*] the patient is discharged and takes responsibility for themselves again. … That's not the stage that we [*MoE-SE therapists*] are at with our clients. We are at the other end, where we enable participation as much as possible, the living life end.

These therapists have positioned themselves in a work sector which has triggered each one to bring into question the *how* and *why* of traditional practice, ending in a perception that they now work differently:

> **Phillipa:** I do believe that we have a lot to offer, but it's just not that traditional therapy model.

They have situated themselves in a new organisation, bringing their past professional life histories to be present in the new context. Consequently, they have blended their past ways with new beginnings, to shape a new and contextualised culture. However, they also continue to draw on their health-based backgrounds to articulate their practice. For example, I note in the field and in the data that they still employ medical terminology for ease of communication with each other, but tend not to label the student in terms of their diagnosis or impairments. In a sense, the therapists are bi-lingual, speaking and thinking both in health-based language and *MoE-ese*, a term I coin to refer to the language and thinking of MoE-SE. As a language, MoE-ese is imbued with the MoE-SE values. This language is learnt after entry into the organisation.

Thus, these therapists have not left their past professional histories or knowledge behind, it comes with them, like valued belongings to be used in the new land. Accordingly, it seems that their journeys revolve around sufficiently unshackling their past professional histories so that a new culture of practice may emerge. Sandra's story serves to illuminate this notion.

Sandra's Journey

Sandra has been with the organisation for many years now, indeed since the inception of SE 2000. In hindsight, it seems fitting that I should begin my narrative of an emerging

culture with the words of one of the therapist community's *kaumātua* (elder). In this vignette, the unfolding of Sandra's story serves to reveal how her particular journey, like others, meandered towards MoE-SE over time. Along the way, Sandra gathered insights and new ways of thinking about her practice, through her experiences of events. These insights culminated in new understandings about *how* to work with students in regular school settings, including understandings of *why*.

Sandra credits the gaining of new knowledge not only to her experiences, but also her relationships with people and what they have said to her along the way. Going back in time she recounts:

> **Sandra:** When I first worked in education I worked in a unit in a school. We had children from age 5 up to 21 all based in primary school. I guess when I first started I felt comfortable because I'd come from Health. We had curtains in the physio room and we had mats and exercise beds and what have you. It seemed alright to spend the first three weeks of term sorting out a timetable as to when you were going to see children and what they were going to be doing, and when we were going to have the paediatric clinic at the school - because we had a paediatrician come in - and when we were going to go swimming, and when we were going to do this and that. I actually hadn't done any paediatrics and I was open at that point in time to do some [*postgraduate*] course work. One of the people involved in presenting that course was a person who had worked in schools overseas. I can remember having conversations with her. A lot of that course was focused on assessment and establishing what a child's needs were. I can remember talking to her about schools and education and asking "how did you work in a classroom?" and - given that my experience at that point in time was the withdrawal thing, that kids would come to the physio room - I can remember her saying to me "just forget about the physio room. Just walk in the classroom and just do it". For some reason that sort of struck a bit of a bell with me, although at the school I was at, at that time, it actually wasn't possible. That just wasn't the structure of the way that school worked.

I see that Sandra's journey and subsequent process of 'unshackling' commenced prior to her arrival at MoE-SE. Metaphor (bell being struck) symbolises a significant turning point in her thinking, channelled by her post-graduate experiences which serve as a catalyst to bring into question the *how* and *why* of her practice. For Sandra, these experiences opened a door to the possibility of a new and different way of being a school-based therapist, one that involved 'doing it' in the classroom rather than withdrawal to the physio room. Continuing, Sandra reveals more of some of what this means:

> **Sandra:** In the late 80s the amendment to the Education Act came and at that point in time a lot of the kids at the school I was at moved into

> the neighbourhood [*regular*] school. … that allowed us to start itinerating [*itinerant service provision*] from the base unit out to the school. And it was when we came to do that, when there wasn't a physio room and there weren't curtains and beds and all the stuff, that you then had to think about doing things in a different way. You just had to do it differently. … there was travelling involved, there were no resources. The only resources we had was what the unit had. … so it was getting out and being in the schools and realising that if you were going to do this job you actually had to do it in a different way. And I think, at that point - I don't think I was thinking so much about the way we think today about participation and removing barriers - I think it was just having to think of another way of working. It was only when I then started doing more postgraduate studies that the barriers [*to learning achievement*] and that whole inclusive-participation thing started to make more sense.

In essence, it means doing things differently. It means swinging away from traditional ways of service provision via centre-based, hands-on therapy in a separate room filled with items symbolic of the rehabilitation model. It means being creative and innovative in the absence of any typically therapy-related resources. It means being an itinerant service provider who travels to many schools. It means going to the place where students engage in meaningful, purposeful occupations: in school-related tasks and activities, in school-based relationships. It also means enabling student participation at school and it is about student inclusion, including learning as a therapist to understand what this means in the education context. Most importantly, it is about contextualising one's practice. Just going in to the classroom and doing it has become a significant part of Sandra's practice of today:

> **Sandra:** I think the way it progressed was when my tutor said to me "just go in to the classroom and do it." It then became a stage of "okay I am going in to the classroom to do it. So I've got whatever resources and what I do has got to be classroom friendly". I had little kits of things that I would take with me to class, but there were a whole variety of things that I could see in the classroom I could use - we still went out and finished off the assessment out of the classroom. For quite a while I had these little kits I used to carry around with me. Now I've got to the stage where I carry nothing around with me, to the extent where I probably forget to take things with me.

Symbolically, Sandra has stepped beyond traditional practice by leaving her "little kits" behind.

Sandra's insights typify many of those of other participants in this study in that she captures much of how these therapists' values and beliefs and ways of behaving have developed over time. For some, engagement in post-graduate study has triggered their

thinking to change. For most, thinking differently about practice has been triggered by their professional experiences and critical reflections. In the field, I note that these therapists have moved beyond believing that therapy services are best offered by withdrawing the student from class. They see students in their classrooms, preferring to use classroom activities and materials as part of their interventions.

All of the participant journeys include practice insights triggered by a series of events and practice reflections which have matured over time. I recall this same journey myself, coming to the realisation that if my service provision was to be educationally-relevant, all I needed to take with me into a school was myself, my diary and a triplicate notepad. I, too, have left my typical occupational therapy kits behind, such as those used for remediating handwriting or hand function. Instead I opt to use the variety of objects, tasks and activities afforded by the school environment, in classrooms and in curricula and to address issues couched in the human environment of people and relationships. For MoE-SE therapists, the realisation is that all one needs to enable student occupations and participation in school resides within the physical, technological, spiritual, social, political and cultural contexts of the school community.

Thus, upon arriving at their new practice context, it seems that MoE-SE therapists find they must swim against the traditional tide, changing and adapting to their new circumstances as they become increasingly immersed in MoE-SE and the nature of its work. From my stance as researcher observing a culture in action, it is as if the therapists are setting a new direction for practice in schools and they are, perhaps, leading the way. They have crossed over into a new culture, sparked by insights into their prior practices on the outside.

Each therapist, whether knowingly or not, committed to step into a new practice context and organisational society, unfamiliar to those with health-based professional backgrounds. In a sense, these therapists have taken their respective professional cultures and their health-based thinking and transitioned into an *other* culture, situated in

the education sector and the employing organisation. In this other culture the language, customs, traditions and symbols are different to traditional medical model habilitation and rehabilitation perspectives.

Forging a Contextualised Identity

For the therapists in this study, residing in MoE-SE is willingly undertaken. An overt sense of excitement surrounds this:

> **Deb:** I actually find it quite exciting. Previously I've worked across health and education, employed by Health, but providing a service to where the student was. So, you are working in schools and are part of IEPs [*Individual Education Plans*] and very much part of education, but we were still health representatives. I think it's actually very exciting working for GSE because we are part of the Ministry. We are actually education professionals.

My sense is that the therapists perceive themselves as complementing their education colleagues, who, in turn, complement the therapists, like Yin and Yang:

> **Deb:** So we are sort of being transported onto the same team, which I think is really exciting. I think that it helps. It makes it a lot easier - it's exciting. It's generally very positive. I think we've got a lot to offer because we are education focused - I'd like to think we are education focused - but we bring with us the other side of the coin. We bring the perspective from the health field and we've got different knowledge to many members of the team, so I feel we have a huge amount to add to the team and to the students.

Deb values that her team members are education professionals. She also values that she adds value to the team with her background in health. Moreover, *teaming* (a local term used to denote being a member of an educational team and the teamwork this ensues) in this context forces and indeed demands collaborative ways of working:

> **Deb:** We are in teams. We are in skills-focused teams, so our team members are the people that we sit beside. I share an office with a psychologist and I don't have any other OTs or PTs in my office. So my colleagues are other professions. I think that certainly helps the collaboration and the interdisciplinary focus, and in schools as well. It's different from health where you are working predominately in a team of health professionals. Quite often we are the only professional coming from a health background working in an education team, so it does change the way that you work.

Yolanda supports this perspective, adding school staff into the team mix:

> **Yolanda:** We have a different set of skills and knowledge which I think really complement what teachers know. Teachers need to know what we know and we need to know what teachers know.

Thus, it appears that for these therapists, their professional identity is enmeshed in *being* an 'education professional'. Deb believes it is important for the MoE-SE therapist to not only be identified as an education professional, but also to identify as one. This serves to shift one's practice attitudes and is improtant, because:

> **Deb:** I think there are some people, when they are employed as health professionals in education, who just do more of the same. So I think there has to be some demarcation. I don't know how, but some sort of cleansing. We have to bring people in and wash them and say "okay now you are leaving that behind you. Right, now you're an education professional, and bring your skills and bring your experience, but leave your health professional label".

Deb clearly highlights that MoE-SE therapists need to do things differently, to not do what they always did in the past. In doing so, she implies that these therapists have their own norms and patterns of behaving that are different to health sector practice norms. Deb is also aware that there needs to be a process in place that would enable a therapist to get to this point of understanding. She symbolises this process by labelling it 'demarcation' and 'cleansing'. Such words conjure up the image of some sort of ritual for cultural indoctrination. However, in the context of the emerging culture, what Deb means is the process of enculturation (discussed in more depth in the next chapter). One learns culture by being enculturated. Perhaps enculturation has contributed to these therapists becoming supporters of inclusive practice.

Journeys towards Inclusive Practice

Throughout the transcripts and in the field, the notion of inclusion is a core value in the therapists' emerging culture of practice. This appears to be what has reeled them in, one way or another, to the MoE-SE context. Accordingly, references to inclusion weave in and out of all the interviews. All of the transcripts reveal this directional flow to the group's practice histories.

Collectively the therapists' experiences, underpinned by their common interest in building an inclusive society, form part of a larger societal journey. From field observations, MoE-SE therapists' practice behaviours simply expose their pursuit and expression of inclusive practice. Yolanda encapsulates this viewpoint by sharing the following:

> **Yolanda:** I've got this view that inclusion is a culture, and policies, and practice, so a little bit of each. Inclusion to me means that children learn in their local schools and they are part of the whole school environment. And all people in the school are learners. Teachers and people with disabilities have a huge teaching role. And so, schools cater for diverse learners and therapists understand the dynamics of, or the collateral effects of therapy in special education, and that sort of thing.

For these therapists, inclusive practice means placing the emphasis on building an inclusive culture, not only amongst students and teachers in classrooms and whole school communities, but also within MoE-SE. Sandra explains what the therapists have come to 'know', revealing the delicate nature of the path these therapists must walk at times:

> **Sandra:** As a person from the Ministry, I think we have to tread quite a fine line sometimes where the school community sees themselves, where they're at in their acceptance [*of the student*] and their ability to educate that student. And I think you can say the wrong thing quite easily and get people's backs up. So you have to be really careful too about assessing the - you don't just assess the student when you go into the schools you assess the school - you know. You look at the environment don't you, so whether there are ramps and toilets and that sort of stuff. But, you also judge by the way the Principal speaks to you and talks about this person [*student*] that may be coming to the school, or may be already there. How the teacher approaches you or the types of questions they ask I think gives you an indication of where this school community is at in its thinking.

One must possess skills in inclusive practice to be a MoE-SE therapist. Following on, Phillipa and Bonnie's vignettes further reveal the nature of participants' journeys in relation to aspects of inclusive practice.

Phillipa's Journey

Phillipa's inclusion view has continued to develop within her MoE-SE practice. Her story differs from Sandra's in that she attributes the beginning of her journey to an individual, rather than a series of experiences or reflections. She reveals how the culture is shared and transmitted from person to person:

> **Phillipa:** I was lucky because, I came here from the [*special school*] service and I had a wonderful [*occupational therapist*] tutor who has schooled me up and helped me to work in a way that is totally different to what I had ever done before as a physiotherapist.

I ask Phillipa what was different and she laughs, commenting:

> **Phillipa:** What wasn't different? I'd been working in a special school, hands-on with kids. Somebody else was telling me when I had to see kids, for how long, when I could do things. And it was basically hands-

> on stuff on the mat in the therapy room, day in, day out. And then to go out to regular schools and see kids who were participating in a regular programme.

Later in the interview Phillipa adds more clarity to some of the reasons for her shifts in practice thinking:

> **Phillipa:** My belief system has shifted hugely. When I first went to the special school and was working on-site I used to see children who had daily therapy and [*they*] were just as contracted [*shortened muscles*] and disabled as any other child really. I didn't think that these children were straighter, or better than any other child, even with daily physio, and so I decided then that that wasn't the answer. And then going to SES [*now MoE-SE*] and hearing another side of things. At that stage SES used to have a value system of inclusion, which I thought was pretty good, although I didn't necessarily agree totally with it. I've gone further along this line. The book that I've just read called 'Disability is Natural' really is a reinforcement of that value system. It's [*the book*] brilliant. Disability is part of life, and it's wonderful because it's been written by a parent. She calls therapy a "toxic antidote".

I wonder at the time how it would feel for therapists to have their therapy referred to as a toxic antidote. Strangely, neither Phillipa nor I found this label remotely disturbing during our *kōrero*. In fact, Phillipa's text suggests the contrary. She is excited by this book. How is it that such an abrasive and controversial label could sit right with us – members of professions that are the perpetrators of toxic antidotes? What was it about our thinking I wondered that potentially allowed us to embrace such a scathing term? I turn to Bonnie' story for a potential answer.

Bonnie's Journey

In this last vignette, Bonnie reveals the interlacing of personal and professional values, a characteristic seen in all the participants. Bonnie begins by sharing what it was like to work in a context where inclusive practice seemed less valued in her eyes:

> **Bonnie:** When I worked at a special school I struggled, I mean I accepted that they [*students*] were at a special school. A lot of them had tried regular schools and not survived, but I still felt that you could put some principles in place there. But you were up against the system. The teachers would write the IEPs and bring them along. Well there was no consultation. They often had IEPs, but they didn't try to make them at a time when parents could come. If you couldn't come on the time, we went ahead without you, and yeah, it was that whole way of working that didn't feel right.

It is as though Bonnie was mismatched with her old practice context. I ask her if she feels parents were being excluded, which she affirms, then adds, "it excluded therapists

too really, when the IEP is already written". I then ask if she felt there was much teamwork, consultation or collaboration, to which she replies "no" and continues:

> **Bonnie:** And lots of, I don't know, lots of things I didn't like. Like talking about the students. You would come in to a class and the teacher would have this huge discussion about students in front of the other students, as if they didn't understand. … I mean it might just be the culture of that [*particular*] special school. I don't know. That's my only experience of a special school.

Whilst it is important to note that Bonnie's description of the IEP process does not necessarily reflect the behavioural norm of special schools. In Bonnie's case her particular experiences seemed sufficient to trigger her to search out a practice context that would be more respectful of students' and parents' rights. Thus, like Sandra and others in this study, Bonnie's personal and professional experiences were catalytic. It drove her to seek a practice context where her own inclusive values and beliefs would 'feel right'.

Bonnie's experiences typify those of other therapists in this study. She wants to practice inclusively and she wants students to be respected as persons, not objects. Accordingly, the MoE-SE practice context offers a place for Bonnie's worldview to reside; a context where she may value students and act respectfully towards them, and where she may ensure that the parent voice is present at Individual Education Plan meetings.

Thinking back to my questions at the end of Phillipa's vignette, it seems that this particular group of therapists had previously found themselves in settings which made them realise they were no longer willing to be the perpetrators of toxic antidotes. It seems each therapist came to know that there is more to therapy, that practice can be more than this. And if this is so, I now see that these therapists' journeys have come to rest, not by accident, but perhaps by conscious choice in a practice context where, just maybe, they may turn the tide of the therapy worldview.

Coming Together: Altered Worldviews

As a group, the therapists echo agreement that their worldviews are now different. Indeed their worldviews have altered resulting in shifts in several of their previously held practice notions:

> **Yolanda:** My beliefs and values have changed.

This altered worldview, however, is not something that the therapists have suddenly woken to. Yolanda, for instance reveals a latent element to her journey:

> **Yolanda:** When I worked in a primary school they had an attached unit. We were on the site of a school and so we had classes for the kids with disability. The therapists really got to a point where we used to go in and run a lot of the programmes and we kind of said "something needs to change here" because there was no stimulation for the children. We, as therapists, had become the stimulation, because we were the young groovy things who came in and did nice programmes and had the nice equipment and stuff like that. They [*teachers*] were wanting more and more of the group therapy programmes, so it was like they needed more and more therapy. But it wasn't about the needs of the kids for therapy. It was about the need to critically evaluate the classroom that they were in and the mix, and ask "why did they have to be in that class because they had a physical disability?" … We kind of agitated at a low level over a period of time … and then those kids went into a mixture of [*mainstream*] classes. And then we got to explore how we might work in those classes. … That was kind of - well not the start of our thinking, but, I mean I've been really lucky, because I started working at a special school on a separate site, then the school moved to a regular school site, but in separate buildings. Then the disabled classes were closed and the students placed into mainstream classes, and the [*mainstream*] teachers took on the kids. Not willingly sometimes, but over time it worked.

Yolanda's journey of adaptation was triggered by changing circumstances and questioning her practice. It culminates in what she now holds to be true in relation to working with students in schools:

> **Yolanda:** And now I've come to work with GSE. And so it's like "okay all kids in the local school and make the adaptations and no exceptions, and let's just keep working until it works". And so I kind of have had the opportunity to come along with my view of OT in schools. But they do reflect like societal changes too, don't they? … There was a big push – SES, you know, for a long time while I was still in that special school, was running up the flag for inclusion.

Yolanda recognises that her insights into inclusive practice, along with the opportunity to work this way are freely expressed within her work as a MoE-SE therapist. She has unquestionably bought into the vision of inclusive education. At MoE-SE, she may unreservedly hoist the flag of inclusion.

Thus, like Yolanda, the evolutionary realisation that MoE-SE therapists eventually come to with mounting conviction is this:- ***going to school for students with disabilities or special education needs is more than about 'having therapy'.*** This thinking is echoed time and time again throughout the therapists' transcripts. Furthermore, I note that it resonates in the fieldwork site, like the constant hum of a generator providing the source for energy and luminous security.

Coming to MoE-SE has allowed these therapists to fine-tune their understandings of inclusion and to explore, expand and intensify their belief in inclusion. Accordingly, each therapist has developed a deep-rooted belief in inclusive practice. For all, the journey's end-point has realised and consolidated emerging practice values and beliefs. For example, they value students as rightful, active learners and members of schools and they de-emphasise the traditional focus on student impairment 'needing' therapeutic intervention. Such notions have been further shaped and honed by the nature of their work within MoE-SE, resulting in construction of an altered worldview.

For Yolanda, there is no question about whether a student should, or should not, be able to go to a regular school:

> **Yolanda:** I've seen the power of the whole school, the whole school catering for all school students. … I think the school should be getting ready for [*the student*] and that he should be able to go to school even if he can't sit up, or speak. Doesn't matter how he goes to school, he just goes, and he should be included. And we should help the school to plan how they would need to teach him and how they would need to prepare the other students and how they could do that in a constructive way.

Here, Yolanda puts the onus squarely into the domain of society. That the child has a disability or 'special need' is moot. Disability resides in society, not the student. This attitude fits with the NZ Disability Strategy (MoDI, 2001) and lies at the core of the bond which binds MoE-SE therapists, part of the substance which binds MoE-SE workers to the organisation.

> We live in a disabling society. … Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments people have. … Disability relates to the interaction between the person with the impairment and the environment. It has a lot to do

> with discrimination, and has a lot in common with other attitudes and behaviours such as racism and sexism that are not acceptable in our society. (MoDI, 2001, p. 3)

For the group, inclusion-related insights into the *why* and *how* of MoE-SE practice has shifted them beyond being the groovy, stimulating young therapists Yolanda referred to earlier. Having come to a place of seeing that there is more to practice, these therapists have taken up residence in an organisation whose global thinking fits with their altered worldview. They have bought into the inclusion narrative, not only at the personal level, but also at the professional and organisational level which include the settings in which they work and the legislative framework that frames the context. In addition, they have bought into the governmental level, where policies that espouse inclusion philosophy and policy are first pitched.

These therapists have become not only enablers of functional performance; their key focus is on fostering student participation and learning, filtered through the vision of inclusion and, therefore, inclusive practice. This is a group who zealously embraces the principles of inclusion. Accordingly, these therapists are passionate in their stance for inclusion, working within a legislative framework that emphasises inclusion (MoE, 1999, 2002a, 2003c, 2004a; MoH, 2001). However, whilst the group commonly shares this belief system, variation is acknowledged regarding perceptions and expressions of inclusion and inclusive practice:

> **Bonnie:** You see such vast differences in inclusion anyway, just because the legislation says this, doesn't mean it happens so.

Despite this, all the therapists in this study share the belief that students should fully participate in school life and belong to their local school communities, indeed to society as a whole.

They also believe that students with special education needs should be citizens of schools, with rights and responsibilities like any other student. Holding the inclusion flag high for sustained periods of time, years in fact in the case of some of these therapists, however, can be a troublesome task. One almost has to be a trooper:

> **Bonnie:** I pick my battles, but when I go in to bat, if I go in to bat for the student, if I think they are getting a raw deal, and there is, from what I see a reasonably simple solution, then I will go into bat and battle for it.

Nonetheless, these therapists set great store by the notion of inclusion, working hard to foster and instil such attitudes and values in schools. It can be wearying work:

> **Deb:** In a way I think that [*it*] could be made easier for us if these schools were given the hard-line and told "look you've got to do this, you've got to include students". In a way the Disability Strategy is sort of helping that because schools have to comply with it.

Whilst Deb knows that inclusion is a complex concept for people to take on board on many levels, she wishes inclusion could just be enforced in society. Life would be so much easier if it were. Suffice to say this is not that simple when attitudes are underpinned by people's beliefs, which in turn are linked to their own cultural or societal upbringings. How does one enforce attitudinal change under such circumstances? And how does one persevere when so few are running up the flag for inclusion? As Deb highlights, although there is government legislation to espouse the building of an inclusive society in Aotearoa/NZ, it is not mandated. Indeed, a system of beliefs can not be *enforced* on a society by Government, nor policy. To do so would be dictatorial and undemocratic.

Living and breathing inclusion philosophy as they do, reveals one of the reasons why these therapists embrace the principles of inclusion so passionately, whilst others do not:- if they [*therapists*] do not, who then would? Where would the hope and dream of inclusive society or inclusive schools be? It strikes me that one *has to be zealously committed to inclusion* in order to sustain such a belief system in the likely face of adversity. Perhaps such commitment and zeal is vital in order to survive in the culture and work context. Reflecting back on my fieldsite observations I wonder if once one recognises the collective worldview and vision of inclusion and inclusive practice, that is, *when one knows what the work is truly about*, inclusive practice falls into place.

Recognising Inclusive Practice

Given that inclusion is such a pivotal concept in their practice, I was interested to learn more about how they know when they are practising inclusion, or inclusively. For most

MoE-SE therapists, inclusion has become the filter through which they apply their clinical reasoning. Cherie, for example, chooses inclusion over therapeutic solutions:

> **Cherie:** Sometimes the most therapeutic solution is not the most inclusive solution for a student, but I will often choose the one that includes them over what might be [*therapeutically*] right as a therapist. For example, I provide a walker so they can get to the library at the same speed as their class, rather than use quad sticks which take the child twice as long to walk the distance.

This reveals a highly poignant point about the group's culture and subsequent practice behaviours. Cherie's decision making, filtered through her belief system, focuses more on participation outcomes than on what might be, in therapeutic terms, the 'next step' in developing the student's walking skills. Whilst one might question Cherie's right to make this choice for the student, it is not surprising that she follows this course of action since her vision is set squarely on ensuring that the student is part of his peer group when going to the library, that he is not lagging behind because he is practising walking with two sticks:

> **Cherie:** I keep the concept of inclusion in my head when thinking about what the student might need from me. I focus on their participation.

Pauline also works at making her therapy suggestions fit with the classroom context so that the student may continue to be part of the daily flow of class routines:

> **Pauline:** It means that a student with a disability is a student just like any other student. They just happen to have a disability and so the outcome effect is that they are included in normal daily life with some adaptations, because people have to make [*adaptations*]. … I promote those values. And I think I also know that I am working in that sense [*inclusively*] because I am not imposing things on a student or a teacher or a teacher aide that actually require exclusion, that require the student to be out of the class. I always try to be very careful to make suggestions that can actually happen in the classroom.

Similarly, Melinda is an agent for change in schools.

> **Melinda:** To me mainstreaming means that the child is fully integrated into an age-appropriate class, that the school is comfortable with having that child [*and he is*] part of the class. I appreciate that they [*students*] can't always do everything in the lesson that's the same, but they are with age-appropriate peers and if the lesson is appropriate, that they are part of it, with adaptations if necessary. Schools have different ideas of what inclusion is, but the child does belong at that school if these schools or teachers find it [*including the student*] easier, than others. I think that that [*happens*] over time.

Melinda is an inclusion ambassador for the Ministry of Education:

> **Melinda:** As more teachers get used to having students with disabilities in their class, they will find it easier to adapt the programme and accommodate. You know, sometimes there are schools when you first arrive and they say - that first question to you is, "don't you think they [*student*] should be at a special school?" and you straight away know that you've actually got quite a lot of work to do. That's the attitude that I have to either work through - not work with, because, I mean, the school knows that the child can go there, and I know through experience that they can be well integrated there, and the family has chosen [*the school*].

Melinda's beliefs about inclusion match those of her colleagues, as do her expressions of inclusive practice. Theirs is a vision for students with special education needs attending their local schools, being accepted for who they are. It is a vision for students being a natural part of the learning context, learning alongside their peers. Like others, Melinda believes her role is to foster and support the student's inclusion in the family/*whānau*'s school of choice.

These therapists hold a big picture moral overlay to their inclusive practice:

> **Sandra:** When I started, inclusion to me was the child or the student just being in that school. I think probably we might have called it mainstreaming back then - mainstreaming was more of a sort of "in" word to describe what was happening - but now, to me, inclusion is an individual's participation in society. It's what everybody does and what everybody wants. Everybody wants to be part of society, the society they live in, whether it's a small rural village community, or a city. People, regardless of their disability - they want to be part of the group of people around them and where they live. … and … the expectation of families, this is what happens to a person within their family who has some impairment to still be able to participate in things.

However, whilst they unanimously signal that theirs is a culture of inclusion and inclusive practice, it is still an emerging culture. A culture bereft of the written word to clearly articulate their 'different' practice beliefs and thinking. Yolanda calls the group and the organisation to account for this:

> **Yolanda:** I think we have done a poor job [*of articulating practice philosophy and actions*] and in a way our organisation has done a poor job in telling people about why we act differently in this setting. I don't think that we have given them any background information. We don't have best practice guidelines so we can't say that this practice is based on sound research. It looks like we are just a bit slack sometimes. And that's a shame because I think we could make a lot more progress if we could do some work in this area.

Perhaps, it could be said that theirs is currently a lived and emotive culture; one that is bound within a practice world where efforts combine to assist school communities to

develop acceptance of *all* students as learners. Moreover, it is a culture which aims to ensure that students with disabilities or special education needs are fully valued as active, integral members of their school communities. Here lies the force which draws MoE-SE therapists together and which drives their values and belief systems. Such notions are expanded upon in subsequent findings chapters.

Summary

This chapter presented insights into the nature of *how* and *why* the therapists journeyed towards MoE-SE, arriving at new beginnings nestled within organisational culture. The therapists now stand in a practice context that resonates with practitioners from a range of occupational groups who, collectively, strive to "make a difference to the lives of children and young people with special education needs" (MoE, 2004, p. 2). It is a context where the notion of change in practice is recognised and embraced:

> We live in a world that is constantly changing. The same can be said of the knowledge and expertise that shapes special education practice. Over time, practice changes as we develop solutions to old issues, come to grips with the latest research, analyse and measure the impact of our work, build up our skills and experience, and incorporate the knowledge and experience of others. That is the way it should be … (Barbara Disley, CEO, MoE-SE, MoE, 2004c, p. 2)

MoE-SE culture is a principled culture, underpinned by the special education legislative framework and a specific set of values and beliefs through which all service provision is viewed (MoE, 2004c; MoE-SE, 2005a). For these therapists there has been an awakening to an altered worldview. Their emerging culture of practice is now informed by the education system and inclusive practice, driven by the notion of inclusion.

The next chapter addresses their enculturation as MoE-SE therapists.

Chapter Five: Becoming Enculturated

Tevita – aged 4 (personal photo)

Introduction

This chapter addresses the notion of enculturation, a key cultural construct revealed in the findings of this study. As it is for my cousin Tevita (pictured above), who was born into a Pasifika heritage, enculturation is the process through which he will learn his culture, one that is shared, taught and transmitted amongst his family members, his community, and the Tongan society to which he belongs. This is what happens in all societies and all cultures. So too, was my own Pasifika (Pacific) enculturation, now fused with western or rather *pākēha* (European) perspectives.

In this study, enculturation is conceived as the process whereby members of the MoE-SE therapist group learn to act, think and speak in socially appropriate ways as defined or judged by the group (Cockerhan, 1995; Fratkin & Bates, 1999; Haviland, 1999; Miller, 1999). This process renders each and every MoE-SE therapist fit for living (practicing) in the company of others, that is, amongst their colleagues in the organisation and their school-based practice contexts. To this end, this chapter aims to present aspects of enculturation through which the therapists' emergent culture of practice is seeded and cultivated. The process of enculturation is conceived as the means by which the group's

culture emerged and may continue to flourish, despite the challenges of their practice context.

Birth into a New Culture

When the therapists in this study joined MoE-SE they were born into a new culture which they have had to learn, albeit they may not have been aware that this would be the case. In light of data presented in the previous chapter, for some of these therapists the values and beliefs underpinning their emergent culture are not new to them. For these therapists, likened to pioneers or innovators of the culture, their journeys were more about seeking a practice context or work place that was in line with their already shifting belief system.

Others, however, were newly born into the culture, thus their learning was akin to the unwitting cultural learning a baby is exposed to when born into a particular family context or ethnic background (Bates & Fratkin, 1999; Haviland, 1999). For instance, Tevita (pictured) as an infant could not have predicted nor sensed his culture, yet his enculturation began from the moment of his birth. Tevita has been observing and experiencing culture, learning from being fully immersed in day-to-day acts of culturally-driven patterns to a point where he achieves *cultural fit*. This process also occurs for MoE-SE therapists on joining MoE-SE.

Beginning Cultural Fit

Having been immersed in the fieldwork site for many years now, I speculated that like the infant, each therapist has had a birth point of entry into MoE-SE. At their point of entry, despite spending most of their practice lives in another culture (primarily shaped by health sector perspectives), each therapist engages both consciously and subconsicuosly in pursuing cultural fit in the new context, weaving together the many strands that now form their collective sense of who they are as a group of MoE-SE therapists. In doing so, the therapists have had to sift and sort their health-based notions, discarding those which do not fit their new culture, whilst keeping those deemed most meaningful, to interlace

with notions from their new way of thinking. Some of this may have occurred during induction.

In most organisations, induction or orientation is a common, routinely occurring event that serves enculturation to some extent. Induction may be likened to a form of ritual indoctrination. Such events may be formal as well as informal in nature. For example, common formal induction rituals for my MoE-SE District Office are the mandatory *powhiri* (formal welcome ceremony) or *mihi whakatau* (less formal welcome) and the workshop on the Ministry's *Code of Conduct*. Informal induction activities include meeting with the Human Resources officer to run through pragmatic and logistical issues, plus a 'meet and greet' walk around the office. Events such as these serve to induct workers to the work community and organisational culture, thereby setting the foundation upon which all professionals will situate their respective practice ideas, values and beliefs.

Over and above routine organisatonal induction strategies however, the therapists in this study perceive a need for a further formal induction process. Earlier in Chapter 4, Deb referred to an initiation process that extends beyond organisational induction, one that is *therapy-specific* and *contextualised.* In the main, current therapists' enculturation occurs via informal processes, where locally-made induction packages supplement District Office induction programmes:

> **Tracey:** We have an induction programme with all new staff here and any new OT spends time with all team members to get an "across the team" feel. We have some old hands at inclusion in our office who all push the theme! New therapy staff spend time out on visits with me or the PT first, before they get their caseload. They have time with Assistive Technology Coordinator regarding equipment applications and she is hot on linking with the curriculum.

Locally-designed packages, tailored to therapy perspectives, are perceived as helpful by the therapists:

> **Jackie:** The introduction pack put together by the OT/PT MOE-SE Lead Practitioner has been very useful.

However, ad-hoc induction systems are just not enough:

> **Phillipa:** What we give people when they come is, you know, some articles and things, it's not a philosophy. It's probably stuff that we've put together ourselves. And each office is different. … What I would

> like to see is something; a lot of written stuff and a formal induction or a formal process that people could go through to develop things, particularly with the physiotherapy skills that they need in GSE.

Sharing the Culture with Each Other

Coming together for formal, contextualised, therapy-specific induction regarding the group's social structure, norms and practice is seen as necessary by the group. It is seen as a vital part of learning to practice within the accepted culture. In the past, such induction courses were offered on two occasions (Simmons Carlsson & Caswell, 1999, 2001), but are not routinely provided by the organisation. The therapists, however, value formal induction, believing it to be a space and place where new therapists may be exposed to the shared practice values, beliefs and patterns of behaving and thinking as a MoE-SE therapist. Absence of this type of induction is, consequently, voiced by participants as a need:

> **Phillipa:** It would be really nice to have some formal sort of educational training, not only for PTs and OTs. … Probably we, because we are experienced when we came in - it's easier for us to actually start down that journey, but for some of the younger therapists, for them, it's really difficult. So I definitely think we need this therapy training. It would be really nice to have it as a pathway.

Sometimes, however, early exposure to formal concepts which fit within the groups' culture may not work:

> **Tracey:** I sent the last occupational therapist to the workshop on inclusive practice by Anita Bundy. In hindsight, I think it was too soon for the new OT.

Sometimes people are just not ready to be enculturated. Tracey hints at the notion of cultural readiness. Thinking back to the first findings chapter, it strikes me that perhaps for each therapist in this study, their pre-MoE-SE journeys were part of achieving cultural readiness, such that when they stepped into their new practice context, they were already set to weave the beginnings of the tapestry that was to become their culture of practice.

According to Phillipa, the organisation has "an expectation that they [*therapist*] will come and just start working," however, she adds, "I know they've come from way away from where we need to be". For the group, however, this is an unrealistic and perhaps naive expectation on the part of MoE-SE:

> **Phillipa:** I don't think people can just come in and just do it. It is a big stepping on thing and I really feel sad … it takes a long time to get to that. And if people aren't taken through the path and they are working in isolation, then they mightn't be sort of joining us on that pathway.

Like others in the study, Phillipa reveals tacit *knowing* that practising as a MoE-SE therapist does not come about purely because one has stepped into the job. Nor does it come from participating in the organisational induction programme. On the contrary, the communal cognisance is that an additional induction process is paramount for facilitating therapists' learning of the *how* and *why* for going about their jobs. Knowing such things leads to a clearer identity of *who* an MoE-SE therapist should be and *why*, as well as *how,* to behave in a manner consistent with the culture and the practice context.

That the therapists in this study tacitly know this process is necessary suggests that it has occurred for them. Furthermore, this type of induction is seen as a vital part of communal activity for socially nuturing new entrants into the culture. A right of passage, so to speak. Rightly or wrongly, the group's stance is that new therapists should not be left to find their own way, they should be supported, and they should be shown the way:

> **Deb:** I think it's just, I think there is a paradigm shift between working in health and working in education. And I've often thought about how to help people make that shift. And I think it's quite scary that they [*organisation*] leave people [*therapists*] to do it on their own and not guide them. Because if, I think, you don't help therapists to do that, then it will (searches for word) - damage their reputation … it reflects on all of us.

These therapists wish to build their culture. They are also protective of it. They wish to preserve it and help others to understand it and learn to live it. But it is still an emerging culture, tentative and mostly invisible, imbued with meanings that often appear hidden to those on the outside.

In the main, theirs is a spoken, rather than written culture, primarily articulated through the group's words, actions and their emotions, a lived culture. It is a culture yet to crystalise:

> **Deb:** I mean, I know there are things written, but there almost has to be some sort of - like a position statement - "This is where we stand! This is where we collectively agree that we think and do". And you almost have to induct people into that through some sort of process, not necessarily showering and stripping, but some sort of, you know,

> like a course, or like, people have to do this five day course. … It's a very sensitive issue because most of the therapists we have are experienced and it's not like – in some ways it's almost better to get a new grad [*graduate*] and then you can indoctrinate them – it can almost be even more difficult with experienced therapists who have got lots of experience - just to help them make that pradigm shift (trails off).

Here, Deb illuminates the process of enculturation, that is, the process of learning and transmitting culture from person to person within a group. There is general agreement that one cannot come in to MoE-SE and just do it, even though the first pioneers or innovators of the emergent culture had to come in and do it. One must learn the culture and one must be brought up in it, immersed over time. The group's stance on this is unanimous; they all express a view that shared learning serves to bind the group, as well as cement their shared identity and practice focus. Engaging in a learning process renders each new therapist fit to practice as an educational professional. Thus, it appears that enculturation allows both the individual therapist, and the group as a whole, to explore and learn how to act, interact, think and speak in ways that are socially and practically appropriate to their new practice context.

These therapists also set store in having a formal component to enculturation, recognising that shifting cultures or practice paradigms may not be easy for everyone. As a community, the therapists are bringing each other up, enculturating each other through a range of methods. Cherie, for instance, uses a broad range of strategies:

> **Cherie:** I talk with them, [*do*] joint visits. They come out to schools with me. I go out to schools with them. I get them to peer review my work; provide their supervision, present case presentations to them for example at the District therapy team meeting. We have an induction process that we work through over the first term. This is supported by an induction folder and some PowerPoint presentations on curriculum, inclusion, and working with students on ORRS. We have termly *[once a school term*] District therapy team meetings.

Liz uses "role modelling, joint visits, peer review and reflective practice". Supervision is also highly valued by the therapists, as by the organisation (MoE-SE, 2005b):

> **Tracey:** Ongoing supervision for new staff from me and the PT is offered … We still have to remind our staff about expert versus the collaborative model … It's about being consistent about what you provide, to whom, where, and time … continuity of practice … taught on to the next OT.

Alternately:

> **Jackie:** If supervision … is not frequent enough for sharing knowledge and asking questions and reflecting on practice ... set up a buddy system … which would mean the new therapist could really ask, discuss everything which she/he might not want to put on the email link.

Technology also offers an opportunity for enculturation to occur. For example, being connected via the MoE-SE therapists' national email LISTserve allows the community to connect over geographic distance:

> **Phillipa:** I think having the OT/PT GSE email list is really good because you see a lot of practice reflected on that.

'Speaking' via email seems to sit comfortably alongside speaking face-to-face for these therapists. The LISTserve offers the group a means of engaging in "questions and conversations about practice" (Yolanda). In the field, I note that 'e-conversations' are, in the main, always respectful of others opinions, reflecting a core value held by the group.

Scheduled meetings also serve to connect the therapists locally with each other. These occur in the Districts as well as in the Regional areas:

> **Cherie:** We have termly regional therapy team meetings. At these meetings we try to have open time for discussion about issues. I try to make sure there is some practical school-based "how do we do it" relevant time in these meetings.

Local OT/PT meetings act as important events for helping each other take on the communal thinking of the culture, as well as a place for passing on of culture. Such meetings are akin to when tribal generations huddle around the communal camp fire. They are symbolic of a community bonding ritual, where the sharing of stories about practice life and culture occurs. Accordingly, these meetings serve to strengthen social relationships amongst members of the therapist community, as well as across generations of 'new' and 'old' members.

In the field, I noted that these gatherings are times where professional histories, specific to MoE-SE ways, are shared and where cultural notions are explored and cultural norms and rules adjusted to fit with the group's changing circumstances. In this way, the group's values, beliefs, customs, practices and traditions are debated and refined to

become expressions of the culture's foundation narrative. In addition, such gatherings serve the transmission of culture, as well as to sustain and maintain order to the group's social structure for all members. They also serve the purpose of housekeeping practice and culture, routinely keeping both elements alive for all MoE-SE therapists.

Emerging Cultural Markers

Findings from this study reveal that the process of enculturation enabled the participants to begin to weave a way of being and practising, informed by several factors. These include their experiences and interactions with each other, the organisation, the special education legislation, and increasing demand for social justice in the education system.

Embedded at the core of this cultural tapestry lies the founding strands which mark the culture, including a deep-rooted belief in inclusion and the collaborative practice this ensues. Theirs is a culture infused with inclusive notions, a culture of inclusive practice that strongly identifies with social justice and fostering student citizenship in schools. As emergent culture, it is bound up with attempts to change societal attitudes towards disability.

It's about Inclusion and Inclusive Education!

Enculturated by inclusion philosophy, these therapists have bought into the vision of inclusion. Inclusion is at the heart of their practice reality, enmeshed in their practice behaviours and reflected in their values system. Because of this, being confronted with a school that may not act in accordance with an inclusive worldview can bring out the inclusion activist:

> **Bonnie:** Students belong not just in the classroom, they belong where everyone else is! Because I don't think having a student in the classroom at a desk against the wall when everyone else is in the middle of the room is - I mean the student may as well not be there I think - that's not inclusive. … let other students share the space or have two or three places where students can go for that. Not just take this one student and single them out.
>
> **Cassie:** Children with disabilities have a right to be out there in the world rather than shut up in a special facility. However, having said that I think that there are some students with quite complex disabilities

> that possibly need a more protected environment, but I believe that all children should at least try the regular school environment, and they have a right to be there.

Underneath the activist lies the vision of student inclusion and participation:

> **Yolanda:** We work within teams to ensure that children are able to do what they need to do at school. I think a key skill is to design enabling environments. So we are looking at adaptations that might be needed to the physical or the human environment … that would enable them to participate or to perform tasks at school.

Alongside this sits the drive to foster such phenomena in schools:

> **Yolanda:** So they are thinking and planning their curriculum for diverse learners … they are planning for diverse learners. I guess because we have seen it and we have been a part of it, it's something that we believe in, is possible, and we want to pursue it and make it possible.

In the fieldsite, this steadfast belief in inclusive education observably underpins MoE-SE therapists' practice behaviours. Following this path appears to bring joy and satisfaction to the participants' work:

> **Phillipa:** I really enjoy my work because I think we can make a difference. We are not just standing there holding a pair of hands. We are trying to guide them on our path - which I firmly believe is the right path for the child - to take part in school, as much as they can, not to be taken out of a learning situation to do something that's probably of no benefit to them whatsoever.

> **Sandra:** I think that the satisfaction is more than just my personal satisfaction … I find that I get the satisfaction from that whole group of people feeling that we are supporting [*the school*] in doing a really hard job.

It seems that this staunch belief in inclusive education anchors the therapists to their work:

> **Cassie:** I obviously have a belief around inclusion otherwise I wouldn't be working here.

Accordingly, as a culture of inclusion, the group's assessment and intervention strategies become culturally driven. They focus on *enabling learning* and *participation*, two further cornerstones of the culture, and therefore, practice:

> **Cherie:** I try to work out what I can provide that is best going to help the student participate in school, being there and being the best learner they possibly can be. … Often by the end of the discussion, they [*school*] have really understood where I am heading and have already made additional suggestions to what I have made.

Assessment and intervention strategies, therefore, involve naturalistic observations of the student participating in school tasks and school life. For instance, Bonnie is not just observing and analysing *what* the student can or can not do in a classroom:

> **Bonnie:** When I start doing classroom observations, the things I am looking for are whether the student is actually participating in the learning, the same learning as their peers. Where they are sitting in the classroom, how interactive they are with other students? How does the teacher engage with them? How does [*teacher*] treat them compared to other people?

Bonnie's role is inherently imbued with identifying inclusive practices in a school. Her observation lens is coloured by her 'inclusion eyes'.

Ensuring student participation, therefore, sits at the forefront of these therapists' practice. It has become the primary filter for their clinical reasoning and their actions in their particular practice context:

> **Bonnie:** One of my goals if I see that [*inclusion*] not happening - that will be my first goal. How can we get some more of that happening? I would start there and forget about everything else, that would be the first thing I would tackle. Yeah I think too the language that's used, the way other students behave towards the student. Looking at whether teachers talk to the student the same way they talk to everyone. Are they just one of the class and does the teacher just do a circuit and tap the student on the shoulder and say "that's lovely work" and keep going, just like they do with everyone else? You know, how are they regarded in terms of sharing the teacher's time? Those sorts of things, and the language that other students use - because I think they model that off the teacher.

Brokers of Inclusion

As a principle, inclusion is a non-negotiable, wholeheartedly embraced 'given' for these therapists. Therefore it ensues that MoE-SE therapists will strive to bring about inclusive principles and practices in regular schools. This aspect of culture is imposed not only by the employing organisation, but also results from government policies. As members of the wider organisation, inclusion is *the* revered characteristic of the group's culture of practice.

By all accounts these therapists are brokers for inclusion. Inclusion is *taonga* (treasure), *taonga whītiki* (prize) and *taonga tuku* (legacy) of both culture and practice. Yolanda takes great pride in this aspect of her culture:

> **Yolanda:** There is a huge pride in what we do … there is a huge pride in the inclusion [*of students*] in the area. I really like that schools remind me, "we can't do that because that would mean that the student is always away from their friends and that's why they are here". It's [*inclusion*] the philosophy and the strength of the team and also of the schools.

Moreover, brokering inclusion and bringing about inclusive change requires MoE-SE therapists to take up the role of *educator*, not, however, as educators of students, but of those who interact with students.

This is a societal role that MoE-SE therapists don. Change in others is the expected outcome, not just of the individual, but also of society:

> **Bonnie:** I think our big focus is really on educating teachers to understand what their [*students*] needs are. I think my focus [*is*] getting the teacher to change rather than the student and I think that's probably my prime focus of my practice.

As an inclusion educator of others, Bonnie's role is akin to being an agent for change in school communities. Her ecological focus shifts to the teacher-client, one who is part of the student's environment. By ecological approach I mean students' needs are considered in context, from the micro (classroom) to the macro level (school system, sociocultural, political levels). Bonnie takes a socio-environmental perspective on the student's needs, that disability is 'in society'. She therefore shifts away from the notion that the student is the needy one, to seeing the teacher as in need of education and support in relation to including the student in education.

From observation in the field I note that this is an aspect that all MoE-SE therapists know they must attend to when they practice. They also know that effecting change is a cyclical process: "The teachers usually change every year for the student" (Jackie). It is a process that restarts with each new transition a student encounters in the course of their entire schooling life, with each new teacher, with each teacher aide, with each new group of classmates and school community. A change process that begins when a student first

enters school at the age of five and exits, some 13 to 16 years later given that some students may stay at school till the age of 21 years.

As agents for change, MoE-SE therapists recognise that the educator role also involves ensuring schools are informed about special education policies and that resources are appropriately used to support students at school:

> **Cassie:** One of the principles [*of practice*] would be about being knowledgeable about the funding structure and giving that information to the teacher, so that they know that there are other supports around. And at the same time if the SENCO [*Special Education Needs Coordinator*] isn't feeding that information down [*to others in school*] then being in a role where you're actually saying: "Well, what is happening with [*resource*]? Could this be used that way, or could the [*Specialist*] Teacher release the class teacher, so that the he or she can have time with the student, or with me?"

This requires the therapists to be fully knowledgeable and conversant with legislation, so that they may guide others in just application. This aspect seems paramount in the culture, revealed in the interviews, expressed in the patterns of behaviour observed in the field and in their enculturation of each other. These therapists believe that one must *know* the special education legislative framework, one must *know* the NZ Curriculum framework and one must *understand* the education system to be effective practitioners in the regular school sector.

There is, however, acknowledgment that it takes time for attitudes and perspectives to change in schools and, indeed, in society. Sometimes, the process of change takes years:

> **Cassie:** I think it's taken six years to get some schools, students and families in that space. They're now the schools with students where they're not ringing us up a lot, and when they do ring us up it's really clear they've thought it through beforehand and they've rung us up, not as a last resort, but "hey we now need you to be part of our problem solving around this particular issue for this student". But it has taken a long time. It's taken six years for us as a team to get there. If we were resourced properly it wouldn't take as long. So yeah, and it's taken six years to build the relationship with schools on an itinerant basis.

This is not surprising since the reality of bringing about societal change is complex. There are many barriers to effecting change, including the reality of being a part of an emerging culture:

> **Pauline:** In other contexts [*referring to special school*] people seem to know quite readily what you were about, whereas, because in this job you provide a service to support children in the education system, it is not so clear for people who the client is and what our role in that respect is, because it is so new. So you need to educate around that role much more than you need to do in the other contexts. I think that it's important to educate. So let the schools, the teachers, but also the parents know what our role is. It's very important to communicate and unfortunately you don't see the hand-over from one year to the next. We are going back in starting again each year, so you have to start again.

One must be prepared to have "stickability", to be "in for the long haul" in order to reap the *taonga* (treasures) of societal change, or one's work as an MoE-SE therapist.

Educating around role shift

Part and parcel of being an educator also involves educating others to understand the altered role of the MoE-SE therapist. A role that has shifted beyond that of traditional therapy:

> **Cassie:** I guess there's a general one [*role*] in terms of educating school staff on what your role is, you know. A simple example, "I'm not here to take Johnny out to work on his hands, I'm here to actually see how Johnny is doing in the classroom, see how he fits in your class community and see how the curriculum, what and how he accesses the curriculum, and in order to do that I need to be in the classroom.

Liz states, it is "important to give clear explanations of my role so that there is no confusion as to how I work within the school environment". Addressing role clarity also serves the building of relationships and attaining shared vision with clients and amongst team members:

> **Cherie:** We all need to understand what our roles are and how we all fit together as a team. There is no point in just pushing our own ideas forward. We need to listen to each other and be prepared to let go of some things that we feel are important, that are not necessarily the most important thing for the child [*student*] at the moment.

In her MoE-SE work Pauline believes that "you need to educate around that role much more than you need to do in the other contexts" in order to reach a state of role appreciation. Explaining one's role to others becomes a natural part of the practice process:

> **Melinda:** A lot of it is explaining to school staff why you are doing what you are doing, but also why you are asking them to do what they do. There is a lot of education around physical disabilities … so people understand disabilities. I find that even over 12 years down the track at mainstreaming, some schools still haven't met students with

> physical disabilities. A large part is explaining how the disabilities impact on the student.

In addition, Sandra believes MoE-SE therapists must learn *how* to articulate their role so that others may understand:

> **Sandra:** I think it might be the way you sell it. I think for some schools it might be a bit threatening to have this group of specialists coming in and tell them what to do. Other schools might ask for it. And I think that makes all the difference.

Thus, being inclusion brokers and educators are important characteristics of inclusive practice. Moreover, these roles are deemed necessary by the group to support schools to understand their students and to become accountable for all students' learning and participation. Both these roles require establishing relationships and strong collaboration with others.

A Culture of Collaborative Practice

Based on the findings, for MoE-SE therapists, theirs is a culture of collaborative practice, a frequently espoused tenet in all the transcripts:

> **Deb:** I think that commitment to being collaborative; I think that is really important.

Such practice is also upheld by the organisation (MoE, 2004c). Collaboration is an "aspect of everything that we do," Deb explains to me, "it underpins everything".

School-based practice for these therapists, therefore, relies on collaboration involving partnerships and the artful dance of consulting, communicating and negotiating. Collaborating is at the forefront of their practice behaviours:

> **Melinda:** Once a child has been identified, I meet with the child, the parents, carers, school staff and together collaboratively coming up with some goals that can be met.

In the field, collaborative practice becomes recognisable for these therapists through working in equal partnerships with others who have diverse experiences, expertise and perspectives. Such others may include MoE-SE colleagues, the student, teacher, support worker, family member, the Principal, an outside agency, or another division of the MoE:

> **Deb:** Being collaborative [*means*] just taking into account the rest of the team's priorities, taking into account the teacher's priorities, the

> student's priorities, and well, there's the family's priorities as well, and not going in there with a fixed idea. Really working together to problem solve around what's best for that particular student, and communicating effectively as well. Not just saying "oh this is what I think, do this".

The aim is to combine and design shared approaches to intervention. Thus, in addition to their focus on environmental and participation outcomes, MoE-SE therapists focus on achieving decidedly collaborative outcomes:

> **Yolanda:** Generally I think that our behaviours need to be highly collaborative and we need to understand the occupations that kids engage in at school and we need to carry out our assessments in relation to those, but in doing so, we need to really collaborate and in some ways to walk with the people who work with that child. We need to try and get into their shoes and understand why the difficulties may be experienced in order to put our OT programme or suggestions into place. So I think that it's that collaboration, and to put our skills and knowledge into context of the child's life, the school's life, and the GSE team. To work with other team members so we don't just deliver OT services. … We need to think occupationally and we need to collaborate and we need to think about adapting environments to meet needs.

Although Yolanda uses the metaphor of 'getting into another's shoes' in the above excerpt, what she really means is the process of taking time to get to know where somebody is coming from, since one is never really able to see a point exactly from the other's perspective.

In effect, these therapists aim not to dictate or impose what they think should happen as professionals:

> **Leanne:** Every one working with a child, no matter how inexperienced, is an expert in some aspect of the child and the needs, and therefore has important information that needs to be contributed to the whole picture.

Instead, they formulate professional impressions and draft plans, seeking out the ideas and opinions of their partners, given that these are the people who will ultimately carry-out intervention suggestions in schools. To do this, the therapists consult and collaborate with others to arrive at mutually agreed upon solutions, openly seeking others' opinions. They have learnt to to trust others' perspectives in relation to what may or may not work for students. Mutual understanding and mutual action is the desired outcome of this way of being. The expectation is that change will occur in the school environment to the benefit of the student. Sometimes, however, this outcome is hard to achieve:

> **Deb:** I think collaboration is one of the foundations [*of practice*], but sometimes it can be really difficult to do that. I make it difficult as well. But with some team members it's just really difficult to have that collaborative process. And sometimes you think it's much easier to just work on my own and do what I need to do, rather than trying to get that person on that same level … I know that's not in the best interest of the student, but sometimes it's the only way that we can do it. I know that's not ideal, but sometimes it's too much in the hard basket to work through that collaborative process.

In the culture, high importance is placed on collaboration. Indeed, collaborative practice is a pivotal component of the group's behaviours. For Yolanda, collaboration *is* her mission:

> **Yolanda:** It's about negotiating and working out what the priorities of the school and the child and the family are, and then working to achieve those. Often that means standing back. And so the collaboration might mean that I'm not important now, or that I'm not going to do anything for a good reason. I want the school to own the child and I want them to work with the child and feel confident, so I don't want it to be about occupational therapy.

As Yolanda explains *how* she collaborates to me, I note that this is a role in keeping with consultancy or rather *collaborative consultation*. Like her peers, Yolanda is duty-bound to collaborate, to consult and to communicate in a particular way. Accordingly, one aspect of collaborating is about coming to a place of understanding that perhaps the therapists does not need to do anything for the student as a member of the team. For instance, in the above excerpt Yolanda saw that she was superfluous at that moment in time. However, she is comfortable with this notion, couched in the collaborative partnerships which she has formed with others.

A Culture of Communication and Consultation

For this group of therapists, communicating and relating also symbolises the culture. "Communicating is the basis of everything!" Pauline tells me emphatically, but as Leanne points out "communicating requires time". Pauline sees communication as part of quality service provision:

> **Pauline:** The [*other*] key thing in providing high-class service is ensuring that adequate time is allowed for communication between all the people who need to share information, especially the class teacher. It sometimes feels as if I spend more time talking to people, or communicating via email or telephone messages back and forth than I do actually working with the student. It is important to have the time to do this to provide the best co-ordinated and comprehensive service possible to the student.

Beliefs and attitudes about *how* and *why* one communicates are plentiful. These therapists strongly value others' viewpoints and contributions, recognising and appreciating that others may have different worldviews to theirs. Because of this, they believe it is important to treat people with sensitivity and with dignity:

> **Melinda:** It's just learning how to communicate with different people. I want them to feel comfortable so that they can come to me at any time. I don't want them to feel pressured or that they can't ask questions, or, yeah, they [*parents/whānau*] are comfortable knowing that I might be going in [*to school*], even when they are not there, to spend time with their child, and that they feel comfortable about that.

Communication is also a valued process of *listening for*, *talking with*, and *getting alongside*. It requires *taking the time* to engage in communication, in listening:

> **Liz:** Listen! Listen! Listen! It is important to hear others' perspectives of what the problem is before offering a solution. If you offer ideas based on your own perception of the need, you may be missing the point of what the actual problem is and therefore not responding to the actual need at all.

It serves the process of getting at 'how might I best serve you (the client)':

> **Sandra:** Talking <u>with</u> not to, and listening … I think it's being able to get alongside and being able to problem solve with them [*student, family, school staff*] and not, "this is what I've come to do". Rather say to them "what can I help you with? What have you seen? How's it going for you? Is there anything I can give you some assistance with?"

Thus, communication is about *listening for* and *honouring others' perspective*, a 'getting at the heart' of the other person's stance. It is a process that requires a humble approach:

> **Deb:** It's listening to all points of view, to everyone equally. Sometimes easier said than done I must say. ... I think it's something that's learned over time. … And I think part of it is maturity [*as a therapist*] as well. Realising that you don't know everything, and quite often the teacher aide has got a much better solution than the one than that you came up with.

One must therefore allow the process of communication to take its course. Such concepts remind me of what forms the crux of being a consultant (see Appendix 19).

In the field, I note, too, that the respecting of others and taking time with communication is embedded in the therapists' collaborative practices. Sandra explains what this means to me:

> **Sandra:** I think it all comes to that word respect. That if you take the time to know where somebody is coming from, then the other things should fall into place.
>
> I think the really important thing is the encouragement to talk to people and to talk to people outside your discipline. Talk to the other people who are involved because they are the holders of a lot of the information about that person [*student*]. You need to talk - that's the one thing that I think perhaps people coming into the organisation who have worked in a health model where they've had their relationship with the patient who comes in and then goes again - they find the hardest, that talking to a whole range of people, gaining information from them, and valuing it, and knowing that it's actually important to what you are doing.
>
> I think the other risk of that is that they could all be passing different messages on which could end up in everybody being confused. So the need to talk is to find out what they are saying. You know, "are we all moving along the same track?" Even when you have got the same goal, you sometimes don't all mesh together in the way that you are doing it, so "are we saying the same thing? Are we understanding how each of us can bring our particular skills to bear on one particular goal?" I think that's why you have to talk. … you'd expect as a result of the talk for you to change something about what you are then going to do in the school … I think everybody gains.

Thus, expected behaviours for collaborative practices include MoE-SE therapists emulating the following values:

- Teaming and working in partnership
- Respecting and valuing others
- Being ecological in one's approach to assessment and intervention
- Being collaborative
- Being inclusive
- Communicating sensitively, and
- Listening to *and* hearing others' voice.

These ideals form the foundational structure for social rules around collaborating, consulting and communicating in the MoE-SE practice context.

Indeed, these therapists are enculturated into being collaborators, consultants, talkers and listeners. They value communication and they work hard at it in their relationships,

seeing it as crucial for understanding others points of view and more importantly crucial to achieving best match of service:

> **Phillipa:** When you are working with people, what I like to do as much as possible - and I'm not always good at it - is to listen to what they are saying because usually, if I tried to tell them something, it's important to actually get hold of where they are. There is no point in something that's so far removed from where they are that they are not going to do it. So you've got to come together a bit, or you've got to shift more than them initially and hope that you shift them a little bit. What I try to do is listen to where they are then try to put something in that moves them slightly. I like to talk about things too, but I think all the talking in the world, if you are poles apart, can be very difficult.

A Culture of Relationship

Couched within collaborative practice the group recognise that relationships are socially constructed and therefore they take time to build:

> **Liz:** Effective relationships are essential in order to work effectively with students.

Social structure is founded on respect, trust, partnership and understanding the perspective of others. Such values essentially underpin their practice behaviours:

> **Cassie:** Sometimes I spend all my time just working on the relationship, respecting there are good and bad times to visit [*school/class*], keeping the teacher informed at all times, listening to the teacher aide - model for them or provide them with sufficient information and strategies that will make their work better with the student, modelling for them that the teacher is responsible for the [*student's*] learning … simple things like, you know, be polite, be respectful, ask.

There are particular ways of building relationships that work best in the minds of the therapists, expressed in terms of 'walking with' and 'talking with':

> **Cassie:** It's all around communication isn't it? There's a way of building a relationship. I think you need to start by building a relationship on equal footing … I have to behave in a way that respects where they [*the teacher*] are, that will let them know that I'm going to walk with them and find solutions, rather than chuck a solution at them and just say "this is what I think you should do". There's a way of communicating and establishing the relationship and trying to work towards that, I guess, mutual respect and mutual trust. … and together we can come to a solution that works for them. Because at the end of the day, I go away, and they're left with "what do we do and how can we assist this student of ours". I learnt to do that very quickly when I started. Nobody wants you to come and tell them what to do. In actual fact the road to success is much easier if you walk it together, basically.

Moreover, social rituals are seen as a necessary part of building relationships:

> **Cherie:** I try to have coffee with individual work colleagues with whom I'm trying to form positive relationships and give lots of positive feedback and encouragement. [*It is*] different in each setting. I take time to get to know people. With teachers, I try to spend time with them informally. This might be at morning teatime when we'll have a coffee together, or I'll walk around and do duty with them, or just get them on their own away from the classroom. E-mail is a good way of keeping up a relationship with a teacher. With parents I try to meet the primary caregiver early on in working with the child. This is usually a get together at school but I have also gone home (or met in a café) and just had a good chat about life in general. I call parents prior to a series of visits. E-mail is also a really good way of keeping relationship with parents. Attending orthopaedic clinic appointments or wheelchair appointments with child and parent is a really good way of developing a relationship due to the amount of time spent together waiting at the appointment!

Simple day-to-day rituals, therefore, become important aspects in the process of establishing relationships for these therapists. Cups of tea or coffee in the staffroom are not so much about taking a break, as they are about relating, communicating and connecting with colleagues. Additionally, in the workplace, tearooms and staffrooms, as well as corridors, have become symbols of the communal hub, akin to the social hall where people gather to meet and greet on a regular basis and co-construct their social relationships through interaction. The symbolic importance of sharing food in this construction is also recognised by the therapists. It is simply part of what works in the culture. Sitting in the school staffroom with a teacher, over a cup of tea, or 'chatting' in the corridor with colleagues about clients has simply become legitimate behaviours of the culture.

Building relationships also requires clarifying expectations and roles and seeking to understand each other's perspectives:

> **Leanne:** When starting a new relationship I try to find out what the expectations of the person or people I need to work with are. At this point, I try and clarify what is possible and what is not. … I usually find that taking a problem solving approach works best to form the basis of my relationships, until the trust and mutual respect and shared understanding - which I feel are essential for a good working relationship - can be developed.

Maintaining vast numbers of relationships, however, is not always easy for these therapists. In the field, a high degree of contact is required to develop and sustain such

collaborative relationships and this is often restricted by insufficient time and high caseload demand, especially if one is working in a part-time capacity:

> **Cherie:** I guess I'm not really good at ongoing collaboration … once I feel the teacher or teacher aide understands the principles about participation etc. I tend to leave them alone until I either hear from them or an issue arises, or I call them because I haven't seen them for a while. … I must admit that I don't often have really strong relationships with the students as their family and school team feature much closer than I do. However, that doesn't mean that I don't get on well with them or that they don't know who I am. Going home and spending time with the student at home away from their peers is a good way of developing the relationship with the child.

In their relationships, the therapists also report that they value feedback. They also value collegial support. Feedback from others is important because it provides "a way of finding out whether what you are doing is working", it provides "a way of being able to come back and re-evaluate what you are doing and look more carefully" (Sandra). Collegial support, it appears, is akin to community or *whānau* support, which helps one to keep going in the job:

> **Sandra:** I couldn't do it without the collegiate support I've got from everybody. And when that collegial support feels a bit dicey, that's when you start to lose your grip a bit on your job.

Such support becomes vital when things get rough. The team becomes a place of safe haven.

A Culture of Teaming

Teaming or teamwork is a manifestation of the therapists' enacting collaborative practice and the therapists highly value teaming, underpinned by collaborative relationships:

> **Cherie:** Teaming occurs through developing good relationships with the school team and the family.

Teaming, for these therapists is a dance of *collaborative consultation*, culminating in the coming together to define the issue that the therapist may, or may not, need to address in relation to a particular student in his or her particular school context.

In the field they seek to engage and foster joint cooperative action with others as a means to an end. Part of this process, ensues spending time with team members

because the therapists believe doing so serves to enrich one's skills and enhances the ability to consider the 'big picture':

> **Sandra:** I think the more you work the way we work at the moment, the more you pick up bits of information from each professional group that you work with. So you gain a richer understanding of the child's needs and how that impacts on the classroom. … you've got to think of the whole.

Thus, the drive to foster student learning and participation in regular schools is enacted, in part, through team-based activities. The team is symbolic for ensuring wholeness of services. There are numerous references to co-activities with team members in the interviews.

For these therapists, teaming offers many things, such as sharing a common purpose, collegial support, role release, interprofessional practice and work enjoyment. At the organisational level of community, these therapists clearly identify with their interprofessional teams. There is a strong commitment to being in touch with each other through communication when teaming. It seems that the team both bonds and binds the therapists to the other professionals in the organisation, in turn enabling the work that they do:

> **Yolanda:** What enables [*our work*] is the team. There is a real sense of example in the teams. And strength in the teams. And a sense that we know the schools, we know the kids. We are all connected. We are a community, which provides support and collaboration [*to students, families and schools*].

Sharing a common purpose with the team is an important enabler of practice:

> **Pauline:** I think the attitudes of our team influences our work when they have a similar kind of philosophy.

Belonging to the organisation, is therefore, symbolised by belonging to the team. The notion of *team* is co-constructed, a system made up of interdependent health (therapists) and education professionals who make up the whole:

> **Leanne:** I'm part of a team with lots of ideas between us that allow us to problem solve and prioritise and allow the child as much freedom as possible to join in fully [*at school*].

Accordingly, teaming is part of the ethos of communal ownership of services to students in schools. The belief is that no one professional holds the responsibility for the student; they all do:

> **Melinda:** Within this work setting, I believe in having a team around the child so that one person isn't feeling as though they are left holding the baby. And you've also got somebody else to bounce ideas and share, and feel as though there is more than one of you trying to cope with it. [*I*] value team-work.

Thus, teaming and teamwork are also symbolic of *collective knowing*, *connectedness* and *community*.

Working together

Having a team shared view of the student is a notion that the therapists revisited often in their interviews. Shared worldview serves to reinforce and maintain consistency and continuity of service:

> **Deb:** The teaming aspect is so important because there might just be a tiny wee part of what we can offer that's necessary, but if we can just share that with someone else who is going in regularly and consult with that team member, rather than having another body going into the school.

Using a team approach makes sense to these therapists and they view the team as extending beyond the organisation to encompass family and school staff alike. As a united whole, the team enfolds and supports the student at school:

> **Cassie:** The student and the school get a multifaceted team made up of people who collectively give a full wrap around service for the student. The team has a shared philosophy … I don't have to be present to know that the things that I'm interested in as a therapist will be addressed by the next team member who goes in. Actually, it's quite freeing up, because I, sort of don't have to get in that uni-disciplinary mental mode that only "I" can attend to the things that an occupational therapist might look at. Because as a team, we've got this merged vision of the student and what it is that the student needs and we've also got this huge - I want to use the word respect - that we're all going in the same direction. … The thing is, that when you've got the GSE team modelling that, eventually - because we're only half of the full team, there's the school team as well - eventually the school team comes on board as well. And then there's, like this huge school-GSE team. And the parents obviously want their child included and participating in school as well. So we've got this, like a 360 degree wrap around. I mean, that's painting a rosy picture, but that's how I sort of see it going.

Whilst Cassie espouses the ideal of teaming, Deb points out an issue that may hinder the social structure of the team. Not everyone will be on the 'same page' or have bought in to the shared philosophy of inclusion:

> **Deb:** I think we are getting there, but I don't even know if we've got that, even with inclusion. Not everyone within GSE has got the same ideas about what inclusion should be. So I think having a common philosophy as to what we are working towards is really important.

Melinda on the other hand is optimistic, "yeah I would like to think that teamwork always happened".

Teaming with others, however, can be challenging on a practical level: "we are a big team and just catching people in the office is almost impossible" (Cherie). Nonetheless, these therapists believe that from good teaming springs trusting, respectful relationships, role release and understanding of others. There is joy to be gained from teaming:

> **Bonnie:** I think staff relationships [*are important*] when you are teaming. If you've got someone you are working really well with - and we do also have a lot of people who refuse to team - but the ones I team really well with, and who really want to team, we have a lovely time working together, we really enjoy [*working with*] the children.

Longevity of team membership is valued, linked to cultural notions of the team growing up together and journeying together:

> **Phillipa:** Having other stable staff members here that come through the same way - we talk a lot – the OT [*occupational therapist*] and I talk a lot and we try and travel together sometimes to the rural area so we can talk about things. It's just having colleagues. I think this is really important and having colleagues who are on the same journey is really important.

Being on the same journey as team members fosters strong bonds producing a sense of *we-ness* or *connectedness*.

> **Bonnie:** Some of it's around having a shared kind of worldview I guess. For example, the physio and I, we write joint reports when we go together. We would never write a physio report and an occupational therapy report unless it was very obvious when we got there that it was around a student's walking and needing some inserts in their shoes, or something. And we alternate. We opt who is going to start the report, do the bulk of it and then email it to the other to finish. And we trust each other when we have done it that we can send it out without it having to go back to them for checking. So I just think it's that way of working where you see things from a similar paradigm I guess.

The unity gained from teaming reveals the valuing of a harmonious way of working. Cultural fit is achieved through working together, as is the collective sense of cohesive community, of togetherness and tacit knowing. There is strength in this connectedness or shared vision, which when viewed from the stance of culture is not something to be surprised by. This cultural fit makes Bonnie feel safe within MoE-SE:

> **Bonnie:** Sometimes you just have a way of seeing things that just gels and so when you are working with someone who sees things the same as you or in a similar way you feel quite happy about them going off and representing you. Whereas if you didn't, with other colleagues I would be a bit concerned.

Bonnie trusts her colleague to do right by her and to act in a manner that is consistent with approved cultural norms when she is not present. She and her colleague simply share the culture they have been enculturated into, sharing and attaching similar meanings to events in their practice world and sharing patterns of behaviour in common. Because of this, they are able to alternate roles for some shared tasks and they take each other's thinking for granted as they go about their day-to-day practice. Together they make sense of events, knowing the socially appropriate ways of practice without the need for complicated explanations or digressions. They simply interpret and view practice through the same lens. In short, their practice is contextualised and expressed through emic meanings known to them, part of their very own culture of practice, part of their enculturation.

MoE-SE therapists therefore recognise and acknowledge that social rules and rituals are necessary for fostering communication, building relationships and providing services within a team approach. Accordingly, they speak of working to achieve communication harmony through engaging in multiple avenues for communication with others:

> **Tracey:** Much communication. I link with Health [*agencies, services and workers*] and other personnel. I get a lot of phone calls on all sorts of topics and have attended wheelchair clinics, or gym groups to observe, or input regarding education goals. I have facilitated 'Strengthening Families' meetings. I offer to talk to the class, staff, school as required for a parent regarding medical conditions etc. As I often visit with the physio, we will time our visits for a class, PE, dance, school sports time. I have been known to read a story to the class so that my physio colleague can talk to the teacher when time has been of the essence.

It is as if the therapists can be found anywhere and everywhere. Tracey's final statement in the above excerpt is a powerful recognition of her commitment to supporting her team mates. As an occupational therapist, reading a story to the class frees the teacher up so that she may have time to consult with the physiotherapist. Amidst the complexity of the practice context, this stands out as a powerful beacon, illuminating major shifts in role perspectives.

Tracey sees that the best service she can provide as a therapist in that school, at that point in time, is to become a substitute teacher, so teacher-physio collaboration may occur with the least disruption to the class. For experienced MoE-SE therapists there is no hesitation to question whether one would, should, or could do what Tracey did; one simply does what is needed and one is comfortable with the role switch. It is, after all, what these therapists have learnt works in their practice context. Here, I am reminded of much earlier SES days when a novice therapist once lamented to me: "I feel like a glorified teacher's aide if I am just sitting alongside the student observing". Tracey does not feel like a glorified teacher's aide. There is absolute purpose in her act of reading a story to the class. She knows the consequences if the teacher does not have time to collaborate with the physio. There would be little to no gain made to the benefit of the student on this visit if this type of teaming does not occur. Tracey reveals the degree of cultural adaptation these therapists have undergone.

It seems that in pursuing cultural fit the therapists have adapted to and shaped a culture that has empowered them to become education professionals *in addition* to being health professionals. As a concept this may seem strange given some therapists may have naively believed that they could just step into the education sector and continue to do what they have always done in the past as health practitioners. To have done so, however, would have been ethnocentric.

Cultural Adaptation

It is evident from the transcripts and through fieldsite observations that enculturation has helped the therapists in this study learn to adapt to their new practice context. Typically, cultural adaptation occurs to enable beneficial adjustment of the individual or society to the available environment, in turn allowing a society or individual to fit the particular conditions of a given environment (Haviland, 1999). Change is a necessary occurrence in order for a culture to remain adaptive.

Indeed, the very act of joining MoE-SE requires therapists to engage in cultural adaptation. Being flexible and possessing an adaptable attitude is, therefore, a necessary trait for the person:

> **Sandra:** Flexibility, the ability to be very flexible in the sense of being prepared to listen and take on other peoples - where they are coming from. But also the fact that you haven't got a fixed work place, you've got to be flexible to be able to work in the high school, primary school, out in a rural school where there is only one classroom - you've got to be flexible from that point of view. You've got to be flexible in the sense that you may be the only person visiting a school or you may be one of six specialists. So you've got to be flexible in your professional relationships, as well as within the school. You've also got to be flexible when you turn up to the school and they look at you and go "oh, were you coming today?" and you've just driven an hour to get there. So you've got to be flexible in that sense in your work as well. And I guess now that GSE is arranged so that we [*therapists*] are now members of different teams, we have to be flexible. … So if you can't be flexible and you can't fit into all those things, I think you would probably not cope with the job and would just hate it.

Without such flexibility or adaptability, one may not survive the challenges of the MoE-SE practice context. I wonder whether one must possess such a trait before entering the culture or does one learn it by being immersed in the culture?

However, enculturation occurs over time and, perhaps, because of this, the process of enculturation for these therapists may go by unnoticed. Bonnie draws my attention to the temporal and hidden nature of her enculturation, whilst highlighting some of the ways one learns culture, or is enculturated by others:

> **Bonnie:** It's hard to remember back when I first started as to how much I came with and how much I've acquired over time, and how much of it has come from talking to colleagues and listening and observing.

Simply working with colleagues embeds Bonnie in the process of enculturation, such that she draws from what she has seen and learnt from members of the wider community to which she belongs. She is aware that such things have contributed to shaping her practice and her thinking. Whilst Bonnie is unsure of what she has brought with her or how much she has acquired as a result of being immersed in her new context, her words show her awareness of being enculturated through her social interactions:

> **Bonnie:** I guess some of it comes from working with colleagues in schools, other people on my team, other disciplines. … I was lucky enough to work with a psychologist who just had a lovely way of working in classrooms. She had teacher experience so she had more classroom experience than I did, but she was very valuing of everybody and she was just lovely to work alongside and I think I learnt a lot of that from her actually.

Whilst Bonnie may have been "born" into her new culture with an existing professional culture, she reveals that she is willing to take on another's way of life.

Anthropologists propose that we grow up thinking that our own culture is *the* way of life and that other ways of life are strange and perhaps even inferior to ours (Bates & Fratkin, 1999; Haviland, 1999; Miller, 1999). Accordingly, one tends to learn about cultures from this position, given it is the position one knows first. Indeed, the more different a culture is from ours, the more we may find the other culture lacking and this can result in prejudiced attitudes towards the other culture, in other words ethnocentrism (Cockerham, 1995). In the main, however, peoples' lives are spent in the particular culture in which they are born. In the world of therapy, I liken this to professional culture.

Traditionally, a large number of therapists' practice lives are spent in the dominant culture of the health sector. For this reason they may tend to view this health-based culture and way of practice as not just normal, but superior because it is *the* culture that is most meaningful to them. Given this situation, perhaps it would not be surprising if the therapists in this study, or any new MoE-SE therapists, were to enter the practice context with prejudiced attitudes. It would be natural for them to think that a health-based way of life, that is, the cultural position they knew first should be the way of life in the education sector. However, it would be ethnocentric to believe that health-based perspectives

would necessarily translate across sectors. Similarly, it would be ethnocentric not to recognise that the health and education sectors are two very different 'neighbourhoods', made up of different groups of people and, therefore, cultures.

Risk of Ethnocentrism

In looking through the participants' transcripts, I hoped to find absence of ethnocentrism, but I suspected there would be some trace, since perhaps being ethnocentric is a natural part of being enculturated. I did not have to look beyond the transcripts for tones of prejudice, finding ethnocentrism exposed in the text of one participant:

> **Cassie:** The longer I stay here the stronger that belief has become. And now, if somebody says something about mainstreaming and that "that child should be in a special school" it makes my hackles rise. That belief has been really hardened by working here, because I see that it [*inclusion*] works, you know, when you see that it works - going from a student who the school community did not want and fought really hard not to have … to flip from that to [*saying*] "this is the most fantastic thing that we have had happen." … that "yes it's been a long slow hard road to hoe, but we wouldn't have it any different." That just has reconfirms my belief. And the families that persevere with this system that doesn't provide them with sufficient resources, and still every year they keep going back to their local school and it's working. But you know, a lot of us would have left by now because it's taking a long time to work. I think in a special facility children get a lot of therapy and they don't really get a lot of learning 'cause it's not an expectation that "you are here for academia" but in a regular school - and I think that as a team we actually maybe push that attitude, you know, that belief "you're here to learn", the belief that children can learn and therefore they learn in schools. I don't know how much they'll learn, but they can learn. We're needs driven rather than "oh disability equals therapy input" as a given.

Cassie holds up her MoE-SE culture as the dominant culture. Whilst her beginning message reveals her belief in inclusion and that one must persevere with the dream of inclusion, midway, lurks the form of a zealot. She is overtly judgemental in her claims about which context demands more learning from students, voicing non-acceptance of schools who covertly do not want students with special needs as part of their communities. I wonder if this somewhat righteous and judgemental stance is an inherent risk of being part of the MoE-SE culture.

One hopes that Cassie is less of a zelaot outside her work setting, that she is respectful of other people's values and beliefs rather than seeking to be the dominant voice, since such ethnocentrism would only lead to the exclusion of others, juxtaposed with her belief

in inclusion. I also wonder, however, if Cassie has become so enculturated that she is blinded by her new culture, and, if so, is this true for the group as a whole? In looking through the data, I find the answer to such questions is mostly "no". Whilst the therapists worldviews are altered, from my observations their patterns of behaviour, in the main, appear not to be ethnocentric. Naturally, however, there are exceptions, as is the case in any cultural group (Bates & Fratkin, 1999). I must note here, however, that as I am part of the culture I may not be the best judge of the degree of ethnocentrism within the group. I myself may be purblind to this aspect.

The poignant insight here, however, is that *context* and *culture* are interrelated. What works in one practice context will therefore not be right for a different practice context. Therapists must therefore be cognisant of this when either judging or traversing practice contexts that are not of their own. It is a case of different strokes for different folks depending on context *and* on one being culturally aware and culturally sensitive to the threat of ethnocentrism. Thinking back to Cassie's situation, perhaps one could say that Cassie has become so enculturated that a reverse ethnocentrism has occurred. That is, perhaps she has become so immersed in seeing her practice through the lens of inclusion that she has become judgemental of others of her own profession who do not take this cultural stance. She has become judgemental of the very biomedical perspectives which first formed her professional culture.

Ethnocentrism can also result from pre-MoE-SE professional culture as articulated through the words "we are at risk of doing what we always did in the past" (Deb). Such words hint at the potential for ethnocentric entrapment in medical model perspectives where impairment is seen as a personal tragedy rather than part of human diversity, such that the problems arising from disability belong to the individual rather than society. My observations in the field suggest that this viewpoint, however, does not radiate from the therapists, nor did I find this to be so in the transcripts. This may be because all of the therapists in the study have worked for MoE-SE for more than two years and have been

immersed in this culture long enough to have adapted their ways of thinking. An insight expressed by Cassie illuminates why this may be so:

> **Cassie:** I think sometimes for the therapists the paradigm shift is already happening and you get driven to GSE. I think sometimes people search out this job because there is something in it that hooks them.

Perhaps being drawn in to the practice context from the outset of their journeys has contributed to shifting the therapists in this study beyond the risk of biomedical ethnocentrism. Instead, they have used their health-based backgrounds, that is the position they knew first, as a helpful framework against which to compare their innovative practice within the education sector. And, because they have used this framework to compare and contrast differences, the pillars of their new culture stand out for them, thereby facilitating their thinking into a different domain.

Ways of Being in a New World

As previously revealed, all of the therapists in this study are advocates of inclusion and inclusive practice. Many of the therapists had already begun the process of enculturation or paradigm shift, long before they were "born" into the new culture. Some, for instance Sandra, Cassie, Phillipa and Bonnie, were already in pursuit of that 'something' in the practice context that would allow them to express themselves differently. This resulted in their seeking the very job that would enable them to further pursue *the culture* of *best fit* with their maturing values and beliefs about school-based practice. They sought a practice context that was most meaningful to them, despite the position they had known first. That is, they sought a context that would allow a distancing of biomedical perspectives and the embracing of a social model of disability, one that is not fixated on impairment and therapy for impairments.

Thinking differently

There is a transformational insight across all the therapists' transcripts. In particular, they *tacitly know* that they think and practice differently, but as previously stated, they do not yet clearly articulate the *why*, or *how.* At best their culture is still unfolding, yet I note in the field that they are mostly confident in its emergence.

It seems that a key aspect of what has changed for the therapists is their thinking, that is, the values and belief system and the reasoning which sits behind practice. I wonder whether here lies the real meaning for ascertaining difference amongst therapist groups and practice contexts, perhaps this is where one must look for meanings. One must look to the shared philosophical underpinnings and cultural constructs of groups of practitioners. Yolanda, for instance, is able to recognise old and new ways of thinking in others because of her own insights into her own journey, showing heightened awareness and sensitivity to others' perspectives:

> **Yolanda:** I think that it's been quite interesting to kind of reflect [*in the interview*]. I do often think about how I used to work, and how I used to think, and I can sometimes see that in the other people and in conversations that we have. And so it's interesting as to how you can have conversations about that, without saying one's wrong and one's right, because I don't think that's the case. … It's not about, kind of whether you should do this, or that, it's your thinking, and your reasoning, and your beliefs which kind of sit behind it.

Yolanda neither judges nor advocates one perspective above the other. They are simply different perspectives, neither right, nor wrong, situated within different practice contexts.

During the interviews, reflective thinking brings clarity around what has hooked and reeled participants into MoE-SE. Not surprising, this hook, whether evident at the outset or yet to be uncovered, is the notion of inclusion or inclusive practice. For Jackie, as for others in this study, it is simply a matter of following the New Zealand Disability Strategy (MoDI, 2001). She quotes the Strategy's vision of a fully inclusive society whereby "all children, youth and adult learners will have equal opportunities to learn and develop in their local, regular educational centres", adding "if this is the best option for them and if this is what the parents have chosen".

However, whilst recognising that parental choice counts, the therapists also share the belief that the student has a choice in whether they receive services from MoE-SE therapists or not. Herein lies another difference in the group's culturally-based thinking:- *whilst their professional health-based opinion may be driven by prior understandings that*

students with disabilities would benefit from therapy, the therapists respect that the students themselves have a say in whether they wish to be seen or not.

Being observers

One of the behaviours that serve honouring the student voice is about the therapists being in the background as observers, rather than immediately stepping in the student's space at school:

> **Sandra:** I do a lot more through observation. If I'm seeing somebody at the school for the first time and I say "can I come see so and so? I'm just going to sit in the corner if you don't mind." And teachers can see that, because that's the way that they do some of their assessments, they do observations and they use their running records and they do all those sorts of things.

This mode of observer involves periods of quiet watching, reflection and problem solving, amongst others. It seems observation is a ritual of *being with* the student as he or she participates in learning activities:

> **Jackie:** The main approach is at the beginning of my intervention: observing, listening and observing. I may do observations in class and/or during a time when he or she [*student*] is learning in a smaller learning group. In order to be able to make recommendations for College students to overcome barriers to access the curriculum, it usually works best to observe the student doing functional tasks in a situation with either a teacher's aide present or on a one-to-one basis.

Thus, these therapists are often found sitting at the back of classrooms observing what goes on in the classroom, occasionally madly scribbling on a triple copy pad. They may be found sitting on the side of school pools observing a swimming lesson or in the playground observing students' playing and interacting with peers. They may join fitness and PE classes. Alternately, they may sit alongside a student whilst he or she is writing, occasionally intervening to model or instruct the teacher's aide or the student. At other times, they may be found in the school staffroom, cup of tea in hand, talking with a teacher.

MoE-SE therapists also attend IEP meetings, but not all IEP meetings. There is no seemingly observable consistency to the patterns of their work on the outside, yet on the inside it is about *sitting with* others, *walking with* others, and asking sensitive questions to *gain understanding of others' meanings and goals*, before actions for intervention, if any,

are taken. These therapists therefore participate in lots of talking with others, in keeping with a culture of collaborative practice. All of which requires time.

Being observers of students' participation and activities is, therefore, temporal in nature:

> **Leanne:** Observations … often mean spending quite lengthy times sitting in the class watching the normal daily routines and activities, then discussing them with the people involved.

Taking the time to observe typifies this mode of practice and one learns the patient art of sitting and watching. It is a starting point for intervention:

> **Tracey:** I start the initial contact with the student in the classroom with some time in observation – [*looking at*] student interactions with classmates, teacher, teacher aide position in classroom, movement around classroom, chair sitting, writing, gathering books and so on.

This watching mode is part of being able to gain insights into the big picture, using an ecological approach:

> **Bonnie:** The key thing we do is getting a feel for what's happening in the classroom, in the school for the student, for their teacher and anyone who is supporting them [*students*]. I have a big focus on the classroom.

Thus, being observers allows the therapists to gain a contextualised subjective and objective understanding of what is happening for the student. In this mode astute perceptions of interrelated social and physical dynamics of students' school lives may be gained. For example, friendships may be observed as well as any restrictions from the physical environment which impede a student's function, participation and access to learning opportunities.

What strikes me here is the underlying shared understanding that students' functioning and participation and indeed school lives, are perceived as being socially, culturally, and physically constructed and influenced. One must therefore become part of many school communities, a "community-hopper", so to speak, and in turn be familiar with each school's local culture:

> **Sandra:** Because we do get involved in the community of the school and that does make the job so different. When you travel and visit as many schools as we do you are part of these communities all over the place. I mean it's not just one school we are going to - I don't think I've counted up the number of schools I go to, maybe 34. They are all

> different … they have to be. There are different people in them so they have to be different

Being visitors

As visitors to multiple communities, however, sometimes one can feel like an intruder and this can restrict the process of becoming part of a community:

> **Jackie:** This is an ongoing challenge to me as I like not to always intrude into the teacher's programme.

Whilst the therapists are invited or asked into a school community to do a job, they feel the need to be vigilantly mindful that they are visitors, at times unwanted or unwelcome by those whom they have come to help. In effect, whilst they are part of the overall extended community, as a subgroup they may still be regarded as strangers and as 'others' in some school communities.

It seems that one must, therefore, learn the art of cultural diplomacy and quiet intrusion as a MoE-SE therapist:

> **Bonnie:** … it depends on how comfortable you feel in the school and in the classroom. I probably am different when I first go in … to a classroom. I try to be as unobtrusive as possible because I want to just observe. So I always start with some distance, but then my interest in the student gets the better of me and I find I creep closer and closer until I am actually with the student … I mean they [*student*] are usually pretty clued up and know that you are there for them anyway … which is why I try to be as unobtrusive as possible. I try to not make it more uncomfortable, or make them stand out more than they already do, and I find that gets more challenging in intermediate and secondary school. I don't feel comfortable particularly doing classroom observations at that level. I always check with the student first and some students don't mind, but some students, you know, they just don't want you there.

Bonnie's words are paradoxical. How then does one provide a service to students when they don't *want* the service? What tack must one then take? How must one behave under such circumstances?

For the MoE-SE therapists, observation and intervention roll into one. There is no clear distinction where one process starts and the other ends:

> **Bonnie:** I'm not very good at delineating assessment observations in practice, for me, they kind of roll into one. If I'm doing observations and I see a student struggling, I can't leave them to struggle. I leave them long enough to observe *why* they might be struggling, but then I

> think “well I don’t have a lot of time to come back” so I would probably try and get right in.

Time also seems to be a factor in this process, thus one must ensure that school visits and contacts with students and school staff are, therefore, always useful and helpful.

These therapists believe in giving something back in return for the indulgence of visitation and observation that they have been offered by the student, the class and the school staff. It is akin to a cultural custom of reciprocity.

> **Bonnie:** I think for me every time I go in I try and leave something behind in terms of strategies, or feedback, or comments, something that is going to be useful so that it’s not me taking all the time and not giving something back.

When one visits one should make a difference before leaving, no matter how small. Moreover, it must be useful difference making in that what is offered needs to fit with what people (clients) need and want:

> **Melinda:** I would like to think that we are offering the best … I suppose you would like to think that, you know, you are providing all you possibly can for a student to physically be at their optimum … that is reflected out there, that the school and student’s family are feeling as though they are getting a good service from GSE. Our precedence is always the best. I like to think that what I am doing is not so much appreciated, but it’s what people want, not me personally … there is a fit between what you offer and what they want, the people want. And so I think that that’s really important.

Knowing what is Right, Feels Right

As previously stated, for the therapists in this study it appears that ways of being in their new practice world are fostered through cultural comparison of the position they knew first with their current contextualised practice beliefs and behaviours. In the interviews, each therapist tended to hold up new or current experiences against the past, using this to determine what may be good and desirable in MoE-SE.

I note again, that knowledge of what is acceptable or the ‘right’ patterns of behaviour and what is unacceptable or ‘wrong’ in the practice context are expressed as feelings. For example, Bonnie states, “when I started I felt like I should be doing more assessments and pulling children out, but it didn’t feel right to do that.” When I ask her where the

sense of practice 'not feeling right' comes from she replies, "from experience". I also note the tension between ingrained past ways of being and current ways of practising, signalled by Bonnie's use of the word *should*. Whilst all the therapists in this study know what they need to do when practicing inclusively, it is perhaps still difficult at times for them to fully move beyond past conceptions and uphold the new belief system.

Recognising Change

In the excerpt below, Bonnie reveals that her practice has changed, drawing from the past and the present to clarify her story. It is as though the reflexive act of speaking about her experience allows her to recognise and articulate what has changed. Through her narrative, words begin to shed meaning on her, so far, unwritten cultural underpinnings:

> **Bonnie:** When I worked in the health sector I was seeing some of the same students in schools, I don't think my practice has changed, although - no that's not right - no, it has changed because when I worked at [*a community organisation*] you didn't have children on your caseload like you do with the ORRS children. You got a referral for something specific and you went on and did it. I think I still approached it in a very similar way. I still went in and did classroom observations and tried to talk to the teacher and find out what the issues were for them. I don't think that's changed. I think the way I worked in that service and the values of that service kind of set me up well for coming in to GSE … there was a whole move to look at inclusion.

I comment that this sounds quite aligned with what MoE-SE therapists are doing and she agrees:

> **Bonnie:** It is really. So, I think that was a good grounding for coming in to work in this area. Before that, I was working in a hospital that was very clinically focused, very time-framed in getting people out of hospital and working on other people's deadlines really. I mean I think the way we work now, we have much more freedom to be self-directed in what we do, which way we go, and how we do it, I think.

"If that's the case then," I ask, rather leadingly in hindsight, "is there a particular way that you have to be, or come with as a therapist to be able to work more autonomously and to be able to go down different roads if you need to?"

> **Bonnie:** I think you have to be someone who likes to explore down different roads and to be someone who can cope with not having answers in a box. There's no answer in any box. I think you can have multiple boxes that never look the same the second time you go back to them. I mean, I've tried to box my therapy if you like.

I am interested to learn what this might mean and what happens when one 'boxes' therapy, so I ask.

> **Bonnie:** It [*therapy*] just becomes sort of merged, I sort of start - I try every now and then again - I think "I will have a little box that's just hand assessment stuff". But then you've got secondary school children, you've got five year olds, you've got children who are autistic, you've got children who you know are fifteen but developmentally aged two. So you can't take a box out and think that that's going to meet those needs. So every time I have a box it doesn't work.

I am suddenly reminded of Sandra and her little kits:

> **Bonnie:** I leave those boxes behind now. I might grab a couple of things if I know I've got a child who I know perhaps might like particular toys. I might pop something in, in case there is nothing in the classroom, but pretty much I use what's in the classroom. Most classrooms have interesting things to interact with and the normal activities provide all of my motor stuff really, my assessments are sort of much more functional now than they would have been before, so why wouldn't I use functional things that are in that room.

The 'aha' factor here is that Bonnie has tried to do what she traditionally might have done in her previous practice with children, only to find that it no longer works. Why would one take toys and activities into a school when classrooms are abundantly stocked with just what a therapist might need to be educationally-relevant in a student's given learning environment?

I am also struck by the sense that practice for these therapists is expressed in terms of it being purposeful, meaningful and 'right', including knowing when it is 'not right', rather than by the things one should do, which I refer to here as the *what* of practice. Culturally, such dialogues and expression of feelings signal the *how* of practice reflecting the underpinning values system of practice. In other words, what is deemed good and desirable in the context (cultural norms) is crafted by values and beliefs.

Knowing when it doesn't feel right is meaningful to the therapists in this study. Sandra knows she is doing 'right' through recognising how it *feels* when she isn't practicing inclusion:

> **Sandra:** Perhaps it's more knowing when I'm not. When you go into a school and the specialist teacher says to you "come up to the yellow room, I'll go get him for you" and you know then that that isn't what - I'm not doing what I feel comfortable with, so it's really when I know that I'm not.

Such inherent, tacit feelings signal to these therapists when they not acting in accord with their culture. Feelings have become arbitrary symbolic signals for recognising inclusive practice and culture imprints through such feelings. This is perhaps not surprising since values and belief systems are tied up with the emotional system. Hence one will find passion, zealousness, joy, excitement and dogged commitment in a culture. Characteristics I note in many of the participants of this study even, perhaps, ethnocentrism.

Challenges to doing what 'feels right'

Doing what feels right is not always plain sailing, however; there are challenges to grapple with. One such challenge relates to being true to honouring the student voice:

> **Cassie:** Sometimes it's unfortunate because the parents have 'power over' the child and therefore we can get caught up in that situation.

It seems listening to the students' wants and wishes can conflict with family/*whānau* wishes:

> **Cassie:** The student didn't want a [X] to happen and I got told by the parent categorically "you're not to talk to my child about things without actually clearing it with us". It was a little bit of a "right that's a really clear message to butt out of being an advocate for the child". That door was very firmly closed. You know, kids say things and parents can always override.

Here, whilst Cassie's actions and behaviours were driven by her cultural upbringing, in this instance she discovers they are mismatched with the expectations of the student's caregivers:

> **Cassie:** In this instance we [*therapists*] all professionally felt that the student was correct. I guess because of the whole scenario the parent eventually worked out that there needed to be a compromise, because too many people were raising the issue, not just the student. So we came to a happy compromise. [*When they told me to "butt out"*] I just thanked the parent for being open with me and then we came back to the office and then I was all upset. Yeah, I didn't feel that I had a right to challenge this family's way of being. So yeah, I mean, best practice might say "let's talk to the student as well", because they have their own rights, but there's also the parental thing as well. And then I went back to the office and was upset.

As Cassie continues, I see that that enacting their culture can be, at times, risky on an emotional level for these therapists. There can be tension between honouring the voice of two clients, in Cassie's case that of the parent voice and that of the student voice. The

challenge and artful skill comes in being able to navigate between the two as master consultant.

Not being the expert

For the therapists, doing what feels right is often about not being '*the* expert'.

> **Cassie:** We are not the expert; we are there to walk with [*them*]. I think there's a way of behaving that is linked in with not believing that you're the expert, but that you are a specialist coming in with some expertise and knowledge and skills about how to address the issues that they've [*school*] identified as being difficult - because if we come in as an expert we very quickly set up the situation where the teachers say: "Well you fix it" - I'm not there to "fix it". I'm there to make it possible for the student to do what they need to do at school and be a part of that school community.

Ironically, whilst the therapists recognise and acknowledge their expertise, they do not subscribe to 'the expert' model. For instance, Liz thinks of herself as a visitor in the classroom rather than the expert who has come to inform the teacher or teacher aides what to do and how to do it. Seeing herself as such helps to shift the social power balance in the teacher-therapist relationship and places her expertise in a less threatening space for school staff. She is not the great 'Oompah', come to solve the problems of the minions.

Indeed, all the participants express a way of working that is mindful of not asserting themselves as the expert. This viewpoint appears to be an important attitude to possess:

> **Phillipa:** I don't believe in that expert model at all. People have got to come to their own conclusions. … I believe in the parent as the expert, but we can guide the parent.

Thus, whilst the therapists all believe they have expertise to offer and can add value to making a difference in the lives of students at schools, they are mindful that 'being the expert' in their context is not a helpful modus operandi:

> **Sandra:** I've seen a bit of the discussion in literature that seems to be indicating that people are more willing to take on board new information if it's given to them by a peer as opposed to an expert, and I mean - that's something a little bit different I've been thinking about lately - but if we go in as an expert it's still not as satisfactory as perhaps another teacher in the school whose already worked with the student, being able to pass that information on. That expert model, sometimes you can become quite close to a school, but they still see us as owning the work and owning the child and coming and telling them what to do with it. But I think if you can get them to take over that ownership and then be willing to share it with the next person in

> the chain at the school, I think that would be satisfactory and more successful in the long term.

It is as if being the expert is culturally taboo:

> **Melinda:** I'm not a dictator.
>
> **Deb:** I think you have to be approachable so that … anyone who is involved with the student can feel that they can ask you, and challenge you, and have their voice heard. … not to go in as an expert and say "this is what I know, this is the training I've had and I can tell you to do this".

Moreover, one must respect those with whom the student spends most time as being the real experts:

> **Deb:** You might see something different to what you've seen at other schools and it might not be what you want to see, but if you go in too sort of hard and say "you must do this" then they won't listen to you at all. So that will be even worse for the student. So it's like little baby steps for some schools, and [*us*] working very sensitively.

Thus, the therapists see that they have a role in sharing their expertise, but to do so they must learn the art of working alongside others and valuing others' contributions. They must first determine where they might fit in terms of making it possible for a student to do what they need and want to do at school. Ironically, it seems they must be experts in consultation and collaboration in order not to be the experts. In this stance, they believe lies the capacity to guide others towards collaboratively determined goals. Such is their enculturation, yet many of these masters of collaborative consultation do not articulate themselves as such in this study. This aspect is buried in their day-to-day actions. It has become unwittingly part of their tacit makeup.

Unwitting enculturation

For the participants, like Bonnie earlier, there has been an unconscious imprinting of culture. They are aware of change, yet they are not entirely aware that they have been enculturated. This is not surprising since, whilst we know culture is learned, much of the process of enculturation occurs at an unconscious level (Miller, 1999), because culture occurs as a normal part of life. When MoE-SE therapists go about their day-to-day practices and social interactions within their practice context, as they informally and incidentally share and discuss what they do and as they observe each other's practice, they are being enculturated *and,* in turn, are enculturating each other. As they observe

each other's day-to-day attitudes, values, beliefs and patterns of behaviour and, in turn, they model their culture to each other. Therein, the process of unconscious enculturation resonates within the normal practice lives of MoE-SE therapists.

Melinda recognises that she now has a different mindset and articulating this comes easier for her than it did for Bonnie. I wonder whether this is linked to the difference in their professions or variations in their enculturation:

> **Melinda:** I mean, behaving as a physio within GSE, it's different. You do have to have a different sort of mindset, or goal setting to your health-hat than you've possibly had before, or the children have often come from. Some of the children have come through early intervention and, or health where they've had weekly hands-on therapy, and you're often met with the question: "How often do we see you?" I usually explain it's on a needs-basis, and then work through what the child's needs are, how we are going to meet them, and then determine how often I visit. I've reached that through experience of setting goals that are practical and functional to the child's daily routine at school.

She continues:

> You have got to start off being a good physiotherapist and knowing what the purpose of seeing the child is. If ever you are in a school, there has got to be a good reason for being there. And if you are going to take a child out of class for part of their day for assessment, or whatever, you have got to make sure that you are not compromising what should really be going on in class. You've got to have a clear goal as to why you are there and meet that goal while you are there.

Perhaps it is because the practice thinking and roles of a MoE-SE physiotherapist seem far more removed from traditional biomedical, impairment-focused, hands-on, remedial perspectives than it is for the occupational therapy profession whose focus is on enabling occupation (Townsend, et al., 1997). Perhaps it is easier to articulate practice as being different when it is so removed from the position one knew first. However, there is no answer to my question in the raw data, for now.

Variations in the culture

In this study, I did not find much variation, if any, in what the therapists reveal as core cultural values and beliefs, nor is there much variation in *what* they *do* in practice (patterns of behaviour). That is, there did not appear to be any cultural differences between the two professions. For example, as a group of MoE-SE therapists they all espouse inclusion philosophy, believing that the student is at school primarily to learn.

Their practice behaviours therefore align to this belief. Additionally, they all value the voice of parents as experts, collectively agreeing that when working with parents/ family/*whānau* the key principles of practice include engagement, consultation and participation. These principles also sit within the MoE-SE service pathway (MoE-SE, 2005a):

> **Phillipa:** I think the first most important thing is to value what the parents are saying. That's easier when you are a parent yourself because, as far as your own kids go, you know a lot more about them than any of their teachers.

Enacting this in practice is simply congruent with this belief:

> **Leanne:** It depends a lot on where the family is at. For some they do not wish to be heavily involved with the child at school. Others are very active members of the team with a very close involvement of every aspect of the child's life. I try and respect the family's wishes and involve them at their chosen level. What support do the families want from me? What information do they want? What role are they wanting to take? Do they want to do activities at home as well as at school? How much? What type? When? How? What extra strain will it place on the family and the relationship between child and family members if they do get more or less involved? How do school staff expectations influence all the above? Do I need to help the family get across a message to school staff or vice versa?

I wonder whether one reason for the absence of variation is because the sample group in this study only consists of the longer-standing members of the therapists' community, the elders, so to speak. Would one expect less variation and more uniformity because of this? Especially since some of these therapists are most likely the innovators and pioneers of the culture and because of this I suspect I would uncover more cultural variation had I interviewed a cross-section of the community, including its newest members.

However, whilst there appears to be little variation in the culture itself, there are many references to *working in a mindful way* that potentially leads to variations in how one enacts the culture (*what* one does). For example, variation in patterns of behaviour occurs because the therapists work in multiple school sites or communities and cultures comprising a diverse range of students and student-related issues and school personnel. Thus in this study, as revealed by the participants, variation in the culture perhaps occurs more in relation to practice behaviours rather than variations in the culture itself.

Summary

This chapter has revealed the cultural naissance and enculturation of the therapists in this study, situated within socio-anthropological understandings of culture. It has also further illuminated some of the core values and beliefs and patterns for behaving that MoE-SE therapists are enculturated into. This chapter therefore holds many of the types of things that all therapists need to take on board and attend to when practising in MoE-SE.

For the group in this study, theirs is unanimously a culture of inclusive and collaborative practice, imbued with the valuing of relationships and communication. This culture requires MoE-SE therapists to apply contextualised modes of practice such as: being inclusion brokers and agents for social change, being visitors to diverse school communities, being observers in schools and not being the expert.

The therapists in this study have come from afar to converge on common ground (MoE-SE), journeying alone, originating from their respective professional backgrounds and cultures and their past work settings. Whilst they have landed on a new continent, so to speak, at different places (District Offices), they have found each other and in doing so come together to forge a new *waka* upon which to continue their voyage together, finding strength, rhythm and unison in the collective stroke of their many paddles. Thus as individual practitioners they have come together and, in finding each other, have become a group: a sub-community within the organisation.

Whilst each pioneering participant's journey towards the organisation and each other was ultimately an individual path, the journeys share similarities which reflect a communal shift in their practice beliefs and values. Theirs is a shared vision of student inclusion, of student learning and student participation in schools. Furthermore, theirs is a culture that is primarily yet to be captured in text, until now (this study).

As a group, these therapists are keen to ensure that their culture is shared and transmitted amongst MoE-SE therapists, in particular new members. They believe that there are negative consequences to leaving a therapist to find her own way. To counter this, they see the need for therapy-specific, contextualised formal induction, however, such cultural induction is not routinely available through the organisation. The absence of this type of induction is seen as detrimental to the new therapist's ability to settle into the organisation and to develop understanding of *how* and *why* practice is as it is (cultural underpinnings). Furthermore, the group agrees that without this induction the therapist's ability to shift his or practice beliefs beyond traditional, primarily biomedical model perspectives will be compromised. One will not achieve cultural fit and one is unlikely to survive the culture or context. There is potential for becoming an outcast of the culture because of this.

The last findings chapter presents the notion of *being inside* the emergent culture. It further builds upon many of the key cultural concepts revealed in this chapter, thereby adding depth to the findings thus far.

Chapter Six: Being Inside the Emergent Culture

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(See Appendix 20 for a larger version).

Introduction

This chapter focuses on the therapists' culture from the stance of *being inside* the culture. The text of this chapter is, therefore, presented through a lens which conceives the emergent culture as being contextualised, influenced and nestled within the group's practice setting. This includes the culture of the employing organisation, the Ministry of Education, Special Education. As for the previous chapters, findings are drawn from participant transcripts, my own experiences as a therapist, fieldsite observations and archival data, namely that which represents organisational perspectives through its documents and policies, symbolised by the service pathway depicted above.

In this chapter, I begin by revealing aspects of what the therapists in this study value most. These stem from core characteristics of the culture identified in the previous chapters which include inclusion, inclusive practice, teaming, enabling learning and participation, consultation and collaborative practice. I also attend to revealing the

principles of the organisation and the Government's special education policy because these principles resonate as values within the group's culture of practice. In other words, their culture is nestled within that of the organisation. To finish the chapter, I raise some of the cultural tensions that the therapists face in their practice context.

What the Therapists Value Most

Whilst inclusion sits at the heart of the therapists' culture, there are also several key values within the culture. Core values, discussed in Chapter 5, included teaming and teamwork, having a shared vision, relationships, communication and collaborative consultation. In addition, the therapists value *people*, including students and colleagues and they value students being students. They also value *making a difference* in students' lives and *client voice*. Lastly, at the organisational level, the therapists value the freedom to be self-directed in their practice.

Foremost, nestled within inclusive and collaborative practice, the group value their relationships with people and their colleagues. They particularly value the students, who serve as an inspiration:

> **Sandra:** [*I value*] My colleagues, and the kids. What you learn from the children, they are the best teachers. They [*students*] are the ones that have over the years sort of inspired me to want to do what I do. And when the times come and you think "I don't want to do this job anymore" it's always the children you come back to as to being the reason why you are there.

Students being students

They value *students being students*. This simply means students being learners, peers and friends at school. Cassie explains: "Children at school doing what the rest of the school students do, in their own way, and seeing them being accepted". Facilitating this state of *being a student* on behalf of students is one of the aspired goals for these therapists. They also aspire to making a difference in students' lives through ensuring and enabling student participation in the school setting. This, too, is the vision of the Ministry of Education, whose official letterhead states captions such as: *Beyond what I imagined I could be*, *Raise Achievement* and *Reducing Disparity*.

Leanne tells me “the aim is to enable the child with a disability to participate as fully as possible in the school setting”. In the below vignette, Bonnie captures some of the types of enabling acts that she and other MoE-SE therapists engage in:

> **Bonnie:** I’m just thinking of one [*student*] I worked with … it was a battle to get the school, not to include her, but to meet her needs right across the board. I went in and made recommendations for property modifications and we looked at classroom furniture … they [*school*] went off and did their own thing. They thought it would be alright. They had builders in the school and they just got them to alter the toilet … it was hopeless. He couldn’t use it and so we kind of did battle and we went through it all again and got all of that changed … the parent was very proactive and we worked together and got that done. They also really wanted [*the student*] to go onto the computer; they wanted him to be seated over at the computer to do all of his work and he is only 5. I said "no, no, no" and Dad didn’t want him doing that either … we got him a chair on wheels which he could move around the class and he just zipped around up to the mat and back to his desk and that was lovely to see … he was just so proud the day he took me in to show me his toilet, that he could actually go in, and that he could reach the taps and he could do it without the teacher aide having to go in … the child was the measure of the success … he knew what he wanted to do, he, already at 5, didn’t want me pulling him aside to do things. I always feel really satisfied when I think the student’s satisfied with the outcome.

Having one’s contribution recognised and affirmed is also valued by these therapists:

> **Phillipa:** I value it when parents value what I do.

Strangely, I am struck by the absence of value placed on addressing students’ impairments in the therapists’ stories. For these therapists, the value-emphasis is placed squarely on student inclusion and participation:

> **Pauline:** It’s really great to help people to make things work well so they can get on with life. That’s the underlying value for me.

These therapists value that they are part of being able to make a difference in this way. They also value that they *add value* to the team:

> **Deb:** That added value for the students. Like, me as an OT working with education, I can bring something to that student that no one else on his or her team can bring, so having that feeling that it’s worthwhile, it’s useful, and it’s making a real difference.

Client voice

Throughout their transcripts, the therapists also espouse the valuing of client voice, in particular that of the student voice. In their practice, I observe that they seek to listen to and honour the voice of student:

> **Cassie:** I think they [*student*] should be at the IEPs, if they can. I think they should have a say, 'cause it's their life, you know.

The communal belief is that students have the right to refuse interaction with a therapist, that is, they have the right to decline 'help'. Listening out for the voice of students is therefore culturally embedded in the group's practice behaviours. Practice may therefore be perceived as being client-centred at the level of the student:

> **Cassie:** I think respecting their need to be individuals and to be at school. If a student says to me "I don't want to see you in the school day", respect that. It's my job to be creative in finding another way of getting to either see them do what I need to see them do, so I can do my job, or negotiating with them around how we can get round that.

Being true to honouring the older student's voice and choice is not without tension, however, given societal expectations of young people's right to self-determination[7].

Other client voices are also valued, including the voice of family/*whānau* and school staff. Phillipa feels that "the first most important thing is to value what the parents are saying". Yolanda also echoes this belief: "I think it's the student … and family voice in our service":

> **Yolanda:** Families and children would be identifying what they wanted to work on, and when. Respond to the problems or issues that are raised by the family and the child. With that comes listening to the child's voice, what do *they* want and respond to that.

Yolanda also expresses concern that, in practice, this aspect is not strongly realised. She sees the student and family voice as "a gap … in our service". Liz is bluntly open about this issue:

> **Liz:** How do I work with families? Not well enough! This is an area that I find difficult and I feel that I do not do well. I find it most difficult to form relationships with parents as I don't see them as often.

The voice of school staff is also valued by the group:

> **Melinda:** We work from where the school is to identify what the student has difficulties with.
>
> **Liz:** I am only with the student for a fraction of the time compared to the staff who are with the student often all day. It is therefore important to hear others perspectives and to offer suggestions as required and as appropriate.

[7] Whilst I raise this important factor here in relation to the potential impact this may have on MoE-SE therapists practice and their clinical reasoning, further critical discussion on students' self-governance is beyond the scope of this culturally-focused study.

Practicing freely

Freedom to be self-directed in one's practice is also highly valued by the therapists:

> **Bonnie:** The freedom with working where I do in this office … is wonderful. I can work in any way I choose really, there's no restrictions.

For the therapists, working this way makes work enjoyable, because it does not restrict the therapists to traditional practice:

> **Melinda:** [*I value*] autonomy. Although I am part of a team, I can choose who I see, on what day, for how long. So when I go out during the day, I haven't been told "you will see Johnny, and you will stretch their legs".

Melinda reveals that being self-directed is not so much about working alone, as it is related to having the freedom to make decisions about one's daily schedule and clinical actions. Autonomy or self-direction is a symbol for independence, an expression of self-sufficiency as well as a symbol of being trusted by the organisation to do right by the students and one's clients:

> **Melinda:** I really enjoy what I do. I enjoy being a physiotherapist with children. I enjoy what I do out there and the opportunity to be a physio in schools. I enjoy it, yeah, and making a difference hopefully to those children, and the collegial support.

Culture Nestled within the Organisation & Special Education Policy Framework

As indicated in Chapter 1, the special education policy framework ring-fences the practice of MoE-SE therapists. Because of this, their emergent culture nestles within, and is bound by, policy to a large extent, as well as organisational culture (norms, values, beliefs and behaviours).

Policy serves a cultural purpose for the group: it provides them with a philosophical base and assists them to define and co-construct their social structure, and, thereby, grow their culture. In addition, it gives them a means to understand and articulate their practice amongst themselves, translating these understandings into the *how* and *why* of their practice.

One key guiding document in the policy framework is the operational protocol for occupational therapy and physiotherapy services (MoE & HFA, 1999). Précised in Chapter 1, this protocol provides core practice principles from which MoE-SE therapists may interpret what they 'should' and 'should not' be doing. The protocol provides the collective starting point. Accordingly, the group takes on board organisational values or principles. These are reflected in their language and their practice behaviours and, as such, are observable in the field:

> **Yolanda:** Avoid referrals to treat the child, to remediate, to "fix" their hands, to assess visual perceptual problems every year, or every six months for a student's entire schooling period, you know. We need to respond to problems which are functional and occupational and which relate to the child's access to the curriculum and the school environment.

Yolanda reveals her emphasis on learning and participation:

> **Yolanda:** I think that [*remediating/fixing*] has some covert messages in it to the child, and I think those messages are about "you need fixing" and "you are not quite right". … It didn't give them a message that "you will be learning with the other kids, and we will just give you things that you can learn, and then you will learn, and then you will feel pleased with your progress, just like everybody else does". … it's that message to the child and family "try hard and the deficits will come right". If I had to go back to doing only remedial work, I would have in the back of my mind "what's the message for this child about who they are" and "why do they need therapy and not education" and "why isn't the school teaching this child, why are they having therapy?"

She values the student as a learner and member of his school community, articulating her belief that children with disabilities should and can be catered for in regular school like any other student. She also believes that difference should be honoured and valued as a positive aspect of the student, not perceived as a problem. She seeks to empower schools to recognise and respect the student for who he is as a student and learner, rather than to focusing on his impairments. She also seeks to de-emphasise what many schools typically often expect from therapists, that is, for therapists to place their therapeutic focus on the student's impairment.

True to her cultural underpinnings, Yolanda chooses to focus on ensuring that the student can be at school as an active member and learner in his school community. Like the other MoE-SE therapists, she believes she has a key role to play in promoting inclusive attitudes in schools. Her practice behaviours seek to dispel the process of disablement.

Thus, her behaviours and key messages align with the organisational drive to build inclusive schools. Her role is one of advocating student rights in the education sector.

I see that Yolanda's practice is a reflection of her culture. Her culture, in turn, is a reflection of the principles of the special education policy and MoE-SE culture. Couched within such principles, MoE-SE therapists have weighed the need to address impairments against individual student's needs, as well as social and environmental factors, and these latter three factors have won. Social and environmental participation have become core values and desirable outcomes of practice, as has the drive to shift others' attitudes about disability. Thus, it appears that the practice experiences of these therapists have helped them hone and refine the very principles and patterns of behaviour which befit inclusive practice:

> **Bonnie:** In past experience *we* assessed children. We assessed everything and wrote up some goals. We identified what the needs were and what the goals were instead of being able to step back from that and being able to think "well they are not my goals that should be happening", you know. What are the student's goals? What are the school's goals? What are we trying to do?" This makes a lot more sense, much more sense.

Moreover, practice has become environmental in its focus:

> **Yolanda:** In my experience, I think a key skill is to design enabling environments. So we are looking at adaptations that might be needed to the physical or the human environment of the child that would enable them to participate or to perform tasks at school. So we need to think occupationally and we need to collaborate, and we need to think about adapting environments to meet [*students'*] needs.

Indeed, it seems the value of inclusion has become a matter-of-fact attitude for the group. So much so, for example, that Yolanda emphatically takes it as a given:

> **Yolanda:** Children are children first, all children can learn. Disability is a natural part of our society and population. Disabled people learn best when they are included in their local community. All schools should cater for children with special needs, or all schools should cater for all children. And, I've started to think a lot about taking the special needs label away from special needs service delivery.

Like Yolanda, Pauline also perceives such things as 'givens':

> **Pauline:** A student with a disability is a student just like any other student. They just happen to have a disability and so the outcome effect is that they are included in normal daily life with some adaptations. And I think our team in general, most of the time, thinks that is how it should be. I promote those values and I think I also know that I am working in that sense, because I am not imposing things on a

> student, or a teacher, or a teacher aide that actually requires exclusion, and that requires the student to be out of the class, because I always try to be very careful to make suggestions that can actually happen in the classroom.

Such attitudes therefore, *are* matter-of-fact, being part of the very fabric of these therapists day-to-day practice lives and social structure. I wondered as I listened to the therapists in their interviews, whether those on the outside of the culture would agree. It seems that the therapists have travelled far beyond practice that is based on the curative or rather rehabilitation and remedial models. Students with special education needs or disabilities are viewed as a natural part of society and, because of this, practice behaviours simply align to reflect this worldview. *The student is, in fact, not the problem or the issue.*

Working Beyond the Traditional Student-Therapist Dyad

Thus, one critical aspect arising from the data is the notion *that the student is not necessarily the therapists' central client*. Whilst the student is indeed the end beneficiary of all MoE-SE therapists' services, he or she is not the focal point of therapists' endeavours. The significance is that *change is expected in factors beyond the student, so that successful change may occur for the student, for instance in the people surrounding the student or in the environment.*

Collectively, the group identify and talk about multiple clients. Client group includes, but is not limited to, the student. 'Client' for instance may include the whole school community:

> **Cassie:** There's another client group and that's the school system. So, the teachers and the support staff that work with the student. So I've got individual clients and then I've got those systemic clients.

Thus, when working in schools MoE-SE therapists often shift their focus to work systemically, that is, the client focus shifts away from the traditional student-therapist dyad.

The group reveals that MoE-SE therapists work systemically because they work from an ecological approach, recognising that whole social networks influence educational

outcomes for children and young people (MoE-SE, 2005a). If change is to occur, it must be at a higher level than the individual. Furthermore, they believe systemic work achieves a good match between the student's need and the school environment (physical, socio-cultural and political). Whole school communities therefore stand to benefit, placing this type of work at the level of societal orchestration.

Working with parents

The group also reveals that MoE-SE therapists work with parents and families/*whānau*, believing parents, as clients, should lead the way:

> **Phillipa:** We are sort of saying "well you know best" and they [*parents*] don't feel that they do know best often …

However, paradoxically, emphasis seems to be placed on helping parents to come alongside their (therapists) practice values and beliefs. Thus it appears that work with parents encompasses a role of helping parents to vision their child as a student; as a learner and active participant who is included at school. Phillipa's story throws light on this inconsistency:

> **Phillipa:** Obviously I've got to be guided by the parents and I'm not going to say to them "I totally disagree with you", but my personal philosophy is that we should be maximising the child's ability to take part in more activities at school. So, there is no point in getting them to walk along with calipers and a walking frame at morning tea-time when it means that all their peers have run off and left them behind.
>
> A lot of the parents don't have that same viewpoint and I certainly like to draw them perhaps towards that, because I think it's really important for their child to be with their peers, as the child gets older. I do think they [*parents*] definitely come along that track. Although I've changed a lot, probably those parents have changed too because their kids are growing up and they see them now as not a kid who is going to be fixed. I think as therapists we have to have a professional viewpoint as well as being led by the parents.
>
> I had a situation last week ... the parent was saying "what you offer is no good anyway because … I know more about this kid than you do"... and of course she [*parent*] does, she's her mother … of course she knows more about her [*child*] than I do. ... I talked to her about the therapy and I said, "if you find it stressful yourself, doing what you want to do for your child, we can use some of your carer support hours and I can work with the person who is doing that to set up a programme that they can do that's outside of school. That can help your child to have that therapy that you want". … we talked it through and in the end she said, "no I don't want her to have stretches." At the end of about an hour we were great friends and she was saying … "I worry too much" … she was seeing things differently, she was looking at her child more as a child with needs, rather than as a subject for therapy, yeah ... but she needed to go through that process and, you know, you might say

> something to yourself like, "well you were a fat lot of use there" because, you know, what did you do, just sat there and talked to the woman, but she came a long way in that time …
>
> I think that's really important to us that we have the parents understanding and making the decision for themselves ... they are the ones that are going to be looking after that child aren't they, for life, not me …

The perspective, therefore, is that these therapists' see themselves as playing a key role in helping schools and families/*whānau* to understand and see the benefits of integrating therapy into naturally occurring activities and contexts, in keeping with their culture.

The collective is feeling is that *children are not subjects for therapy just because they have a disability.* Ironically, and contrary to this belief, however, the therapists reveal that they often find that what is expected of them by others is the traditional therapist role:

> **Sandra:** You still get that sense from them [*school staff*] that if you haven't actually taken the student out [*of class to work with them or do hands on therapy*], that you just really quite haven't done the job properly.

It's not about Fixing the Student

One centrally embedded cultural belief is that *the therapists see themselves as not being there to 'fix' the student*. They hold to this belief, despite public perceptions, including those of school staff, outside agencies, parents and sometimes even the students themselves. Endorsing this stance of not fixing the student with parents or schools, however, can be fraught because:

> **Phillipa:** It's part of their [*parents/ families*] belief system. They've been told right from the time that their child was small that they need these people [*therapists*] to help them with their child.

Thus, whilst much of what the therapists focus on in relation to the student's function and performance follows usual practice, for example they look at handwriting, hand skills and functional mobility, what the therapists do, and especially in terms of *how* and *why* they do what they do, differs in so many respects. Consequently, at times, MoE-SE therapy practice may appear strange to others, perhaps even conjuring outside perceptions that MoE-SE therapists are not doing the right thing or 'doing therapy'.

These therapists do not intervene with all students who have met the special education policy's eligibility criteria, even if the student may have a known or diagnosed disability or a specific impairment. On the contrary, these factors do not flag an immediate ticket for therapy, despite the traditional unspoken given being: "if you have a disability you will benefit from therapy":

> **Deb:** I must admit I'm quite alarmed sometimes at the amount of people that are in schools with kids and I think that can make us feel superfluous. And sometimes, if you have to go … because someone has asked me to come in, it can be quite hard to say "actually you don't need me" and not do anything. Because parents have got that expectation that they [*student*] should have it [*therapy*] or, you know, the school.

There is tension in living the emergent culture. Accordingly, the therapists seem caught between public or outsider perceptions of traditional, health-sector-based ways of practicing and their innovative, culturally-driven, education-sector ways of providing services for students in regular schools.

The group's collective attitude is that *the student is not 'broken'*. This belief brings with its own source of challenge:

> **Sandra:** I don't know about occupational therapists, but I feel it really strongly about physio – the "fix it" people. They [*public*] are used to seeing the physio run onto the field during rugby and they squirt the water bottles, and rub the knees, and put the ice pack on, and this sort of stuff. It leads to a dependency and an expectation that you can give them [*consumers*] a list of things - "if you do this, that's going to sort it and it's going to be fine, everything is going to be hunky-dory". That's not - that isn't the nature of disability and impairment. You can't leave them [*school/family*] with something that's going to "fix it". I think I've had to work really hard to say that that's not what physiotherapy in schools is about.

Whilst impairment is a consideration in their practice, the focus is not on ameliorating specific performance components, unless linked to the curriculum as an identified barrier to school participation or, for instance, linked to the needs of the family/*whānau*:

> **Yolanda:** That's helped us to change our practice and become more inclusive and more ecological, so therapy programmes aren't around therapy equipment, but they are about putting things into the child's natural day.
>
> **Phillipa:** There is no use taking a kid out once a fortnight, or once a month, and doing something to them and popping them back into the classroom, because it's not doing one iota of good. And that's where I think where perhaps we can say to the family "how do you think it is going to be beneficial to your child?"

Sandra highlights aspects of the 'fix-it' expectation others have of MoE-SE therapists:

> **Sandra:** It's what the school want me to do - I'm thinking of a particular school and this student - when he arrives he will say to me: "Are you going to do my stretches now?" And then he will lie down on the floor, and then he will say: "Oh I can tell my dad you've been." And, Mum is very happy that I've been and done that. Whereas, when I leave a note on my triplicate pad, and send a note home that says: "We had a chat today and [*we*] decided that the sports things that he would really like to do are golf, tennis and cross-country", although he would really like to do soccer. The day I did that was when I got the phone call from the parent – he would not ever call me if all I'd gone and done was the stretches - because he wanted to know what the support was. That is what I felt comfortable with, but what the school want me to do is: "I'll go and get him [*student*] and bring him to you".
>
> **Carolyn:** So is that the "fix-it" factor? That traditional model of bringing the client or the patient to you [*therapist*], you do something to them and when you are finished doing what you are supposed to be doing to them with your expertise, you will just send him back along to [*class*]?
>
> **Sandra:** Yes and when you go along to the class teacher and she looks at you with a sort of slightly vague expression on her face when you ask what they are doing in Phys Ed [*physical education*] or something like that, "oh I'm not really certain at the moment".

For Sandra, knowing when she isn't acting in accordance with a role embedded in her culture helps her to identify when she *is* acting in accordance with it. This strengthens her understanding and belief in what is desirable and proper in her practice context, that is, to be educationally-relevant with her therapy interventions. Sandra shows how she seeks to embed her therapy into the student's curriculum, in this case Physical Education (PE), but finds that this is hindered, not only by the student's learnt expectation of having his tight muscles 'fixed' through stretches, but also by the teacher's seeming lack of insight into including the student in PE.

Going to School is not about Having Therapy

Another centrally embedded cultural belief for these therapists is that:- *'going to school' is about students being a part of regular education, their school community and being able to participate in school tasks and activities, despite the challenges that an impairment or disability may pose*. This belief is linked to the greater governmental vision of participation in meaningful education for all students and that of building an inclusive society.

In Chapter 4, Yolanda opened a window for us to see the zeal and drive with which MoE-SE therapists follow their conviction for brokering inclusion, symbolised by Yolanda words: “just keep working until it works”. The very intensity of these words suggests that these therapists reflect a culture of practice that does not give up when the going gets tough. In this very expression, ironically, one begins to gain growing insight into how strange this group of therapists might seem to the rest of the therapy world. How strange that they seem not to focus on ‘fixing the impairment’ and ‘making it better’. How strange that they seemingly work with staff in schools more than they do with individual students. How strange that their practice behaviours involve sitting beside students or sitting at the back of classrooms watching the student’s level of participation. How strange that they spend time having cups of tea and talking a lot with those who are most involved with the student at school, rather than ‘doing something to the student’.

Yet, such things are not strange for these therapists. They are simply part of their culture, expressions of their day-to-day behavioural patterns, related to what they believe and how they see themselves. They are simply manifestations of their cultural norms and cultural patterns of behaviour. At the level of a student’s impairment, theirs is a culture of ‘not fixing’ the student. Instead these therapists attend to environmental factors encompassing the physical, socio-cultural and political levels.

Theirs is a culture in search of achieving a different outcome, namely societal inclusion and participation and, in essence, because of this they are often misunderstood:

> **Yolanda:** I think it shapes outcomes quite a lot in that a lot of the time we are working to help people to understand why we work differently and often that continues to be a mismatch. Every time there is somebody new, the poor child [*student*] has to go through that whole loop of: “Why don’t they fix them? What’s the therapist doing? Why don’t they fix them?” I have also found that as you work with a school and the team around the child to understand the child and we put in the adaptations, that there is a kind of magical quality, and that the child makes very clear gains. And then the people around the child stop with those messages of “why don’t you fix them”. They see that they are in a very powerful position and that they can enable occupation; they can enable participation and that’s what OT is about. And we can be really powerful in teaching other people to let that happen. For me, actually experiencing that in GSE has changed probably my beliefs about therapy quite a lot.

Furthermore, patterns of behaviour for these therapists are enfolded within the constraints of a legislative framework which requires them to practice in a manner that is consistent with Government strategies (MoE-SE, 2005a). This means MoE-SE therapists do not work with the student just because he or she has a disability or impairment, nor because others perceive the student as having a special education need. In addition, they do not provide services to students just because they are eligible under the special education policy. Rather, as highlighted in Chapter 1, indicators for service are linked to the student's *educational need*, and therefore *educational relevance*, as opposed to impairment or disability.

Having a diagnostic label or a known disability does not automatically signal the need for the occupational therapist or physiotherapist to be involved with a student, as it does in the health sector:

> **Yolanda:** Basically it doesn't really matter what the condition is, or the impairment, or the diagnosis. What matters is there is a concern, and that it's expressed by the family, or the school. I think our behaviours need to be highly collaborative and we need to understand the occupations [*activities and tasks*] that kids engage in at school. And we need to carry out our assessments in relation to those.

This is because, for Yolanda and colleagues, students are at school to participate as occupational beings, to *be* students, learners and peers. Mirroring the policy, they therefore believe that "best practice for all of these students is [*for them*] to be included in the class under the responsibility of the class teacher" (Bonnie):

> **Phillipa:** If a kid's in a classroom most of the time and the class teacher is taking responsibility for them, then they are included. If they are left with the teacher aide and the teacher aide is having to make all the adaptations and take responsibility for the kid, then they are not being included.

Holding a Shared Worldview

Thus, in order to realise inclusion for students, all the therapists in this study appear to recognise that they must hold a shared worldview, symbolised through the metaphor of *rowing in the same direction*. Indeed, having a *common purpose* and *similar point of view* is a central construct in culture (Bates & Fratkin, 1999; Cockerham, 1995; Haviland, 1999; Miller, 1999). Achieving a cohesive group or community involves not only

displaying sufficient common purpose and proximity to afford opportunities for communication with each other, but also a sharing of common identity, attitudes, values and beliefs and social structure (Bates & Fratkin; Cockerham; Haviland; Jones et al., 2000; Reekie, 2000).

Whilst perhaps not every occupational therapist or physiotherapist who joins MoE-SE will hold the shared worldview of inclusion, all the therapists in this study do. Moreover they acknowledge the importance of having this common purpose. The shared vision of inclusion is a key aspect to being culturally connected. This is sought not only at the level of the therapist community, but also at the team level, with the school and family and within the wider community of the organisation.

On the other hand, not having the exact same view is recognised in cultural writings and acknowledged as an important part of cultural shaping, where variation in behaviour and diversity can play a powerful role in healthy cultural adaptation (Bates & Fratkin, 1999). In this study, however, the therapists all uphold the principle of having a shared view, or common philosophy, seeing it as a key factor that bonds both the therapist group together, as well as to the MoE-SE team and the organisation. Such notions are emulated in the MoE-SE service pathway these therapists follow.

Following the MoE-SE Service Pathway: Poutama

The therapists in this study reveal that being inside their practice context and operating from their culture of practice means following the MoE-SE service pathway (Appendix 20), depicted in the diagram at the beginning of this chapter. This next section contextualises the role the *poutama* (path) plays in the group's culture.

MoE-SE is a service provider arm of the Ministry of Education and fulfils an obligation to provide special education services in line with the Ministry's mission statement: *Raising Achievement and Reducing Disparity*. Therefore, therapists who work for MoE-SE must work to this mission by "working towards achieving desired learning outcomes for children

and young people" (MoE-SE, 2005a, p. 3). This includes promoting school attendance, participation and access to meaningful learning opportunities, as well as achievement in curriculum areas. Many of these principles are reflected in the MoE-SE therapists' culture of practice. Accordingly, therapists' patterns of behaviour, nestled within these key principles, are commensurate with the Ministry's mission and the special education policy.

At the organisational level, descriptors for such patterns of behaviour are laid out in the MoE-SE service pathway (MoE-SE, 2005a) and include a focus on educational outcomes, fostering active participation of children and young people, working in collaboration with families and *whānau*, inclusive practice, the use of ecological approaches, practicing cultural affirmation, and being evidence-based in practice. Furthermore, behaviours that are in keeping with these principles are said to be consistent with Government strategies.

In the next few paragraphs I will use a participant vignette to illustrate the process of how MoE-SE practitioners help foster inclusive attitudes and principles within schools. The casework exemplar is around transition into school and by way of backgrounding the story I first explain what transition is.

Helping Others Know How to Do It

Transition is a key part of the MoE-SE service pathway and refers to key points in students' school lives, whereby they move into school, move up a class from year to year, and move from primary school to intermediate school and then on to secondary schooling. Two other key transition periods occur when students move from school to pre-vocation or vocational periods of life, and when students choose to change or leave school for various reasons. Student transition periods are deemed high-demand, high-pressure periods for MoE-SE therapists for many reasons, such as those described below:

> **Jackie:** The teachers usually change every year for the student, which means it cannot necessarily be assumed that what was discussed and agreed for the student will be carried over to the next year, or the

> understanding of the intervention, or the student's difficulties, or that new staff will have insight into how the student copes or learns.
>
> **Bonnie:** You don't see the hand-over from one year to the next. We are going back in, starting again, each year. … there was no hand-over from this teacher last year, even though the school assured us there would be, so you have to start again.

Work may be perceived as never complete, since all students' transition at the end of each year, until the final transition of leaving school. Additionally, because of the settling in demands of transition, these periods are epochs of high involvement for MoE-SE therapists. During these times the therapist's presence in the school and her input often becomes particularly visible, and values and beliefs become unmasked.

Yolanda's story typifies many of these aspects as it unfolds below. Woven through her vignette are many of the values that MoE-SE therapists hold as part of their emerging cultural heritage. For instance, her ecological approach is revealed in her actions, as is her focus on collaboration with the family member. Yolanda also illustrates many of the patterns of culturally-driven behaviour that reflect inclusive practice and drive services to be collaborative and well coordinated. Core values related to communicating, negotiation, and relationship development are also evident in Yolanda's story:

> **Yolanda:** This boy went to our local unit for kids with learning and behavioural problems and he had a lot of learning and behavioural problems in that unit. He had ASD [*Autism Spectrum Disorder*] and he had a lot of a support from [*a private service*]. The family were under a lot of pressure to keep him in the unit and to pay for [*private service*] so it was expensive and the child had to travel to the unit. His mum decided to take him to the local school and so I was the OT - in the sort of way that we work - in a kind of collaborative way and I sat next to the SEA [*Special Education Advisor*] - who did the transition - and we talked [*with the parent*], we dialogued, we collaborated about the whole thing together.

Yolanda places collaboration at the forefront of her practice. She begins with collaborative dialoguing and placing significance on gaining the parent's (other's) perspective. It is *this* perspective that she wishes to be true to representing in the local school:

> **Yolanda:** We got to know the child in terms of what the mum saw. We got to know the child and we made sure that the transition went well. We had meetings with everybody and [*did*] a lot of preparation in the school about who [*the student*] was and what he needed, and the strategies. We put them all in place and we practiced them and he built up, and he went to school.

In this, Yolanda reveals the group's belief in representing the perspective of the client, rather than that of the practitioner. Moreover, in doing so Yolanda reveals that the client is not only the student, but also the child's parent. The story continues:

> **Yolanda:** And there were concerns [*at the school*]. They wanted me to look specifically at his handwriting because he used to be able to form letters and then he wasn't doing any of that. They [*school staff*] wanted me to go and work with him. And I did go into the school, but I didn't say I'm going to come once a week, I just said "just try this" and "keep going with this, and this will lead to this, and lead to this". I suggested, "if you had a routine and we got him into the class routine, he'd get the modelling from the other kids and the handwriting would come" - because it wasn't a motor deficit, it was a deficit of understanding and cognition. What he needed was more understanding, not exercises for the fingers.

True to her cultural belief, Yolanda refuses to be drawn into a discourse that views the child's impairments as the problem. Instead she supports the school to foster participation and access to the curriculum. Here, we see how the school is now the client. For this client Yolanda models the attitude that the student does not *need* therapy; impairments do not need fixing, nor do they require therapeutic interventions. Instead, Yolanda extols that much may be achieved through environmental engineering:

> **Yolanda:** I gave him access to the computer as well so he could write on the computer, and I suggested [*a software programme for writing*]. And so none of that involved huge amounts of time, but the collaboration did.

In this piece of work, Yolanda's work is somehow visible, yet also concealed:

> **Yolanda:** I was in the background. The mum knew I was in the background and the school knew I was in the background. I kept on saying, "I don't think you need me now because what you are doing is really good". So I kept almost reflecting with them [*family and school staff*]. I was a reflective partner, but not acting like an OT "service deliverer". I was a team member and a reflective person.
>
> We had a lot of email conversations and I kept in contact with the mum. She [*parent*] told us how it was going and we would respond.

By this, I mean she seeks to foreground the needs of the student and his family, rather than therapy perspectives, being in the background in a collaborative partnership with her clients (family and school staff) for the benefit of the student. Communication becomes the constant factor for facilitating and maintaining relationships, for being connected, and the social structure in this scenario is founded upon valuing communication and collaboration.

Yolanda ends her story with excitement and joy, and I am caught up by the powerful significance of what her story reveals of the culture:

> **Yolanda:** And now he is just so much part of the school environment [*referring to social and learning environment*]. He is really happy, he's got local friends, his behaviour is - he is still autistic and he's got all the same features - but he is a lot more settled. He's happier, he's writing, he's reading. The mum is having the services from GSE [*MoE-SE*]. She is happy with that. She has learnt a whole lot about inclusion. In fact the whole school has. Now new kids have started at that school. What they have learnt for him [*student*] is being reused for new kids. So there wouldn't be nearly so much work for somebody else who goes into that school because they know how to do it. That teacher will teach another teacher in the school. So it's been a systemic sort of intervention hasn't it. And it's very powerful. They know how to do this now.

Seen through the eyes of her culture, Yolanda has won the ultimate prize of her inclusion brokering. One more student has been successfully included in a regular school setting. One more parent's dreams and hopes for her child to go to his local school have been realised. One more teacher knows what it means to include a child who may be perceived as different. One more person in society knows inclusion is possible. One more young person may be accepted by his peers for being himself and, lastly, one more child belongs to society.

Fostering Client 'Buy-in'

Brokering inclusion, however, is not always easy for the therapists. Clearly in their stories there are schools which they come up against that do not welcome students with special education needs. This much is obvious from my own observations and participation in the field and from talking with other MoE-SE therapists and colleagues. Such schools are perceived as not having buy-in to the notion of inclusion and participation, creating a climate of challenge, tension and moral dilemma for the therapists.

That some schools don't buy-in to inclusion means precious time and professional resources are waylaid in the attempt to bring about inclusion for *one* student, within *one* school. I note that sometimes this gives rise to an attitude of 'why bother' in the field. But the thing is that these therapists *do* bother. However, whilst inclusion may be the revered prize for this group, sometimes one has to cut one's losses and simply move on to the next school:

> **Deb:** For some you might work with the systems of that school. There are lots of schools that are at different levels of where they are at. With some schools I can go in a couple of times and make a huge impact, and with other schools I can go in every single week and have no impact at all. But sometimes you prioritise, you have to say "well I can make most impact in that setting" so in a way that does take priority because you've got the buy-in [*from the school*]. Whereas you could spend hours, and hours, and hours and not have any buy-in from what you're trying to do.

I am struck by the notion that the group is made up of 'stayers'. They serve a society where change occurs slowly; therefore one needs to be in it for the long haul. One must foster attitudes such as 'taking time' and 'allowing time' for events to take their course. One must also be patient whilst waiting for change to occur in other people, so that change may occur in students' lives. Thus, this becomes one of the group's ways of being as they go about inclusive practice.

In addition, the role of the MoE-SE therapist often has a hovering quality to it. Earlier, in Yolanda's story, I see that whilst for all intents and purposes she is both active in her role, to a large extent what she does may be invisible to others because she is working in the background, rather than doing hands-on, one-to-one therapy with the child. However, Yolanda, was interested in gaining an understanding of the child from the perspective of parents, rather than that of her own. She saw herself as very much part of the team; however her role was not hands-on in nature. Instead it was collaborative and consultative, sometimes requiring no overt action on her part.

Thus, the role of MoE-SE therapist might seem modest and small, and far from traditional, the approach they take is geared towards being supportive of the student, the family and the school. This requires skilful engagement in complex, multi-layered processes requiring collaborative partnership and ecological thinking. Thus, at times, whilst the therapists may profess that they take a background role, this is not quite so. The impact from the invisible nature of their work is huge, visible through an environmental or societal lens, rather than the lens that focuses on the impairment level.

Furthermore, whilst the MoE-SE therapist may often seem invisible, as Yolanda revealed, it is a role that quietly reverberates in the background. One whittles away to build inclusive options for the student, family/*whānau* and school, intervening only with just the right amount of input as is necessary to support the students at school. In addition, whilst the therapist may be 'in the background', she is not disconnected from parents or the school. Close contact is maintained through communication. In this way she is ready to be available at the first instance of a request for service. Many of these notions sit within the MoE-SE service pathway.

Such is the press of the MoE-SE service pathway for inclusive practice and this is what MoE-SE therapists seek to make known to school staff, families and *whānau*, so that they may also "buy-in" or subscribe to the vision. Furthermore, it is not the 'doing of therapy' that takes centre court; it is the principles of relationship, consultation and collaboration, and inclusion. True to their cultural beliefs, the primary focus of a MoE-SE therapist's involvement as an education-related specialist is to assist the school to identify key learning and environmental issues and to focus on achievable learning goals for the student. This is carried out, not as the expert, but as a collaborative partner, underpinned by the belief that this practice mode is right for the MoE-SE setting.

Moreover, in keeping with the service pathway, therapists' ecological approach extends beyond the micro-level of student, curriculum and school participation, set on a far bigger picture. This vision is for inclusion and for enabling and empowering whole school communities to know how to transition students with special education needs into their communities, of knowing how to include the student in the community alongside all other students. It is a vision that seeks to cascade this 'knowing how to do it', so that Yolanda, for instance, and her colleagues may move on to the next school.

Theirs is a culture of practice focused on building inclusive school communities and enabling participation.

> **Yolanda:** I think a key skill is to design enabling environments so we are looking at adaptations that might be needed to the physical or the

> human environment of the child that would enable them to participate or to perform tasks at school. So we need to think occupationally and we need to collaborate and we need to think about adapting environments to meet needs [*of students*].

Phillipa simply puts it this way:

> **Phillipa:** Because often, it's not the kid that we are going to change, it's the setting.

At the end of the day, it is about the student and valuing the student as a rightful citizen of a school community and society. Leanne sums up the group viewpoint:

> **Leanne:** In spite of often spending least time with the student, it is still the student and what is best for the student that is at the heart of all the work I do. How can I change things to make a long term positive difference for the student? What do we as a team see as the potential future for the student? What needs to happen now, and what can happen now, to help ensure the student reaches that goal? What can safely wait till later in the student's life? What role can the student realistically play within the team? A very young student needs guidance and fun and achievement, while an older student can become the driver of the process. They still need fun and achievement and guidance, but less directive and less controlling. How can I support the student within that role?

However, despite the many tensions related to being inside the emergent culture, the therapists in this study are committed to the culture, and indeed their practice context and the work that they aspire to do.

Tensions in the Practice Context

In the main, several key tensions are revealed in the data. One is to do with tensions that arise when practising with legislation. Another is to do with the tension between honouring inclusive practice juxtaposed beside parent/family/*whānau* and school perceptions and expectations of therapy services. This is linked to the working under the press for traditional therapy practice. Yet another tension is tied to being a part of a politically-bound organisation that has undergone nearly a decade of change. In the main, these therapists work in a pressurised practice context and they live their emerging culture under these conditions.

Practicing within Legislation

Whilst the data in this study suggests that the therapists find it comforting to be nestled within special education policy, this is not without tension. Melinda believes that having the special education policy framework is advantageous because "it is sometimes quite good to have that very formal boundary". It is as if the definitive nature of the policy symbolises an invisible protective boundary for the therapists, behind which they may stand. Furthermore, they use this boundary as a means of articulating the *why* of their practice and indeed *who* they are as MoE-SE practitioners.

Melinda reveals that the policy protects her from feeling overwhelmed. In a sense, it assists her to manage the tension of her past and present cultures, not unlike the tension Bonnie identified in Chapter 5 about practice feeling "right" or not feeling "right":

> **Melinda:** Sometimes you've got to recognise that you can't meet all of the child's [*needs*]. I had a tutor when I was student and she used to always say "well girls in utopia this is what we would do". Then she would turn to us and say, "but this is not utopia and this is what you might do". And, as physios - often you do have a utopian idea of what you would like [*to do*]. But coming into special education you've got to narrow what your limits and boundaries are and what you are offering to that child. Which isn't to say that that child won't have those opportunities, but there are other people responsible [*for this*]. And you just need to recognise that we can't do everything for everybody. So it's good to know what the boundaries are.

Policy serves to clarify caseloads and the extent of service provision. This, in turn, appears to help further shape values, beliefs and patterns of behaviour. For instance, clients' needs are always weighed against the backdrop of policy as well as multiple environmental factors. Because of this, it seems this community of therapists has become a reflective one:

> **Yolanda:** I think that it's really important to question our practice and I think that we need to be having lots of conversations about practice. That's a culture that we need to really promote within our offices and within our occupational therapy and physiotherapy team. What I am really interested in is exploring how much have we critically reflected on the collateral effects of therapy?

And, in seeing this, I wonder if reflective practice therefore serves the purpose of assisting the therapists to manage some of the tensions of their practice context.

Not only do they question their practice, as Yolanda put it, they also question the fundamentals of the policy framework, which potentially constrains their practice:

> **Pauline:** Perhaps there are some students that we should also have intensive contact with to boost their abilities. [*But*] that is limited by the amount of time we are employed for by our employer. The time component prevents it from happening.

Here, Pauline highlights the tension that arises from being a health practitioner who is constrained by organisational issues, policy and cultural beliefs that emphasise student participation and environmentally-driven practice behaviours. I see that life is not easy in the emerging culture:

> **Sandra:** I actually think it's become harder. I think we are more restricted now being Ministry of Education than we were in Special Education Services. All that political stuff. I think that being a public servant and working for the Ministry has now added a level of constraint in what we are able to do that wasn't there before. I think that advocacy role that we did feel reasonably comfortable with doing is not there anymore. I've actually had a parent ask me to do something, and I've said, "well, I'm sorry I can't act as you advocate over that". I said, "well I work for the Ministry, I can't advocate for you in this situation because it's my employer that makes the decision about your teacher aide time". So I think in those situations it has become slightly harder. I think as far as the Ministry goes [being *both funder and provider*] it's like a conflict of interest.

Thus, from what I have observed, heard and experienced in the fieldwork setting, I see that whilst MoE-SE therapists may be convinced of their ways of practicing, living the culture and practicing within the culture is fraught with tensions.

In one sense, being reflective represents a healthy attitude to practice and indeed cultural perspectives, given that truth is never absolute, but rather socially constructed. From my view as an ethnographic researcher, this signals that there is room for flexibility and adaptation in the therapists' cultural perspectives. By this I mean, that whilst MoE-SE therapists may be forming their culture of practice, filled with strongly held and espoused values and beliefs around inclusion, participation and collaborative practice, they still realise what may be 'good', 'right' and 'proper' in their emerging culture may not necessarily be the case. And, because of this, perhaps they are safe from becoming rule bound in their culture. Perhaps they are safe from committing cultural hegemony, seeking to assert their culture upon others to become the dominant culture in the wider

education sector. Thus, challenges, tensions and barriers to practice trigger reflective practice and these are, in fact, healthy for cultural evolution.

The Press for Traditional Practice

There are times when practice is also an uncomfortable place to be for the therapists. This comes through especially in relation to the pull between the biomedical perspective and the inclusive perspective, enmeshed in working with others' values and beliefs and their perceived expectations of MoE-SE therapy services. Cassie's story serves to illuminate this tension:

> **Cassie:** One that springs to mind immediately is when the parents have requested of me a therapeutic programme. For example, a hand function programme. And they expect me to actually take their child out of class, and sit in a separate room and work on getting the hands to work better. Now that in itself is not a bad thing, but for the students where I know professionally that everything they need to drive their hand function actually exists in the curriculum, and that if the student is already engaging in those activities, they will be practicing and repeating those skills that they need - in terms of getting better hand function. But, the family has the mind set that therapy equals - almost like a rehab type situation. Then I feel like I've stepped into the medical model, and I'm not looking at what it is that [*I should be*]. It becomes I'm looking at the impairment, and I'm looking at "fixing" the impairment, and whilst that might be important at different stages of the child's life, those families have chosen for their child to go to school to learn and be a part of the school community. And I'm going in there and actually removing them, and being counter to what they're supposed to be there for. So, it kind of feels not right.

Cassie is caught between two paradigms and two sets of values. She feels compelled to meet the demands and expectations of the student's parents and she feels compromised by this situation because it means she is not practicing in line with her culture. She is being asked to return to her past ways of practice. Like Bonnie and others, the strength of her belief in inclusion makes any other practice feel uncomfortable for Cassie. She now comes from a culture of practice which believes that services are not about fixing the student. However, as she continues sharing her story, it seems that Cassie then contradicts herself, but the reason becomes apparent:

> **Cassie:** But, I've done it [*provided a therapeutic programme*] because what I've done is respected what the family want and gone down that track. You almost have to have a flexible attitude and be willing to sometimes step out of where you see yourself as a professional and put yourself back in a place that meets the family's needs.

Here, Cassie reveals her valuing of family voice. Therefore, in this exemplar she chooses to honour the voice of the family over her cultural beliefs. Even though it may not feel right to focus on the child's impairment level, in the instance above, Cassie reveals that in practice these therapists consider and often choose to honour the parent's voice, to listen to where the family is at and to respect the parent's wishes. For instance, Cassie opts to provide the intervention support that the family has asked for, rather than what she thinks should happen for the student. In this very act of flexibility, Cassie declares that the client, in this instance, is *not* the student, but the parent, and she is willing to work with that accordingly. Her cultural upbringing of listening to and honouring client voice overrides her professional opinion, driven by a belief in meeting the family's needs.

Cassie then shares a further tension in her practice context:

> **Cassie:** There are students that we [*physio*] often talk about - children with cerebral palsy definitely need intensive therapy type things happening in their lives from time to time. We can't provide that, but professionally in my experience they would benefit from that. We don't do any of that because there's no time to do that. But having said that, with an increase in time, I can look at going in and seeing the student more often - not necessarily to take them out to do handwriting, hand function type things, but I can go into that classroom and I can be in that classroom several times with the teacher, with the teacher's aide. Or I can see the student after school and do a therapy programme. A lot of what I am doing is, perhaps, maintaining these children [*with cerebral palsy*] managing them at a level where they won't regress. But if I were able to do the intensive work, their progress might be more - not necessarily in learning, in the physical.

Again, she reveals how it is as though she is caught between two worlds: her current culture of practice and her previous culture of practice. Cassie, like other therapists, believes that providing therapeutic programmes often goes against the grain of the group's practice philosophy, with its focus on enabling learning and participation at school. Yet, flexibly, she also holds up an argument for the case of meeting students' needs at the impairment level. She therefore does not discount the option of providing intensive programmes for student groups according to their health condition. It seems that there is a case for arguing both perspectives as far as Cassie is concerned. This appears to be one of the paradoxical realities of the MoE-SE therapists' culture. Cassie and her colleagues must be prepared to traverse two worlds (biomedical model and

education model) based on the needs of their clients and they must be able to reason which client voice resonates with the most *need*. Perhaps this is one of the end points of becoming enculturated as a MoE-SE therapist? Thinking back to Bonnie's statement, "you have to be someone who likes to explore down different roads and to be someone who can cope with not having answers in a box", I am reminded of what Leanne and Cherie also said about working with families and it becomes clear that this is what underpins Cassie's words. Theirs is, at times, a paradoxical practice context to work in which creates tension and which one has to learn to navigate a path towards the 'right' course of action to take.

Organisational Stressors

Another tension sits with belonging to the organisation, filled with frustrations and stressors stemming from perceived service fragmentation, bureaucracy, organisational restructuring and a lack of organisational understanding of the nature of practitioners' work. Such frustrations are seen by the therapists as barriers to good practice: hindrances that threaten the very core of their connectedness to the organisation and emerging culture:

> **Phillipa:** We are at risk of being a very fragmented service I think. I mean most District Managers have no idea what good practice is in therapy and have no idea of how to provide it. We are sort of working in this vacuum really, and providing what we think is good service and educating people [*therapists*] who come in, but who knows. Well I mean they [*managers*] don't know anything about the way we work. I just do feel it's harder to have the team approach and have that sort of - that same focus - when nobody's leading it.

The lament is for loss of cohesion, fragmentation and lack of organisational understanding of what effective therapy practice means, or looks like in MoE-SE. "All the systems are falling down and there is a lack of understanding as to why we might work the way that we do" (Cassie). Furthermore, constant change has brought about a sense of disintegration to previously strong-bonded teams. The pervasive attitude in the data is that the 'knowing of practice' no longer resides at all levels within the organisation and I sense the potentially destructive undertone of a rising 'us and them' state. At the level of the organisation, it conjures up a vision of a ship with no helmsman or unifying leadership at the grassroots level.

Thus, for these participants, one tension at the organisational level stems from the perception that there are not "always people in the organisation who understand our work" (Yolanda). Moreover, supporting the aims of participation and learning through the provision of educationally-relevant therapy services is hindered by the lack of understanding of what the therapists do. Melinda, however, is forgiving of the organisation:

> **Melinda:** It helps to be positive about the organisation you work for. You like to think that that's actually coming down from National Office, that they actually know what you do. I'm not quite sure that everybody knows exactly what we do, but you know, it is a big organisation.

However, she too signals organisational bureaucracy as a stressor. At the end of the day, Melinda wants to focus on what's really important to her as a practitioner, that is, the student:

> **Melinda:** I am still not sure whether, you know … this policy, that policy, this vision and that vision … I still sometimes think "well I am actually just a little person down there, little Jane Bloggs, and I've got little Johnny and he, oh, can't get that wheelchair up the ramp". Well, I'm not sure whether the CEO is aware that little Johnny can't get his wheelchair up the ramp and to me that's all I care about. That's the coal face, yeah. I want him to be able to get up there. And then there's this big great gap and you are not sure whether all the higher levels actually are aware that that's the reality, there is the reality. Plus special ed [*education*] is so wide. You've got everything, I mean you've got the ORRS students and that's a wide spectrum, from the severe-severe disabled students to the mild or the moderate physical disabilities; the communication strand; the enormous behavioural component. Yeah, it is a big umbrella. Massive. Yeah, I think so. And little Johnny getting up that ramp well (laughs). But you see, to Johnny, he doesn't care about anybody else either.

Like Melinda, Phillipa also finds bureaucracy a challenge:

> But as far as working for the organisation goes I do find that as it's a government department you don't have the same information that you've got when it wasn't a government department [*referring to SES*]. Stuff takes longer to filter down to the Indians.

Constant restructuring has also had a disintegrative effect on the therapists' emerging culture. Restructuring threatens the process of enculturation and the overall effect may be cultural erosion:

> **Phillipa:** As far as the environment of GSE goes I think it is less easy now that we are not working in a dedicated ORRS team. I think when we were an ORRS team it was much easier for everyone to see, work in the same way and the philosophy came through a lot more. Now that we are working in School Focus teams we get a new physio who is in a different team and I will think "well I am going to actually school

> that person up". But it's certainly not my responsibility and nobody - sometimes I don't think that there is any expectation that I will do that. Whereas when it was an ORRS team there was an expectation you would buddy with the other PTs and OTs. Now we are working in different teams and there is one PT and one OT in this team and one PT and one OT in that team.

Sandra, too, has a lot to say about the current systems within the organisation, revealing some of the things that hinder her from going about her work:

> **Sandra:** My personal feeling is more to do with the systems I work in. My employment system at the moment feels to me that they hinder my work, more than going out to schools. I mean you can get fed up when you - when things get said to you at school, but that somehow is different from not feeling supported by your management. I think the type of work we do, you expect difficulties to arise occasionally with the school, or with families or with the hospital, or something like that. To me that's one half of the work. If you feel that you are supported by your management system within your work, your place of work, then they are helping to facilitate you doing your job. When you feel that you are getting it from both sides, you are getting flack from schools and families, but you are also getting - you don't feel that your management is supporting you, that's when the job becomes rather difficult. And I really don't feel at the moment that the systems that we've got in place feel facilitatory for a start.

Thus, I see that this is also a culture of unrest, brought about by changes at the organisational level.

Issues which hinder practice are perceived by the group as lying with 'the system' and 'management'. There is an element of blame in the culture. Whilst the therapists' own culture may be new, it perhaps will remain static and fragile in its crystallisation, immersed in such alleged organisational cultural chaos. As a theme, "restructuring" stands out as a key organisational stressor. It is like the steady pounding of waves on rocks, such that it has begun to wear this long-serving group down, in some respects threatening the base of their commitment to the work:

> **Cassie:** The system that we work in kinda says that these children should be out there [*in regular schools*] and then it actually cuts us off at the knees in terms of providing them support. And now that we've been merged with the system - the system that's driven the policy - we're now actually part of that system. So we're actually the policy makers and the providers. And you have to, I don't know, be stupid sometimes to work in that system, you know, because we're going in and we're saying "I'm here to help you" and at the same time saying "you can't have that, well, not very much".

With this come expressions of feeling unsupported and feeling professionally vulnerable:

> **Yolanda:** I think that practice is unsafe quite often and I think that organisationally there are huge gaps in terms of understanding our work, and having policies and structures in place to keep therapists safe. And I have quite big worries that therapists are going to be 'meat in the sandwich' under the new legislation - that we will be vulnerable under HPCA [*Health Practitioners Competence Assurance Act 2003*]. So I think that the way that we have been called to work is hugely risky without policy around or standards around services.

Moreover, practice feels open to risk:

> **Bonnie:** There aren't safety-nets around caseloads. We don't have a waiting list -makes you unsafe in your practice because there is no measure, there is no safety-net.

> **Phillipa:** We think it's good but not everyone has that same perception of us and that can be quite hard, I think. But what I see is us going out and doing a really good job with kids. [*This*] is not what a lot of people's perception of it is.

Risk is expressed in terms of overload; a harbinger of stress:

> **Pauline:** It's stressful because you always feel so overloaded and that has to do with the amount of time we are employed for and the number clients you are supposed to take responsibility for. And it is always stressful because there are many colleagues out there that don't quite come to terms with how we work and therefore you always walk around with this feeling that they look at you thinking that you are not doing a good job and I've always felt that and I don't think that that is going to change very soon

It is therefore a vulnerable culture in the absence of clearly articulated texts.

Working under pressure

Thus, the therapists perceive many things push and pull in their emerging culture. Cassie reveals some of these things in the excerpt below, as she vents somewhat indignantly in her interview, as if on a pet subject:

> **Cassie:** What really hinders my work is the constraints, the minimal resourcing, the constant meetings about how we are going to do our work, which takes away from actually doing our work and the lack of understanding around ORRS students. It can get in the way emotionally. So I think you have to be a duck, you know, "water off a duck's back", otherwise you'd be a mess [*working here*] I think.

Feeling overloaded seems to be part of the culture:

> **Pauline:** It's stressful because you always feel so overloaded and that has to do with the amount of time we are employed for and the number clients you are supposed to take responsibility for.

There is a sense that the therapists' spirits are worn down by the perception of workload versus worker FTE capacities.

Yolanda sees this as a force which impacts on the quality of her work.

> **Yolanda:** For me workload is just the biggest thing and it means on many times that I can't deliver a quality service, or a service which is the high quality that I would like. And despite working inclusively, collaboratively, all of that, there is way too much work and I think that has a huge toll on people, and on me, and my family, and all of that, so the pressure of work hinders.

Yet, despite all these issues, stoically, these therapists have remained with MoE-SE for many years now, bound by the vision of inclusion for all students in regular school settings. The perception is one of a constantly teetering caseload and a wearied community.

Furthermore, despite the many tensions, the challenges, pressures, barriers and constraints that the participants raise with me, I still sense that theirs is a culture that extols persistence in striving to do the best that they can within constraining variables:

> **Yolanda:** I work across two district areas so they are huge areas. They are huge jobs. The workload pressure is one side of it, but there is a huge strength in the team. I know if I can't get to a school then we could relatively safely put other things in place, or go around that problem. I can have a phone call for a complex problem and then I can phone back and they say "yeap, that worked" and you know that you've made such a huge difference, and it took nothing [*other than a phone call*].

Observations in the field reveal that this is a trait that mirrors an unspoken expectation from the employing organisation, which these therapists have either bought into or hold as a personal characteristic.

Thus, within the tensions of the practice context and tight bounds of policy, MoE-SE therapists seem to have learnt to construct some defences to manage the stressors and frustrations of setting. For example, one defence centres on effecting prioritisation strategies:

> **Melinda:** My question is always "do they have a wheelchair and/or walking frame?" I feel that I should prioritise my time to these students, and only see others if there is a specific reason that another team member cannot look at – and then try to do a once only solution for the other students.

The relationship between the environment and the student's need also comes to the fore when determining who to provide services to, or where to concentrate one's efforts:

> **Yolanda:** The school environment makes a huge difference, because sometimes there are a lot of moves in the school environment. Not always to do with the student, but often in terms of the people around the student. How well they understand the student's needs and can interpret their communication, and so on. So the school environment makes a huge a difference. I've had this thing in my mind because "how do we set priorities about our work?" I think that if there is a problem, and a repeated problem, that's the school that you need go to, and you go a lot. And you need to build relationships and work with them, and when you come to a point when there is not a problem any longer - "this is it". Such a subjective thing, but actually it works really well. So if it's a school knocking on your door to say "this, this, this and this", don't say "don't do that, don't do that, oh sorry no you've got it completely wrong", just go. And just work with them from where they are at, because they don't have a good match between the child's needs and what they can deliver and understand. And if you just work with that school, often then, you can make a difference. And then over time things might change. It's not always the case and we do have some schools that continually need lots of support, and I think that that's because they are wanting us to fix the children, and we won't. We can't.

Thus, in the end, for these therapists it appears theirs is a culture of practice that includes tackling inclusion and societal perspectives on inclusion heads on, driven by their vision of making a difference in students' lives and, ultimately, in the long term, society in general. As such, it spurs them on:

> **Cassie:** It influences and hinders, but it doesn't stop me from doing a good job.

These therapists are bulldogs, they have grasped inclusion by the balls and they are not going to let go! They have bought into the vision of building an inclusive society. Moreover, these therapists enjoy their work, seeing purpose to their contribution and they value this aspect of their work:

> **Deb:** I like the job. I really like the way we practice and I like going to work. I like going out and seeing the kids. I feel that we actually have something to offer working the way we do.
>
> **Yolanda:** I really enjoy the work. It's hugely powerful and I feel really lucky to be in this place, in this time, because I think it's cutting edge practice.

And, as Yolanda reveals, I wonder if perhaps this is where school-based practice needs to go in the next decade, if not sooner.

Summary

This chapter has revealed aspects of what the therapists in this study value. Such values include people, relationships, students being students, and their work with students,

families, colleagues, and school staff. It has also expanded upon some of the modes of practice manifested in the culture, such as their role as inclusion brokers and fostering client buy-in. The collective stance on where their focus as therapists lies, in relation to students with disabilities and traditional practice, is revealed, framed around notions of not fixing the student at the level of their impairment. Rather, practice is more focused on enabling processes and on environmental aspects of a student's school life.

Theirs is a culture that is nestled within their employing organisation and the special education legislative framework. Because of this many of the group's attitudes, values, beliefs and patterns of behaviour mirror the principles of organisational policy. Practice, and in turn cultural underpinnings, aligns with the Government's schooling strategy. To this end the therapists in this study follow the MoE-SE service pathway: *Poutama*.

However, much of what is revealed of the culture of practice still revolves around the core tenets of inclusion, collaborative practice and enabling student participation in their schools of choice. This much is so because the reality of the group's practice context requires it, both at the organisational level and because practice must be consistent with Government strategies and the special education policy framework. It can be said, therefore, that these therapists are *required* to bring about change not only for the individual student and his or her school community; they are required to bring about change at a societal level.

The last chapter of this ethnography will draw the findings together and relate it to what is known, or yet to be known, in the context of the broader literature. Chapter 7 therefore aims to draw the threads of the group's cultural tapestry into some semblance of a meaningful whole, whilst acknowledging that theirs [*MoE-SE therapists*] is a culture of practice that is still evolving, as is the nature of culture. As such, perhaps it will always be an unfinished tapestry, one that is passed from generation to generation of MoE-SE therapists until time moves them on, perhaps in another *waka*, perhaps to another *whenua* (land).

Chapter Seven: Discussion & Conclusion

> We must be vigilant in practice to notice what might support or hinder a positive outcome; it does not matter how theoretically brilliant our recommendations are if families, teachers, and children don't use them because some contextual feature prohibits implementation. The artful dance of practice lies in a therapist's ability to stay relevant to the child and family's lives. (Dunn, 2002, p. 15)

> We envisage that … practice will focus on occupational performance; will be more client and family centred; and as a result, will be community based. We see [occupational therapy] practitioners building partnerships with clients and working collaboratively with persons … to remove environmental barriers that diminish or discourage their participation in everyday life and their community. (Baum & Law, 1997, p, 278)

Introduction

I chose to start the discussion chapter with the above quotes because they seem to epitomise the contextualised 'best practice' or evidence-based practice that MoE-SE therapists are in pursuit of, and which this study is a part of, beginning with our cultural underpinnings. In addition, my quest is for local knowledge, specific to Aotearoa/NZ. This was also the emphasis of my literature review. Because of this, this study did not seek to identify ways that practice in Aotearoa/NZ differs from practice internationally, rather it is concerned with pointing to the consistencies of international trends with local culture. It also sought to discover the goodness of fit in relation to the Aotearoa/NZ context.

At the outset of this study I set out to answer the question: *What is the culture of practice of Ministry of Education occupational therapists and physiotherapists?* In doing so I journeyed a path of ethnography, guided by *kōrero* (dialogue or conversation) with thirteen participants, alongside my experiences in the MoE-SE fieldsite, to get at the heart of the culture, which is also my culture. The last chapter of this thesis, therefore, offers the woven tapestry of this culture. It is an unfinished, yet rich tapestry that fulfils the original intent of this study. I have explored and I have come to a place of cultural understanding so that I might share knowledge of the culture with interested others. Accordingly, this tapestry has been woven to articulate the contextualised *how* and *why*

of MoE-SE therapists' culture. It therefore illuminates some of the reasons why these therapists practice the way they do in Aotearoa/NZ.

In this chapter I summarise the findings and discuss how the findings relate to the broader literature, as well as overview what new knowledge has been generated by this study. Lastly, I consider the limitations of this study, as well as presenting the directions for any further research and audience-specific recommendations.

Beginnings and Endings - Summary of the Findings

My particular view in this study is that people actively construct meanings from the world and from their inter-subjective interactions with others and objects in the world. Looking through a cultural constructs lens, I sought to uncover and reveal the group's shared cultural meanings, including their communally learned and shared practice ideas, attitudes, beliefs, values, and patterns of behaviour. My ethnographic intentions were to culturally inform occupational therapists and physiotherapists' school-based practice, facilitate MoE-SE therapist induction in the organisation and, perhaps, provide a text that might help therapists reflect on their practice with school-aged students in relation to inclusive education.

Analysis of the data from this study uncovered a number of core values and beliefs held by MoE-SE therapists. It also revealed that, in the main, there is congruence between therapists' values and beliefs and their patterns of behaviour. I have framed these into key statements for discussion purposes and for uncomplicated consideration by the reader (see also Appendix 21[8]).

[8] Appendix 21 contains Slide 1 of a powerpoint slides presentation I completed in the final phase of thesis write up. Slide 1 in particular summarises the key outcomes of my study. It represents the core elements of MoE-SE therapists' culture of practice.

The following statements reflect the core essence of MoE-SE therapists' culture of practice[9]. These form the foundation of MoE-SE therapists practice narratives and, therefore, their communal practice behaviours:

- Inclusion is at the heart of all we think and all we do.
- It's about inclusion; it's about inclusive practice.
- We value students *being* students (learners, peers, friends, players).
- It's about enabling student participation and learning in schools.
- It's about collaborative practice and collaborative consultation with others.
- It's about fostering societal change.

Consistent with these values and beliefs are a range of principles that guide MoE-SE therapists' ways of being or, rather, patterns of behaviours, including, but not limited to:

- Respecting and valuing others and their contributions
- Working in partnership with others
- Teaming with each other
- Being ecological in one's approach to assessment and intervention
- Being inclusive
- Being collaborative
- Communicating sensitively
- Listening to *and* hearing others' voice and perspectives
- Not being "the expert", and
- De-emphasising biomedical perspectives of impairment and fostering student identity.

Furthermore, the findings revealed the extent to which the group's culture is organisationally embedded. That is, the therapists' sub-culture seems fully aligned with that of the organisation. This is evident when it is held up against the MoE-SE *Professional Practice* survey of 236 of approximately 800 practitioners (MoE, 2004c). This survey used an email questionnaire and focus group interview methods to identify the core skills of a range of GSE specialist practitioners. Findings were categorised into key attitudes, values, beliefs and key principles of practice, which I have summarised in

[9] The use of the heart as bullet points is symbolic because it signals what lies at the core or 'heart' of MoE-SE

the Appendices (refer Appendix 22). Set against those findings, it is difficult to ascertain where the occupational therapists and physiotherapists' 'sub-culture' starts and ends. The therapists in this study have bought into the vision of inclusive education and perhaps they are not a sub-culture, in as much as they are enculturated by the organisation and by policy. They have been the participants of events and circumstances that have primarily driven them to respond differently as therapists. As a result, they have produced a practice culture that has allowed them to adapt to their context. They have collectively threaded together their sense of identity and patterns of behaviour and this in turn has shaped a culture of practice. Furthermore, they have sought to gain the best cultural fit within their practice context, becoming in effect a sub-culture of their respective professions.

Of interest in the findings was the absence of any real difference between the two groups of therapists in this study in relation to the cultural notions I uncovered. This may be related to the degree of organisational embeddedness of the culture, as well as the depth of their enculturation of each other. Furthermore, it appears that at this point in time of the emergent culture, there is little to no critical reflection by the therapists as to whether this outlook is the 'right' worldview to take in their practice setting. Rather, it seems the culture is at a stage of development that is concerned with primarily ensuring the 'goodness of fit' of elements of the culture within the education sector. I suspect or hope that critical reflection will come for the group once cultural stability is achieved.

To practice in their culture the therapists are cognisant of the need for MoE-SE therapists to fully understand and be conversant with the education system, including the special education legislative framework and the mission, vision and policies of MoE-SE. They must also get to know multiple school communities and each culture that ensues in each school. Knowing the education system and its policies is paramount to learning to recognise what is right to do with regards to social structure and practice in the Aotearoa/NZ education context. Thus it is perhaps not surprising that themes that arise in this study mirror the values and beliefs found in the professional practice survey of

MoE-SE fieldstaff (MoE, 2004c). In addition, MoE-SE therapists' values and belief systems appear to be well aligned with contemporary ways of thinking about therapy practices in the education context (Block & Chandler, 2005; Booth et al., 2000; Brandenburger-Shasby, 2005; Bundy, 2002, 2004; Case-Smith & Rogers, 2005; Coster, Deeney, Haltiwanger & Haley, 1998; Hanft & Place, 1996; MacArthur & Kelly, 2004; MacDonald, Caswell & Penman, 2001; Swinth & Hanft, 2002).

However, *what sets the group's culture aside as distinct is their therapy worldview*. This worldview is focused on linking function or meaningful, purposeful occupational performance with school-based occupations, occupational form[10] and occupational contexts[11]. This seems especially so for the occupational therapists in this study who, I believe, have acted as key drivers in shaping the MoE-SE therapists' culture. Accordingly, this is in line with their occupational therapy professional values system, related to client-centred and occupational practice (Christiansen & Baum, 1997; Fearing & Clark, 2000; Hocking, 2001; Townsend, et al., 1997; Whiteford & Wright-St Clair, 2005). This finding is not surprising, since this is the substance that forms the foundational narrative of the profession: occupational therapy.

Enculturated by the Emerging Culture of Inclusion in the Education System

Culture tends not to be something people think about in their daily lives, except perhaps when they are faced with language or behaviours that are difficult to grasp, and which seem to come from an "*other*" culture (Dickie, 2004, p. 170). It is proposed that this may be the case for the first group of occupational therapists and physiotherapists who took up employment with MoE-SE and were faced with language and behaviours that were different and sometimes difficult to grasp compared to their health sector experiences.

[10] Occupational form refers to objects, materials and environmental surrounds, or characteristics of the physical environment, as well as the socio-cultural dimensions that affect a person' perception and interpretation of actions taken (Christiansen & Baum, 1997, p. 6).

[11] Occupational context refers to elements of the environment (physical, social, political, cultural, spiritual and technological) in which occupations are engaged in (Fearing & Clark, 2000).

As in any cultural transition, these therapists would have had to adapt in order to survive (Haviland, 1999), and indeed they state that they have:

> **Yolanda:** My beliefs and values have changed.
>
> **Phillipa:** We have a lot to offer, but it's just not that traditional therapy model.

MoE-SE therapists are enculturated by their work context and by the inclusion worldview. They have blended their past with their new beginnings to shape a new and contextualised culture of practice. Accordingly, this is part of the nature of learning to be part of a new society (Miller, 1999). As culture would have it, individuals thrown together inevitably become a society through the process of enculturation. Where there is society there is culture, neither able to exist without the other (Haviland, 1999). Most importantly, it seems that the therapists' emerging culture has been powerfully shaped by notions of inclusion, inclusive practice, social justice and citizenship, in keeping with contemporary notions espoused in the literature (Ballard, 1999; MacArthur, Kelly & Higgins, 2004; Slee, 2001).

In general, therapists' personal and professional values and beliefs link who they are as practitioners to what they know (Mitcham, 2003). This is revealed in the data as true for the MoE-SE therapists in this study. So much so, that they either actively sought out or unknowingly found themselves drawn to the very practice context that would enable them to express their inclusive worldview in their practice. Nonetheless, making the shift is not without challenge and struggle:

> **Melinda:** the bottom line is I am a physiotherapist *and* you've got to have an understanding of what education is *as well as* what a physiotherapist does *and* you've got to try and marry the two together.
>
> **Yolanda:** For me workload is just the biggest thing and it means on many times that I can't deliver a quality service … despite working inclusively, collaboratively … there is way too much work … that has a huge toll on people.

Once acculturated, the group's collective values and beliefs come to bear on what they all deem is 'right' and 'good' in their practice lives as MoE-SE therapists. Such notions translate in to what they accept as 'truths' in the world. Paramount truths for these

therapists are therefore inclusion, inclusive education and students with disabilities and special education needs *being* students. These truths are shared not only with the organisation they work for, but are also clearly expressed through the NZ Disability Strategy (MoDI, 2001). Moreover, such truths are called for in the disability discourses of today (Neilson, 2005; Slee, 2001).

These therapists are enculturated into 'living and breathing' inclusive practice. This permeates the very core of the MoE-SE therapists' collective practice worldview, manifested in their actions, as well as in their practice priorities and standards, language and ways of being a MoE-SE therapist. In addition, their values and belief system influence the type of theoretical information the therapists are drawn to and which reflect the basic worldview of inclusion. This in turn serves the process of enculturation. As noted in the field, they draw from the backdrop of a range of literature espousing inclusion philosophy and inclusive practices, such as Ballard (1999, 2004), Booth et al. (2000), Bundy (1995, 2002), Case-Smith and Rogers (2005), Dettmer, Thurston and Dyck (2001), Hanft and Place (1996), MacDonald, Caswell and Penman (2001), Mentis, Quinn and Ryba (2005), Slee (2001, 2004), and Snow (2004a, 2004b) and Swinth and Hanft (2002) to list a few. Practice is also clearly informed and shaped by the Aotearoa/NZ Government's schooling strategies and legislative policy framework on special education.

In anthropological terms, culture largely structures the behaviour of a group, or people, striking a balance between the self-interests of individuals and the needs of society as a whole. However, people are not passive participants of culture (Bates & Fratkin, 1999). Rather, they shape and modify culture and their circumstances. This appears to be the case for the participant group in this study. Thus, whilst MoE-SE therapists have may have come with a pre-wired cultural background, they have adapted and changed to fit within MoE-SE culture. In turn, cultural adaptation has served to shape their culture of practice, allowing them to change and adapt in direct response to events and changes in their practice context and circumstances. As stated, this is in keeping with the nature of

groups and societies and indeed cultures (Haviland, 1999), allowing structuring of behaviour and further shaping and modifying of culture and circumstances.

The fields of anthropology and sociology also acknowledge the shared nature of culture. The notion that no two members of a culture will have the exact same version of their culture is also acknowledged. There will be differences in perceptions. This is not surprising given that the process of enculturation is individual (Bates & Fratkin, 1999; Cockerham, 1995; Haviland, 1999; Miller, 1999). Indeed cultural variation is viewed as an important aspect of culture. Both variation and diversity play significant roles in societal change (Bates & Fratkin; Cockerham). However, in this study, I found little to no variation in what the therapists reveal as core cultural values and beliefs, nor is there much variation in *what* they *do* in practice (patterns of behaviour), however there is tension in living the emergent culture, such as the tension between traditional, biomedical perspectives and occupational practice.

That there is little variation in the findings may be related to the fact that I only looked at a slice of the group rather than the whole. I only interviewed experienced MoE-SE therapists and did not include those who were perhaps in the throes of enculturation, those who had exited the group, or those on the outside who do not want to join MoE-SE. This might reveal variations in the culture as well as any differences.

Inclusion is at the Heart of all We Think and Do

MoE-SE therapists have come to contextualise their practice within the boundaries of not only their emerging culture, but also in line with government strategies for special education in Aotearoa/NZ.

> **Yolanda:** Inclusion to me means that children learn in their local schools and they are part of the whole school environment … schools cater for diverse learners and therapists understand the dynamics of, or the collateral effects of, therapy in special education.

Inclusion is at the heart of MoE-SE therapists' practice reality, enmeshed and reflected through their practice attitudes and behaviours and, moreover, their culture of practice.

Theirs is a culture of inclusion!

The therapists' plans and actions are therefore based on clients' vision and values, whilst taking clients' respective roles, culture and environments into account. In this culture the approach taken is ecological. Whilst there are many types of clients, such as students, school staff, and families/*whānau*, it is primarily the views of the family-client and student-client which prevail in times of dissonance. In addition, the therapists' focus is on curriculum and school participation and they value and adhere to principles of inclusive teaming.

Inclusive practice is, therefore, situated within inclusive values and beliefs, inclusive policies, collaborative partnerships and inclusive assessment and teaching processes (Mentis, Quinn & Ryba, 2005). It is manifested in student participation at the level of school culture, curriculum and community and the reduction or elimination of exclusion from said things (Booth, et. al., 2000). Such are the building blocks which the therapists in this study have collectively come to recognise as the central elements for quality service provision in schools along their cultural journeys.

In addition, these therapists recognise that whilst legislation may espouse the rights of all students to access learning opportunities in regular schools and that a Disability Strategy exists as a framework for fostering rights to participation and the building of an inclusive society, this does not necessarily mean that students *will* be included in school communities as valued members. Indeed, inclusion and inclusive practice go far beyond the simple writing of policies and the location of students with disabilities or special education needs in regular classrooms (Ballard, 1999; Booth, et al., 2002; Dettmer, Thurston & Dyck, 2002; MacArthur, Kelly & Higgins, 2005). Such notions are primarily situated in the attitudes, values and beliefs of individuals, communities and society as a whole (Booth, et al.; Neilson, 2005) and whilst dependent upon educational structures, policies, processes and practices, they are underpinned by "notions of social justice and citizenship" (MacArthur, Kelly & Higgins, p. 66). Someone has to run up the flag for inclusion and these therapists have chosen to.

I am struck by the notion that this is a group made up of "stayers"; a community where change occurs slowly and therefore one needs to be "in for the long haul". One must foster an attitude of "taking the time" and "allowing time for events to take their course" and one must be patient in waiting for change to occur in other peoples' culture, so that change may occur in students' lives. These therapists are required to bring about societal change. This is markedly different to the expectations of therapists in health settings, whereby change is expected at the level of individuals' health outcomes.

Theirs is a culture of brokering inclusion!

Students *being* Students

In the worldview of MoE-SE therapists, going to school for students with disabilities and special education needs is more than about having therapy for their impairments. Going to school is about *being a student,* a learner, peer and friend. Contrary to the traditional belief that the student is at the centre of practice, in this study *inclusion is at the heart of MoE-SE therapists' practice*. This is because these therapists have come to perhaps realise that one can not effect helpful outcomes for the student unless they address contextual or environmental aspects of the student's school lives, not just at the physical level but also technological, spiritual, social, cultural and political.

In the worldview of students, MacArthur and Kelly (2004) identified several restrictions recorded in the literature and from their own qualitative studies that students described as limiting their opportunities at school. These included: being withdrawn from class to a separate room or being grouped with other disabled students in regular classrooms, being made to be different, heightened sense of feeling different and wanting to be like their peers, and when teachers are "boring". In addition, teachers and others making assumptions about the student's *in*abilities, teachers having low expectations of the student, unsupportive or unskilled school personnel or overly close and obtrusive support from adults and absence of privacy, difficulties with forming friendships or being teased or bullied by peers, having others speak to them in a condescending manner and limited access to functional skills in curricula that would prepare the student to transition to adult life.

Accordingly, MacArthur and Kelly (2004) stated that students wish to be viewed as children and young people first and prefer to have their strengths and learning potential as the focus rather than their perceived deficits. They wish to be viewed as one of the members of the class and to engage in supportive and trust-based relationships at school. They also wish to be included, not teased, not bullied. They need to be given access to a challenging curriculum that is relevant and meaningful to them. Indeed, Given (2001) argued against the myth that inclusive education exists to promote social interaction. Her schooling experiences supported the place of academic achievement as a goal of inclusive education. In their narrative study, Marshall and Hocking (2006) also found that students needed to understand and have others understand their learning difficulties. Furthermore, they needed supportive learning relationships with their teachers. Being seen as competent was also important to the young people in their study.

In keeping with some of the above issues, the therapists in this study see that focusing on the impairment level detracts students from participating in schooling and impacts on their belonging to school communities. Moreover, it can interfere with the task of learning and engaging in the role of student. They also see that going into schools to "fix" the student (at the level of impairment) inadvertently sends the message that the student needs "fixing", that there is something wrong with the student, that it is not OK to be "different". This signals a message that is counterproductive to that of honouring and respecting diversity and difference in schools and, indeed, society.

The therapists also understand that if one does not collaborate, consult and team with each other and with school staff, with parents, families and *whānau*, and, indeed, with students to arrive at contextualised and mutual decisions about what might work best for the student, one can expect little to no change to occur in schools. These therapists are working not so much at an individual level, but at the level of school community or rather society in a sense. The student is always the primary end recipient or beneficiary of MoE-SE therapists' services, but the student is often not the focus of the service, or the

primary client. Indeed, the student ultimately is at the centre of their practice, but the processes of collaboration, consultation and teaming is what enables the MoE-SE therapist to get to the core of enabling the student to be just that, a student and, therefore a learner.

Students are valued for who they are

as learners, peers, and friends at school!

Enabling Participation – Enabling Learning

In the introduction to this thesis I defined the term enabling. The findings reveal that enabling is a process which MoE-SE therapists adopt wholeheartedly. This group strives to facilitate, guide, coach, educate, prompt, listen, reflect, encourage, and collaborate with people (Townsend et al., 1997, p. 180). I also asserted that the ultimate aim of enabling is to help individuals, groups, agencies, or organisations to be involved in solving their own problems. This is what these therapists seek as outcomes to their culturally driven practices.

These therapists value participation and they value learning. Participation is celebrated when students belong as full and active members of their school communities as learners, with access to learning opportunities and environments and with learning outcomes, as for any student in the school. Snow (2004b) advocated that "we do not need to change people with disabilities" (or in this case with special education needs), insisting instead that it is us (society) that need to change. In addition, we (society) need to change how we think of disability:

> When we think differently, we'll talk differently. When we think and talk differently, we'll act differently. When we act differently, we'll be creating change in ourselves and our communities. In the process the lives of people with disabilities will be changed as well. (Snow, 2004b, p. 2)

It seems to me, that the therapists in this study are already on this path, so much so, that they seek to sign others up.

Within their practice, sits a greater emphasis at a societal level, focused on fostering change in schooling systems and communities to enable students to become fully active

participants in their school lives. Such practices fit with the World Health Organization (WHO, 2001) *International Classification of Functioning, Disability and Health* (ICF) constructs and its social model of enabling activity, participation and well-being (WHO, 2001, 2002). The ICF proposes that health services have a key objective to help people participate in everyday occupations that are meaningful to them. For students, such occupations mean participation in school-related tasks, activities and environments. To achieve this end, therapists must therefore "look beyond the injury, disease or disorder to focus intervention towards occupations that are important to their clients" (Hocking, 2003, p. 189). Occupational practice, as Hocking (2003) terms it, is concerned with occupation**,** participation, meaning, social identity, health and well-being. Thus, the focus of today's practice must be on supporting clients' occupational goals and aspirations, as well as occupational achievement.

Findings from this study reveal that MoE-SE therapists have to a large extent shifted their practice towards the domain of occupational practice. In many respects this shift occurred because of the press of government and organisational policy, but equally it is because these therapists have taken a stand to question established school-based practices. In doing so, they have concluded that traditional practice does not best support clients' occupation in school contexts. At the end of the day for these therapists, it is about what the student needs and wants to do at school. Furthermore, MoE-SE therapists realise that this can not happen unless they address environmental factors, including the social-cultural-political layers of school communities, whether it is at the level of an individual, the classroom, the whole school, the organisation and government, or society in general. Because of this practice pivots around enabling processes that allow students to access schooling, to participate in the curriculum and to participate in the social structure of school life.

Theirs is a culture of enabling!

Theirs is an emerging culture of occupational practice!

Collaborative Practice

To focus on enabling, MoE-SE therapists engage in patterns of behaviour that match collaborative consultation. They engage in a high degree of interprofessional practice and they value the team and the teaming this ensures. Relationships are also valued and worked at to build strong bonds amongst members of the team. Communication becomes a process of *walking with* and *talking with* in collaborative practice, as does honouring client voice.

In keeping with collaborative practice (Dettmer, Thurston & Dyck, 2000; Haft & Place, 1996), these therapists expect changes in school environments, which will enable students to succeed at school, despite any limitations imposed by impairment or the environment. This is the yardstick against which these therapists measure the success of their collaboration, and therefore interventions.

Theirs is a culture of collaborative practice!

Theirs is a culture of collaborative consultation!

Fostering Societal Change

Lastly, and, perhaps, most importantly, in their practice MoE-SE therapists are fully knowledgeable *and* conversant with the education system and Aotearoa/NZ special education legislation so that they may guide others in its application. This much is paramount in the culture and in their enculturation of each other. One must *know* the special education legislative framework, one must *know* the NZ Curriculum framework, one must *understand* the education system in order to be of benefit to the students these therapists serve.

These therapists are perhaps at the forefront of deconstructing and reshaping the dominant understanding of disability in the education sector, forced by their own cultural shaping to rethink aspects of their therapeutic conception and approach to disability. Such change in thinking is called for today by people with a disability and by disability studies (Kielhofner, 2005; Neilson, 2005; Abberley, 1995). For example, the slogan 'person first, disability second' (Snow, 2004b) suggests that people's attitudes are the

biggest barrier to disability (Neilson, 2005), the need to reformulate professional understanding of disability (Kielhofner, 2005), ensuring that therapy is relevant to the school setting (Hanft & Place, 1996) and participation is the outcome of school-based services (Swinth & Hanft, 2002). Because of this, MoE-SE therapists are in the business of helping others know how to "do it", of brokering inclusion. It may be construed, therefore, that the therapists in this study have placed themselves in positions that serve to help others take on board these principles, such as promoting attendance, participation and access to meaningful learning opportunities and meaningful achievement in curriculum areas.

Theirs is a culture concerned with societal outcomes!

Relationship to Other Studies

As previously stated, this study adds to the studies of Caswell (1998), Marshall (2005), Tutty (2003) and Vaughan-Jones (2001) and the past Ministry of Education research programme into effective integrated therapy practice with students with physical disabilities (MacDonald, Caswell & Penman, 2001; MacArthur, McDonald, Simmons Carlsson, Caswell, & Clark, 2003). Others will follow.

Whilst Caswell's study looked at the nature of physiotherapy services in schools, including both special and regular settings in the late 1990s, this study looks specifically at the cultural and philosophical underpinnings of both physiotherapists and occupational therapists in a specific practice context that includes only regular schools. Findings in this study are consistent with Caswell's, in particular the need for practice to be imbued with shared understanding, collaboration, teaming and a flexible attitude. Moreover, both studies highlight the need for attention to induction and enculturation of therapists as well as the need for therapists to shift their practice thinking away from medical model perspectives to those of the education model. Vaughan-Jones's (2001) study also found that it behoves therapists to be socio-politically aware and be fully conversant with Government legislation that impacts on practice. This is because culture and, in turn, practice in the education sector is both informed and shaped by legislation.

MoE-SE therapists' culture is also imbued with many of the key characteristics that underpin interprofessional practice as espoused by Jones (2005). Examples of these are: working together in an integrated way to develop a common purpose, effectively and efficiently utilising the various expertise of team members to provide quality services to clients, commitment to a common purpose and goals, mutual respect, effective communication, adaptation to change, team development, professional identity and valuing difference. Such ways of being are reflected in the participant transcripts in this study and are, therefore, part of the group's culture of practice

Findings in this study also fit with international literature reflecting collaborative consultation (Bundy, 1995, 2002) and school-based practice (Case-Smith & Rogers, 2005; Llewellyn & Maher, 1993; Sahagian Whalen, 2002; Swinth & Hanft, 2001). This seems especially so when much of the work is carried out in what seems to be an invisible mode of *being in the background*, as is in keeping with consultative practice where the therapist's role is around facilitating, recommending and collaborating for change which enhances student performance and participation (Bundy, 1995, 2004; Dettmer, Thurston & Dyck, 2002; Hanft & Place, 1996). Whilst this all sounds positive, there are, however ,aspects in the culture that the group felt they were not enacting well. For instance, collaboration with parents was identified as a poorly addressed aspect of practice because of time constraints. This creates tension in the culture since collaboration is so highly valued and aspired after in practice. Secondly, the tension between medical model perspectives and occupational practice continues to resonate:

> **Yolanda:** A lot of the time we are working to help people to understand why we work differently and often that continues to be a mismatch … "Why don't they fix them? What's the therapist doing? Why don't they fix them?"

Whilst the therapists appear to have bought into the notion of inclusive education and inclusive practice without question, there is still an air of unsurity and hesitation to completely unshackle the biomedical lens of their past:

> **Cassie:** There are students that … need intensive therapy … in their lives from time to time. We can't provide that, but professionally in my experience they would benefit from that.

Thirdly, achieving some official form of practice guidelines seems beyond their reach due the complexity of an organisation that keeps being restructured.

New Knowledge Generated

In Aotearoa/NZ, little, if anything, is publicly known about the culture of practice of MoE-SE therapists. In addition, literature about the experiences of therapists working within the regular school context under the auspices of inclusive education is scarce, if not absent. We have not known what some of the drivers of therapists' practice with students are, until the findings of this study. No-one has shown what the culture of practice of MoE-SE therapists is until now.

To date, there exist a minute number of studies that encompass some of the aspects of school-based practice in this country (Caswell, 1998; MacDonald, Caswell & Penman, 2001; MacArthur, McDonald, Simmons Carlsson, Caswell & Clark, 2003; Marshall, 2005; Tutty, 2003; Vaughan-Jones, 2001). Most of these studies are qualitative. Even less is known about whether therapists' practice is effective in relation to the goals and objectives of the special education legislative framework. This ethnography contributes a unique perspective to the beginnings of a local body of knowledge in that it sought to uncover the *culture of practice* of a group of therapists who work with students in regular schools. Moreover, it is unique because it addresses what sits at the heart of practice and because it presents emic articulation of the group's collective voice. Moreover, it appears that whilst there have been no studies about culture of practice in other countries, several of the values uncovered in this study are reflected in some other countries, for example values related to inclusion (Booth et al., 2000) and collaboration (Dudgeon & Greenberg, 1998). Findings from this study serve to reinforce and, perhaps, expand international understandings of school-based practice and the cultural underpinnings of said practice. Furthermore the findings may serve to foster reflective dialogue amongst therapists and their professions.

Knowing and understanding what drives and shapes practice can only serve the process of growing and developing therapists in Aotearoa/NZ who richly understand not only *who* they are, but also *why* they are in their respective practice contexts. This in turn serves the process of helping others to understand the *what*, *why* and *how* of MoE-SE therapists' particular culturally driven patterns of practice behaviours and communal worldview. Such understanding may be presented to the organisation which employs these therapists, so that they may know, and in knowing, support their workers through better induction programmes.

Strengths & Limitations of the Study

The aim of this study was to explore culture from an emic perspective. My use of ethnography as methodology is consistent with this (Atkinson, Coffey, Delamont, Lofland & Lofland, 2001), as detailed in Chapter 1. In addition, the findings of the group's culture are articulated in text as a result of this study. Prior to this there was no written description of the culture, thus others may now see it for what it is, thus far. Consistent with a methodology that addresses culture, interpretive data analysis and cultural construction was enhanced through the use of an ethnographic evaluative framework following Katz (2001, 2002) and Fine (2003) and the application of a cultural constructs framework. This framework was drawn by the researcher from a range of books regarding culture, such as Bates and Fratkin (1999), Cockerham (1995), Haviland (1999), Jones, et al. (2000) and served as a means of framing the findings and, therefore text of the ethnography. Lastly, the findings show goodness of fit with Aotearoa/NZ education sector perspectives. These are all strengths of the study.

One has to be mindful that the practice context is unique to a bicultural New Zealand. Having said this, as there were no therapists in this study who identified as Māori, this perspective of MoE-SE therapists' culture of practice is missing. In the context of the bicultural society in which we live as Aotearoa/NZ citizens, there is a dearth of occupational therapists and physiotherapists who identify as Māori, particularly in special education. For this reason, one can only accept the findings of this study as being

primarily viewed through the *Pākeha* lens. Similarly, the Pasifika (Pacific) perspective is also missing. In a presentation that asked the question: "What's so special about special education for Māori?" Margaret Wilkie (1999) suggested that several actions be followed. I include some of these here as they are relevant to building a culture of school-based practice that uniquely reflects Aotearoa/NZ bicultural perspectives:

1. Consider the Treaty of Waitangi in the special education legislative framework and our services.
2. Include *whānau* (extended family), *hapu* (clan) and Iwi (tribe/folk) when providing services to Māori.
3. Create resources and information in *Te Reo* Māori (Māori language) and in plain, easy to read English for all people concerned.
4. Consult with *Tangata Whenua* (people of the land) face-to-face for their views and contributions.
5. Involve Māori in research to inform policy and service development.

Being a Masters level study inherently placed certain restrictions on the study. This impacted on the choice of data gathering methods used, which were limited to interviewing, use of archival data, anecdotal observations in the field and incidental journaling. Whilst immersion in the field is a commonly used method in ethnography, it was not used in this study because of time and financial restraints. However, it was circumvented to an extent because this study was conducted via complete-member-researcher method. This served to accommodate the lack of immersion and allowed use of the researcher's professional history as 'lived in the culture' alongside observations made during the course of the research project's duration. Whilst this raised questions around researcher subjectivity (addressed in Chapter 3), the use of triangulation through participant checks and experts-in-the-field checks served to validate the researcher's analysis and interpretations. Some of the limitations are expanded upon below.

Findings

Findings from this study are affected by inherent features of the methodology. I was a colleague of all of the participants. This may have influenced their responses during the

interviews and in the field. It may have also influenced my interpretation of the data. A further limitation was that the questions I asked participants were informed by my insider perspective. This may have led to the findings being interpreted in a particular way, in contrast to interpretations made by an outsider researcher. However, as outlined in Chapter 3, I used supervision, reflexivity and my own interview transcript as processes to reduce researcher bias (Brewer, 2000; Davis, Watson & Cunningham-Burley, 2000; Ellis & Bochner, 2000; Reed-Danahay, 2001).

Participant sample

The sample size in this study was small and involved only thirteen therapists from ten out of sixteen MoE-SE District Offices. The use of a small sample is a feature of qualitative research, which seeks to describe the complexities and richness of the culture of practice in a sub-community which is peculiar to their particular work setting, as does this mini-ethnography (Germain, 2000).

A particular limitation was that all participants were women. Whilst this is indicative of the majority of the workforce, there are some men in the role at MoE-SE and their experiences may be different. As stated, there were no Maori participants and, excluding myself, no participant with a Pasifika background, therefore the cultural mix of this study does not represent a bicultural Aotearoa/NZ perspective or any multicultural perspective. I only experienced and interpreted the western (*Pākeha*) perspective of the culture. This may have influenced what I saw in the field because participants with non-western worldviews may have taken a different perspective on the group's emerging culture. Their answers to the questions may have been different and this would have added another rich dimension to the findings.

Only participants who were experienced and had been immersed in MoE-SE for two years or more were included in this study. Therefore data was limited to the perspectives of longer-standing members of the group in one point in time approximately 7 years after SE 2000 was implemented. A number of the participants were also the first members of the group, therefore, they were potential originators of the culture and this may have led

the data in a particular direction. It would be advantageous to capture the voices of less experienced members as well as those who have recently entered the group and those who have exited MoE-SE. Doing so may uncover greater variations in the culture. However, whilst capturing a "generational" cross section of the entire group (approximately 52 therapists spread across the country) would have been more representative of the population, this was not possible due to time, travel and financial constraints, as well as the natural limitations of study conducted as completion of a Master's thesis. In addition, I wonder if I had involved more therapists across the generations, if the uniform core of the culture would have been revealed.

Data gathering techniques

Another limitation concerned with data gathering methods was the weighting of data for interpretive analysis being placed on participant interviews, rather than data gained from immersion in the field. Both time and financial considerations placed limitations on the longevity of researcher immersion in the field for a Masters level project. However, to an extent, this was circumvented because I was a member of the group and therefore could draw from my professional life history to supplement the data, whilst using reflexivity and supervision to counter the risk of researcher subjectivity.

In addition, participants were only interviewed once. This may have limited the depth and clarity of the data I obtained. Follow up interviews would have provided opportunity for clarification of data. However, the use of participant checks and multiple 'experts-in-the-field' checks were helpful in clarifying my interpretations, particularly during the data analysis and writing-up phase of the text.

Lastly, I used a two-stepped approach to the interviews, therefore I applied two different forms of interviewing techniques, face-to-face and email. The initial face-to-face interview method allowed me to dynamically engage with what therapists were saying and added the element of being able to ask clarifying questions at the time. The email interview did not have this potential, however it was used a means to triangulate and enhance some of the crude themes that had emerged from analysis of the face-to-face transcripts. In

hindsight, it may not have been necessary to use the email method since I used experts-in-the-field and participant checks to check my interpretations. A more useful alternate method may have been to interview the participants twice over a period of time in order to pick up and clarify any emerging themes. This method may have added a depth of richness to the findings.

Implications of Findings and Recommendations

One of the significant findings that emerged from this study was that the practice of MoE-SE therapists is steeped in a culture of inclusion and collaboration. Whilst this is not new to me, nor to some of my MoE-SE therapist colleagues in the study, it has been affirming to check that this is so through rigorous enquiry, and to be able lay authentic and credible claim to our emerging cultural notions. Of note, however, I was surprised at the depth of the culture's vision of building an inclusive society. Through the vision of building inclusive schools, these therapists appear to see through to an even bigger vision of inclusion. There is passion in the culture in support of the NZ Disability Strategy (MoDI, 2001), knowingly or otherwise. Moreover, there is passion for striving to assist students to do what they need and want to do as students in schools. The implications of such findings for MoE-SE therapists is that they may be encouraged to follow the direction of the culture, recognising that it is organisationally embedded and situated within a greater inclusion discourse. Furthermore, findings may be construed as positive in that the group's emerging culture appears congruent with their practice setting, given that context and meaning making are interrelated.

There are also implications for new and old members in terms of the induction packages that the group puts together. This text will assist new members of the group to develop their cultural identity within the organisation and to enculturate each other on the basis of the findings. Findings will also be useful for inducting students on placements or explaining how MoE-SE therapists work to schools, teachers, parents and students. Indeed some of the content from Chapter 1 has already been modified into a draft handout and pleasing feedback on its usefulness has been received from occupational

therapy students on placement this year. This handout is also likely to prove useful when inducting new therapists. Findings may also assist those who don't prescribe to the cultural notions revealed in this study as a basis for reflecting on their worldview of practice in regular schools. In turn, the findings may also inspire those of us who think we *know* the culture to re-look and, perhaps, question it as a result of critical reflection.

Further implications from these findings are relevant for other groups, as discussed below. They are relevant for therapists who, either do not currently practice in MoE-SE, or who plan to practice in MoE-SE, and they are also relevant for the organisation. Lastly, they are relevant for undergraduate education of occupational therapists and physiotherapists.

One of my aims in conducting this research was to inform the process of MoE-SE therapist induction or rather enculturation, as well as inform others of *why* MoE-SE therapists work the way that they do. I believe that I have captured this essence in the study's findings. In my nine years in the MoE-SE practice context, I have yet to meet an occupational therapist or physiotherapist who has been able to self-enculturate or adapt to fit the demands of the organisation and education sector culture without support, mentoring and nuturing from other MoE-SE therapists. This seems to be the case whether the therapist is an experienced or novice practitioner. Granted, this probably was the opposite for the small number of pioneering therapists, where necessity required them to survive and do the hard graft. However, for the first pioneering therapists, I recall that this was done collectively through regular discussion, peer supervision and review, self reflection, plus organisational support for small group meetings. Such meetings served to formulate the beginnings of the *how* and *what* of practice, which enabled a collective and consistent paradigm for these therapists.

In addition, I have yet to hear another MoE-SE therapist say "gosh [X] has picked up the way we work no problem". The reverse is more often the lament, until time, contextualised, experiential and reflective learning accompanied by supportive mentoring,

fosters enculturation. Indeed, there is a point in time, sometimes six months to a year later, for most MoE-SE therapists, whereby I have observed new therapists eventually declare the insight "you know, when I started, I thought I knew and understood what you did and what you meant, but now I realise I didn't … now I really do understand what you meant; now I really see why we do it this way". It is at this point that the meaning behind the culture and practice becomes intrinsically inherent for the "new entrant". Generally, such insights come when a therapist truly begins to think differently about his or her practice and who she or he is as an MoE-SE therapist (personal observations in the field).

It is paramount that induction of therapists to the MoE-SE practice context ensures they develop understanding and knowledge of the education system and the legislative framework so that they may *know* what is 'right' in the education sector practice context. They must also develop the skills of becoming a master consultant and collaborator. Furthermore, they must understand that stepping into the MoE-SE practice context requires them to become brokers for inclusion and this requires a mind-shift or paradigm shift.

This will be a struggle for many new member therapists because, as revealed in the findings, the occupational therapy and physiotherapy professions appear to still be entrenched in biomedical and rehabilitation thinking, seen in the tension the group revealed around practice feeling right or not right. Many, for example, still expressed that they felt they *should* address the deficit level, even though their emerging cultural identity pulled against this. This raises the question: "How far away are we as professions from the disability rights discourse?" More importantly, it begs the question of our professional educators.

The study shows something of the enormity of the cultural shift one must make to enter the MoE-SE context. This suggests new entrants will require a high level of personal support to make the shift in their worldview. They will be challenged to shift their therapy

emphasis away from a health paradigm to the education paradigm, fully understanding that whilst their services exist to serve students, they are not primarily there to 'fix' the student at the level of impairment. However, as agents for societal change they are there to "grow" a culture of inclusion in Aotearoa/NZ schools. If one does not comprehend this and adapt practice behaviours to reflect this, it is likely one will not survive the culture, nor the practice context. Because of this, lecturers would be well advised to ensure their undergraduates are fully aware and prepared for practice in the education sector. This is because practice in the education sector is fundamentally different to the dominant biomedical discourse in the health sector: politically, socially and culturally.

There are also organisation implications from the findings of this study. At the organisational level the key messages are as follows:

1. Upon entering the practice context within the education sector, novice occupational therapists and physiotherapists do not *know how* to practice in the education system, nor do they know *why* one should practice a particular way.
2. Therapists also *do not know how to shift from biomedical perspectives into educational perspectives without support*, supervision, mentoring and coaching.

This study assists in providing a clear articulation of the nature of the practice therapists are entering. In addition, the magnitude of the shift therapists experienced suggests the importance of supporting therapists to get to where they need to be. This is an organisational responsibility that remains unaccounted for to date. One way of offering this support is the provision of formal therapy-specific, contextualised induction courses related to school-based practice. Doing so may serve to foster the development of a workforce of therapists who know how to practice in line with organisational and governmental philosophy and policies. Moreover, it may serve to build and sustain the culture of inclusion and inclusive practice.

Last, but not least, it behoves lecturers of occupational therapy and physiotherapy professions to take note of the above key messages. Undergraduate programmes in particular may benefit, not only from the insights the study brings into practice in the

education sector, but also as an exemplar of practice in settings that are not driven by biomedical perspectives. In this case, practice is driven by notions of inclusion and enabling activity and participation. Such notions align with WHO:ICF (Hocking, 2003; WHO, 2001, 2002), the NZ Disability Strategy (MoDI, 2001) and the emerging disability discourses of today (Abberley, 1995; Kielhofner, 2005; Nielson, 2005; Snow, 2004a, 2004b). Schools need to perhaps wake up to these issues to do right by their own students and to keep with the times. The study, thus, provides a view of how practice may evolve.

Further Research

Granted there has been an increasing body of knowledge generated overseas, however, it is based on the education systems and legislation that exist for those countries. It is useful to read such literature, because it contributes to reflecting and guiding practice in Aotearoa/NZ. The findings from this study could be added to by further research in the field and more indepth case study. One suggested study might be comparative research of therapists' culture of practice across the special education schools and health services that provide services to students. This would add value to understandings of culture through determining similarities and variations in expressions of culture across different practice contexts and different groups of therapists. Yet another may be to look at whether therapists do find it useful to have MoE-SE practice explained in these terms. An outcomes-based study would help provide practice-based evidence for what works and what doesn't. Furthermore, a study that addresses whether embracing the culture of practice actually makes a difference in the long term for students would be valuable.

The evidence base for school-based practice in Aotearoa/NZ is also absent. It behoves occupational therapists and physiotherapists to undertake research projects that would address this, including discipline-specific and interprofessional studies. This would serve to identify and articulate what professional practice should 'look like' in the education sector, as well as focus each profession's targeted outcomes for students and school. It would also serve to determine the benefits of inclusive practice and confirm or discount our current ways of working. Furthermore, engaging in such studies can only serve to

strengthen the place of therapy in the education sector. Now that this study has identified some of the cultural underpinnings of MoE-SE therapists, perhaps it is time for a study that addresses the therapist-teacher interface or the therapist-parent/family interface. Are they committed or prepared for inclusive education and therapists applying inclusive practice? And how do school staff who encounter therapists from this culture experience them? Other studies could look at issues such as: when inclusion is achieved, what does it achieve educationally and socially; is harm done when therapy services shift away from dealing with impairment or what is the long-term personal outcome to the student when this occurs. Also, what does goodness of fit mean or look like between the student, the environment and the activity or programme in inclusive education. And, if and when this occurs, does it mean the child learns and progresses in learning. Alternately, if scholastic progress is not the aim for some children, is goodness of fit more focused on 'fit', rather than educational progress?

Studies that address the extent to which the therapists' culture and practice considers the Treaty of Waitangi and enacts Wilkie's (2004) suggestions are also warranted to reflect the bicultural perspective as members of MoE-SE and citizens of Aotearoa/NZ. Finally, the voice of the student, those whom we serve, is absent in school-based practice. Whilst it may be helpful for therapists to understand the 'why's' and 'wherefores' of their culture and practice, studies that reveal what it is like for consumers would perhaps truly lead us towards client-centred, occupational practice directions.

The implications of this study may be summarised as follows:

1. It contributes to the body of knowledge related to school-based practice by revealing culture in a group of occupational therapists and physiotherapists.
2. It reveals how culture and context are interrelated and provides an exemplar of how culture of practice is organisationally embedded.
3. It provides a practice exemplar of what it is like to practice in a different paradigm, and of environmental practice.

4. It provides a tool to help ease transition and a clear way to articulate the extent of the shift from a biomedical model to occupational practice in school-based practice.
5. It provides a tool for explaining the level of support required from the organisation to ensure its practitioners make this shift, including access to systems for formal therapy-specific, contextualised induction, supervision and mentoring of MoE-SE therapists who are new into the organisation; and lastly,
6. By way of example, it challenges the professions of occupational therapy and physiotherapy to take up the staff of occupational practice.

Summary

I started my research journey because of a tacit knowing that MoE-SE therapists' practice begins not with theoretical knowledge, but with philosophical underpinnings. I end the journey and this chapter by returning to the two quotes which headed my discussion, repeated here for ease of reading:

> We must be vigilant in practice to notice what might support or hinder a positive outcome; it does not matter how theoretically brilliant our recommendations are if families, teachers, and children don't use them because some contextual feature prohibits implementation. The artful dance of practice lies in a therapist's ability to stay relevant to the child and family's lives. (Dunn, 2002, p. 15)

This study has been part of the 'being vigilant in practice'. I hope that it will contribute to the artful dance of school-based practice so that our practice remains true and relevant to the lives of students', families/*whānau* within the context of Aotearoa/New Zealand schooling strategies. I also used Baum and Law's (1997) quote:

> We envisage that … practice will focus on occupational performance; will be more client and family centred; and as a result, will be community based. We see [occupational therapy] practitioners building partnerships with clients and working collaboratively with persons … to remove environmental barriers that diminish or discourage their participation in everyday life and their community. (Baum & Law, 1997, p, 278)

Having journeyed this research path almost a decade on in time from Baum and Law's words I find that the participants in this study, occupational therapists and

physiotherapists alike, have their lens focused on students' occupational performance in their learning environments.

The therapists in this study have found their way into a key organisation within the education sector and they have converged to settle within this organisation. They have chosen to displace themselves, leaving behind their traditional health sector settings and ways of thinking to work in the regular education sector, a practice context aspiring to inclusive practice and the vision of an inclusive society. Each of these therapists has chosen to immerse herself in an organisation whose culture is imbued by government-driven policies, education-focused protocols, and education-focused thinking. They have changed practice context (Ballard, 1999; Mentis, Quinn & Ryba, 2005) and in doing so have changed some of the philosophical basis of their practice thinking and patterns of behaviour. They have formed a cohesive subgroup of practitioners who are willing to open themselves to new learnings, events, situations, and innovative ways of working in a non-health based context. They do so situated culturally, physically and politically within the education sector and in the presence of an organisational society whose culture extols inclusive, ecological and collaborative practices. These therapists are immersed in a society which strives to emanate inclusion, collaborative teamwork, partnership with others, and the valuing of others' contributions and points of view (MoE, 2004c).

MoE-SE therapists strive to be client-centred despite the mire of teasing out whose client-voice to attend to first. They are community-based in their practice in that they strive to provide services to students in their natural settings, within the context of their daily occupations. And, they seek to remove human and non-human environmental barriers and foster student participation in everyday life experiences of being part of a school community. MoE-SE therapists are also ardent proponents of collaborative practice, being intensely consultative in their practice behaviours and in their pursuit of contextualised partnerships with their clients. They do this for very real reasons. These therapists are knowledgeable brokers for inclusion in Aotearoa/NZ schools. They have

re-positioned themselves as societal workers and their culture of practice reflects this stance. Perhaps they are the new breed of therapist for the millennium era, driven not only by theoretical perspectives, but also by what sits at the heart of their culture (Appendix 21): a student's inclusion.

Finally, whilst this study has unearthed the core essence of an emerging culture of practice in a sub-community of therapists, the door remains open for future generations to continue the journey, alongside those who have forged their founding narrative. For those of us who started the journey and who surfed the crest of the wave of innovative practice, we will continue on that journey choosing not to be complacent, since perfect understanding is never gained. However, as pioneers, our job of laying the first stone is done. Now we must pause to reflect, celebrate, as well as critique our work, before continuing on.

> **Yolanda:** I think that in five years time we will look back and we will say: "That was such an important time".

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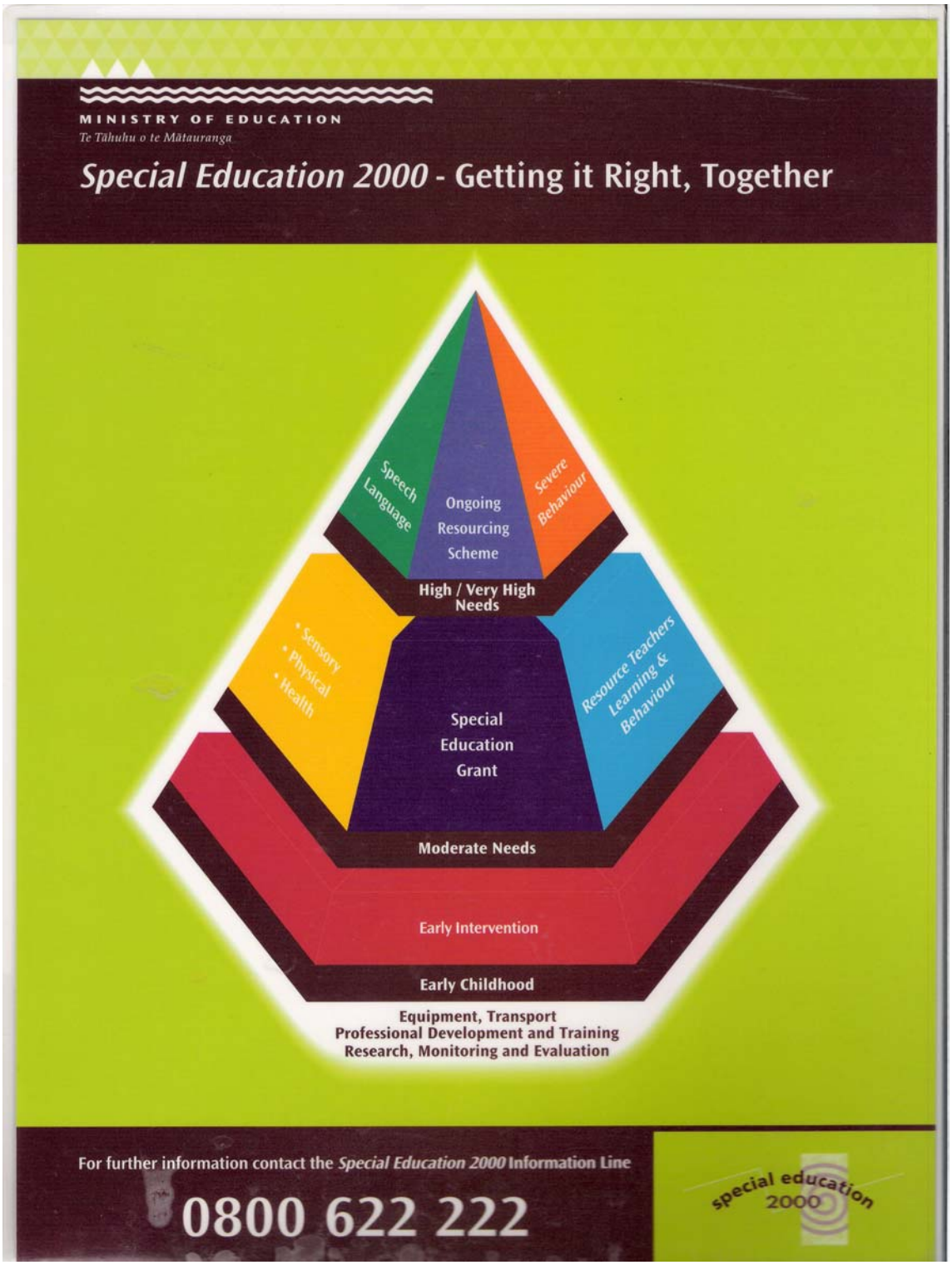
Appendices

Appendix 1: Special Education 2000 Framework



Appendix 2: Overview of Special Education Policy Schemes

Occupational Therapists and Physiotherapists provide education-related services to school-age students who are eligible for support under three schemes: ORRS, MPC and SLS

Ongoing and Reviewable Resourcing Scheme	**Moderate Physical Contract**	**Supplementary Learning Support Scheme**
Students have *High Needs* or *Very High Needs* because they have significant educational needs that arise from extreme or severe difficulty with any of the following: learning, hearing, vision, mobility, language use and social communication. They may also have moderate to high difficulty combined with any two of these areas (MoE, 2004b). To qualify for ORRS funding, students must: • meet the ORRS eligibility criteria • require a combination of specialist services to support them in several of the following areas:- • total adaptation of all, or almost all curriculum content • assistance with face-to-face communications • regular specialist one-to-one intervention and monitoring to help with mobility, positioning, personal care, or needs arising from severe disorder of both language use and appropriate social communication • need for specialist teacher contact time.	Students require occupational therapy and physiotherapy or both. They may be ambulant however typically may have difficulty with their mobility and hand skills, and require assistive equipment to access the curriculum. For example, they may require a walking frame a keyboarding device for recording schoolwork, or assistance to organise their school work. To qualify for services under this contract students must: • meet specified eligibility criteria as set by the MoE • have significant physical difficulties (MoE, 2005b), for example in mobility, physical safety, fine motor skills, and self management.	Students who have significant and ongoing need for support, but who missed out on meeting the ORRS eligibility criteria. SLS offers additional resourcing, including access to a Learning Support Teacher and some specialist support. Eligible students have significant and ongoing need for curriculum adaptation and teaching programmes (MoE, 2006). •

This table formatted by the author from the following MoE Guidelines:

1. Ongoing and Reviewable Resourcing Schemes Guidelines (MoE, 2004b)
2. Supplementary Learning Support (SLS). (MoE, 2006)
3. Services and funding for students with moderate special education needs. (MoE, 2005b)

Appendix 3: Indicators of Integrated Effective Practice

Key Informant Interviews: Services and delivery can be said to be integrated and effective when: • Sufficient, flexible and transparent funding is available to meet individual, programmatic, organisational and monitoring needs • There is local control, development and management of services • Agencies collaborate, coordinate and manage transitions successfully • Case loads are managed to enable enduring relationships with clients and families, effectiveness of service and individual role clarity • Families are informed about options, alternatives and they are respected team members • There is a focus on changing attitudes and environments • The Individual Education Plan is the focus of contact and planning, changes are recorded and documents are regularly reviewed • Physical and educational needs are balanced • Flexibility in programme model, location and delivery occurs • Staff are familiar with the educational context, the curriculum, have on-going professional development, supervision and mentoring	**Literature Review:** The literature has identified the following components of integrated effective practice: • Inter-agency and professional collaboration exists to reduce overlap and avoid problems of communication, continuity and transition • Services aim to reduce pressures on families and work in a client centred, culturally sensitive manner • Clients and families are central in the assessment, development and monitoring of interventions and there is recognition of disability across people's lives • A range of developmentally appropriate non-standardised ecological observation, assessment and treatment methodologies are used • A focus on quality of life outcomes that promote adaptation and functional skills • Change is measured on the analysis of school, home, health, community and vocational factors • Interventions become natural activities in an individual's life • Intervention plans are designed for implementation in natural settings across an individual's day
Measuring Outcomes Effective services are said to have been delivered when programmes focus on: • Inclusion, including access to peers and differences are minimised • Focus on equalising opportunities for students with/out disabilities • Self esteem, confidence, learning • Meaningful and beneficial goals • A long term view, and practical and easily maintained goals • Input from clients and families • Using relevant assessment and monitoring approaches.	**Measuring Outcomes** The literature has noted that the indicators of effective outcome include: • Extensive family involvement • Client learning and achievement • Acceptance, inclusion and friendships • Supports for curriculum adaptation • Interventions that focus on quality of life and include multiple measures, perspectives and components • Built-in accountability measures based on the definition of outcomes and the purpose for which the information is to be used.

Adapted from: MacDonald, T., Caswell, C., & Penman, M. (2001, August). *Integrated effective service provision for children and young people with physical disabilities.* Report to the Ministry of Education's Reference Group on Physical Disability. Wellington: Ministry of Education.

Appendix 4: Dunn's Therapy Service Models Continuum Framework

Service Provision Model	**Key Characteristics of Model**
Treatment (direct model)	This model primarily refers to a hands-on withdrawal service or rather a decontextualised model of service provision which typically involves one-to-one treatment of an individual child, or a small group of children by the therapist.
Monitoring (indirect model)	Monitoring occurs when evaluation and intervention planning is carried out by the therapist, but the intervention is typically carried out by a teacher, or teacher's aide under the therapist's supervision.
Consultation (indirect model)	In consultation there is sharing of professional knowledge, as needed, in relation to specific case-related issues. Consultation includes: ▪ case consultation, where the student's needs is the focus ▪ colleague consultation, such as working with the teacher or other colleagues, and ▪ system consultation which aims at improving how the system (school or community) works so that all students benefit.

(Based on Dunn, 1991, 2000)

Appendix 5 a, b & c: Ethics Approval

a) AUTEC approval subject to amendment/clarification: 2003

MEMORANDUM

AUT

Student Services Group – Academic Services

To: Clare Hocking
From: **Madeline Banda**
Date: 18 November 2003
Subject: 03/176 Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists though an ethnographic lens. A descriptive study.

Dear Clare

Your application for ethics approval was considered by AUTEC at their meeting on 10/11/03.

Your application has been approved subject to amendment and/or clarification of the following:

1. Information Sheet is overly long and is to be précised to two pages. Applicant can add an addendum with further information if desired
2. Letter - last sentence should read: "2003 round"
3. Note grammatical error in Information Sheet - "no more that 2 hours"

Please consider this point/these points and provide a response to me in writing, as soon as possible. Please note that where approval is given subject to specified conditions being met, this does not constitute full approval. The conditions must be met before full approval is granted and research can begin. Please quote the application number and title in all correspondence.

Yours sincerely

Madeline Banda
Executive Secretary
AUTEC
CC: Carolyn Carlsson

From the desk of ...
Madeline Banda
Academic Services
Student Services Group

Private Bag 92006, Auckland 1020
New Zealand
E-mail: madeline.banda@aut.ac.nz

Tel: 64 9 917 9999
ext 8044
Fax: 64 9 917 9812

b) Memorandum to AUTEC regarding amendment/clarification

MEMORANDUM

Carolyn Simmons Carlsson
52A Princes Avenue (on Parau Street)
Three Kings 1004 **Tel: (09) 623 3910 extn. 741 (work)**
Auckland
New Zealand **email:**
Carolyn.SimmonscarIsson@minedu.govt.nz

To: Madeline Banda
From: **Carolyn Simmons Carlsson**
Date: 18 November 2003
Subject: 03/176 Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists though an ethnographic lens. A descriptive study.

Dear Madeline

As requested by AUTEC in a Memorandum to Clare Hocking dated 18 November 2003 I have made the recommended corrections and amendments to Appendices B and C of the above ethics application. I resubmit Appendix C - Information Sheet for your consideration.

Amendments & corrections made:

1. Information Sheet - now précised from six pages to two and a half pages with an addendum. This is attached in my email reply to your Memorandum. (Applicant believes that any further editing of the Information Sheet will lead to participants' not being fully informed of the project and doing so may potentially compromise the interest of volunteers in the project. It is possible to reduce the page numbers further by reducing the font size/margins however this does not make for easy reading.)
2. Letter – last sentence should read: “2003 round” and this has been corrected
3. Grammatical error in Information Sheet – “no more that 2 hours” has been noted and corrected to "no more than 2 hours"

I look forward to your response.

Yours sincerely

(sent electronically)

Carolyn Simmons Carlsson
Student Number: 981507

CC: Clare Hocking - Principal Supervisor

c) AUTEC approval for methods amendment: 2005

AUT
AUCKLAND UNIVERSITY OF TECHNOLOGY

MEMORANDUM

Academic Services

To: Clare Hocking
From: **Madeline Banda**
Date: 19 April 2005
Subject: Ethics Application Number 03/176 **Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists though an ethnographic lens. A descriptive study.**

Dear Clare

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved an amendment of your ethics application at their meeting on 11 April 2005. Your request for approval of an additional data gathering method and an extension of time for a further three years was granted and your ethics application is now approved until 20 November 2008.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2 which is available online at *http://www.aut.ac.nz/research_showcase/pdf/appendix_g.doc* , including a request for extension of the approval if the project will not be completed by the above expiry date;
- A brief report on the status of the project using form EA3 which is available online at *http://www.aut.ac.nz/research_showcase/pdf/appendix_h.doc* . This report is to be submitted either when the approval expires on 20 November 2008 or on completion of the project, whichever comes sooner;

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 917 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

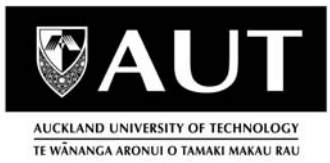
Cc: Carolyn Carlsson kero.oskar@xtra.co.nz

From the desk of ...
Madeline Banda
Academic Services
Student Services

Private Bag 92006, Auckland 1020
New Zealand
E-mail: madeline.banda@aut.ac.nz

Tel: 64 9 917 9999
ext 8044
Fax: 64 9 917 9812

Appendix 6: Participant Information Sheet



INFORMATION SHEET FOR PARTICIPANTS

Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens. A descriptive study.

Researcher:

Carolyn Simmons Carlsson
Tel: 09 623 3970 extn. 741
Mobile:
Fax : 09 623 3981
E-mail: carolyn.simmonscarlsson@minedu.govt.nz

Principal Supervisor:

Clare Hocking
Tel: 09 917 9999 extn. 7120
E-mail: clare.hocking@aut.ac.nz

Supervisor:
Valerie Wright-St Clair
Tel: 09 917 9999 extn. 7736
E-mail: valerie.wright-stclair@aut.ac.nz

What are the aims of the research project?
The overall aim of this study is to explore, understand, and describe the insider perspective of the 'culture of practice' of Occupational Therapists and Physiotherapists (OTs/PTs) who work for the Ministry of Education, Special Education (MoE-SE), within the context of their work/practice setting and the special education legislative framework (SE 2000). In this study 'culture of practice' is construed as the learned and shared set of practice ideas, attitudes, beliefs, values, knowledge, and patterns of behaviour amongst members of a group. This study forms a thesis that fulfils part of the requirements of a Master of Health Science from the Auckland University of Technology.

The objectives of the study are to:

1. Explore the nature of the group's shared 'culture of practice' through qualitative descriptive inquiry using an ethnographic approach to reflect this particular group's unique and emic (insider's) perspective.
2. Describe, articulate and write-up the group's 'culture of practice' so that their shared set of practice ideas, attitudes, beliefs, values, knowledge, and patterns of behaviour may be made known to others, and for current and future, MoE-SE OTs/PTs to recognise and understand their unique practice mores to enhance service provision to students, families/*whānau*, and schools.
3. Describe the group's 'culture of practice' within the context of SE 2000 and their being employed by an education-based, rather than health-based organisation.
4. Relate the 'culture of practice' to key components of integrated effective service provision as identified by MacDonald, Caswell and Penman (2001).

What types of participants are being sought?
I am seeking participants who are MoE-SE OTs or PTs and who are able and willing to volunteer to be interviewed. Selection criteria will apply (see Addendum).

What will participation involve?
If you agree to participate in the study, and are selected, you will be asked to sign a *Consent Form* that shows that you understand the study and wish to participate. I will then ask you to take part in an interview with me. Your involvement will be as follows:

1. A confidential, one-to-one, semi-structured interview (lasting a minimum of 1 hour and no more than 2 hours). This interview will be audiotaped and transcribed, by myself, and analysed for content and themes. If you live outside of Auckland, I will interview you by telephone.
2. Afterwards, I will ask you to read your interview transcript and confirm that the content is correct, or needing amendment and extending, or both, before returning it to me.
3. Lastly, two expert-level participants (see Addendum), one from each discipline, will be invited to read and comment on the draft write-up of the group's 'culture of practice', in order to provide an 'expert in the field' perspective on the findings.

How will confidentiality be maintained?
I will use individual codes on the data/information collected; your name will not be used, or divulged. I will explicitly request you not to name any student, school, school staff, family/*whānau*, colleague, or other agency, during the interview, nor provide identifying information of any such persons, or settings. Data will in no way be linked to any specific participant, student, school, nor organisation. My project supervisors may have access to some or all of the data and they will be bound by the ethical boundaries of this project. All of my interview material will be confidential to me; data will be securely stored so that only my supervisors and I will be able to gain access to it. At the end of the project any personal information will be destroyed immediately, except that, as required by AUT's research policy, signed *Consent Forms* and a copy of the transcripts will be retained in secure storage for a period of six years, after which time they will be destroyed.

What is the researcher's role in this particular study?
In an ethnographic study it is typical for the researcher to be immersed in the culture/group that is being studied. Because I am also one of your colleagues, my role as researcher is explicitly one of "participant-observer" and therefore my stance in the project is one of 'listener' and 'learner'. I will make every endeavour to discuss this with you, and to separate the information gained from the study from any future working relationship and day-to-day practice through careful and conscious processing. This will minimise any potential risk of compromise and avoid any ethical dilemmas and potential 'conflict of interest' between my being the researcher and my being an occupational therapist/work colleague. My task as researcher is only to *explore*, *understand, describe* and *explain*, rather than interpret, the group's *shared* 'culture of practice' as a whole.

Can participants change their mind and withdraw from the study?
You may withdraw from the study at any point without giving a reason and without any disadvantage to yourself of any kind. Any data or information collected from you will be removed from the study and destroyed.

What data or information will be collected and what use will be made of it?

I will use semi-structured interviewing which means I will have a range of questions to guide the interview, but it is not possible to say exactly what questions will be asked beforehand, and some questions will come as we talk. You may decline to answer a question if it makes you feel hesitant, or uncomfortable. I will also be interviewed before the study starts so that I may expose my own perspectives and perceptions of the 'culture of practice'. This will assist in limiting any potential bias and negative influences on my achieving a new understanding through ethnography. I will collect and analyse the following data:

- participants' interview transcripts and researcher's notes
- researcher's interview transcript and notes
- researcher's fieldnotes / personal journal (notes on my reflections, thinking, feelings and behaviours as the research project progresses).

The results from this project will be written up as a thesis which can be accessed through the AUT library on completion. In addition they may be published in an article; used in conference presentations; written up in a report for MoE-SE management, and be part of the MoE-SE OTs/PTs induction/training information. I may also send a summary report through the MoE-SE OT/PT list-serve. You may request a summary of the results of the project from me should you wish.

What are the potential benefits of the study?

I anticipate a number of benefits for you, the participant, as follows:

- an opportunity to participate in research focusing on your specific 'ways of being' and thinking as part of a group with a shared 'culture of practice', and to examine and reflect on your own practice attitudes, values, beliefs, thinking and assumptions,
- a chance to contribute to describing and making known the group's particularly unique perspective on their shared philosophical underpinnings for practice, by identifying and unmasking a 'culture of practice' within a solely education-based context
- to contribute towards enhancing understanding for entry-level, novice, and experienced OTs/PTs in relation to the necessary cultural constructs and concepts that are required to practice effectively in the education sector. (Potential benefits to others are listed in the Addendum).

Are there any risks?:

No risk, or harm to the participants, nor the organisation, any students, schools, families/*whānau*, school staff, colleagues, and any other agency is foreseen in this study.

What if participants have any questions?

If you have any questions about the study, either now, or in the future please feel free to contact either:

Carolyn Simmons Carlsson or **Clare Hocking**
Researcher **Principal Supervisor**
(See top page for contact details)

For concerns regarding the conduct of the research you should contact:

The Executive Secretary AUTEC
Madeline Banda
E-mail: madeline.banda@aut.ac.nz
Tel: 09 917 9999 extn. 8044

This project has been reviewed and approved by the Ethics Committee of the Auckland University of Technology
AUTEC reference number: 03/176

ADDENDUM TO INFORMATION SHEET:

Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens. A descriptive study.

Participant Selection Criteria

Participants will have:

- worked for Group Special Education for a minimum of one year and working more than .2 FTE
- previously worked in the health sector
- worked for more than 2 years with children and young people
- providing services to regular school settings.

Criteria used to select the two field experts will include:

- worked for MoE-SE more than five years and consistently exhibited evidence-based practice and leadership in the field over this period of time
- proactively contributed to the development and shaping of practice ideas and service provision of MoE-SE OTs/PTs
- holds a recognised leadership role, for example Lead Practitioner, or Practice Advisor.

Potential Benefits

For the organisation:

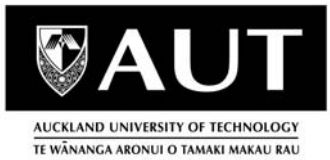
- identification and knowledge of the 'culture of practice' for a sub-group within the organisation may provide insights into the practice of this group,
- identifying and unmasking a culture of practice within a solely education-based context will enhance understandings of the necessary cultural constructs and concepts required to practice effectively in the education sector for entry-level practitioners, novice and experienced OTs/PTs,
- it would enable therapists to reflect on their attitudes, values and beliefs about practice in relation to education sector principles and policies, and to hold any new found notions up against old notions for critical examination,
- insights gained may highlight any gaps and discrepancies, or both in relation to the organisation's perceived 'cultural norm' from the perspective of management, and thereby these aspects may be further examined and rectified, or both,
- the articulated 'culture of practice' for this group may prove to be translatable across fieldworkers; recruitment and induction processes could be benefited and enhanced; any organisational culture as such could be reinforced thereby building organisational capabilities,
- by articulating this 'culture of practice' in writing, the therapist's transition into the organisation from the health sector could be smoothed; written description will assist OTs/PTs to come up to speed philosophically, this will assist to enhance service provision to schools, students and their families/*whānau*; it may also encourage others to seek employment with the organisation through new understandings of practice, and
- highlighting the salient characteristics of the group's shared culture may assist in distinguishing it from medical-model/health-based practice culture; providing insights and understandings in relation to the health-education interface; enabling smoother collaborative dialogue and transition between agencies.

For the wider community:

- a new work highlighting the phenomenon of a 'culture of practice' in the education sector and making visible the shared attitudes, beliefs and values that are inherent in our practice and thinking,
- articulating in text for general knowledge what is culturally reflected and embedded in our practice and service provision when supporting students with special education needs who attend regular school settings, and

- findings will indirectly benefit students, schools and families/*whānau* to whom we provide services as a result of insights gained by therapists from dissemination of findings.

Appendix 7: Participant Consent Form



CONSENT FORM

Title of Project: ***Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens. A descriptive study.***

Project Supervisors: Clare Hocking (Principal Supervisor) and Valerie Wright-St Clair
Researcher: Carolyn Simmons Carlsson

I have read the *Information Sheet* concerning this research project and understand what the study is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know and understand that:

1. My participation in the project is entirely voluntary.
2. I am free to withdraw myself from the project, or any information I have provided for this project at any time without being disadvantaged in any way. If I withdraw, I understand that all the relevant tapes, fieldnotes and transcripts, or parts thereof, will be destroyed.
3. The interview will be audio-taped and transcribed.
4. I am explicitly requested not to name any student, school, school staff, family/*whānau*, colleague, or other agency, during the interview, nor provide identifying information of any such persons or settings.
5. The data [*audiotapes and notes*] will be destroyed at the conclusion of the project, but any raw data on which the results of the project depend will be retained in secure storage for six years, after which it will be destroyed.
6. This project involves an open-questioning technique where the precise nature of some of the questions which will be asked have not been determined in advance. Instead, questioning will depend on the way in which the interview develops, and that in the event that the line of questioning develops in such a way that I feel hesitant, or uncomfortable, I may decline to answer any particular question(s), and/or may withdraw from the project without any disadvantage of any kind.
7. The results of the project may be published, but my anonymity will be preserved.

I AGREE TO TAKE PART IN THIS PROJECT.

..... ……
(Participant's Signature) *(Date)*

.....
(Participant's Name)

Project Supervisor Contact Details: Clare Hocking, Principal Lecturer, School of Occupational Therapy, AUT, Private Bag 92006, Auckland. Tel. 917-9999, extn. 7120.

This project has been reviewed and approved by the Ethics Committee of the Auckland University of Technology
AUTEC reference number: 03/176

Appendix 8: Advertisements

MEMO

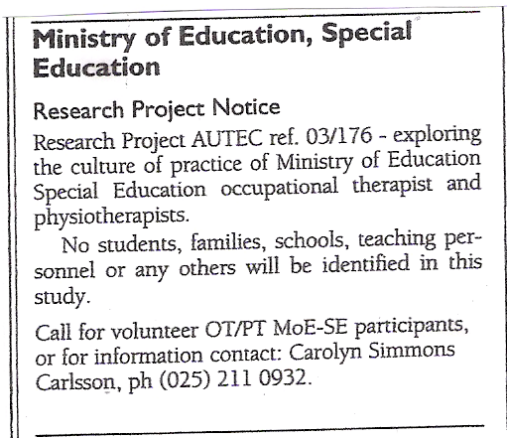
To: **NZ Herald - Classified Ads**

From: Carolyn Simmons Carlsson
(Address)
Phone:

Date: 06 January 2004

RE: **PUBLIC NOTICES SECTION**
Insertion date: Saturday 10th January 2004

> **Research Project AUTEC ref. 03/176** - exploring the culture of practice of Ministry of Education Special Education occupational- & physio- therapists. No students, families, schools, teaching personnel or any others will be identified in this study. To volunteer/for information contact Carolyn Simmons Carlsson (*Mobile number supplied*).



Ministry of Education, Special Education

Research Project Notice

Research Project AUTEC ref. 03/176 - exploring the culture of practice of Ministry of Education Special Education occupational therapist and physiotherapists.

No students, families, schools, teaching personnel or any others will be identified in this study.

Call for volunteer OT/PT MoE-SE participants, or for information contact: Carolyn Simmons Carlsson, ph (025) 211 0932.

Notices: General. Education Gazette, 83(1), 26 January, 2006.

Appendix 9: Participant Inclusion Criteria

INCLUSION CRITERIA (PARTICIPANT SAMPLE - DATA SPREAD)
MoE-SE Occupational Therapists and Physiotherapists

Participant Code	O1	O2	O3	O4	O5	O6	O7	O8	O9	10	11	12	13	Total / Range
Pseudonyms														13
District Office														10 out of 16
Number of years at GSE/SES														5 - 8 years (17 total)
No. yrs practicing														16 - 41years
Number of years in paediatrics														7 - 35 years
Full Time Equivalence														0.5 - 1.0 FTE
Part Time														10
Full time														2
Occupational Therapist														7
Physiotherapist														6
Other role														4
Urban Schools														12
Rural Schools														6
Working with ORRS students														12
Working with moderate needs contract														11
Ethnicity														All Pakeha
Health setting experience														All

Carolyn Simmons Carlsson #9815071/thesis/AUTEC 03/176
(Formatted as an Excel Spreadsheet)

Appendix 10: Participant Response Form

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

PARTICIPANT RESPONSE SECTION

Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens. A descriptive study.

My name ……..……..……..

I am interested and willing to participate in the research study: YES / NO *delete one*

My District Office is …… Urban ☐ &/or Rural ☐

My contact details are:

Telephone: Mobile:

Email: Other:

I am an: Occupational Therapist ☐ Physiotherapist ☐
Male ☐ Female ☐ Ethnicity: …….. ……

I have been an OT / PT for ☐ years ☐ months *(since graduation)*

I have worked in paediatrics for ☐ years ☐ months

I am employed as ☐ FTE and have worked for the MoE - Special Education (include SES period) for ☐ years ☐ months

I have past experience of working in a health sector position YES / NO *(in paediatrics)* *delete one*

I prefer to be interviewed at: **N/A for email interview**

☐ work *permission given* ☐ home ☐ other: ……..

I prefer to be interviewed by during these days/times: ……..

Please write here anything that might be important for me to know about you or your possible participation in the study, or any questions.
……
…….. *(Please use over page if needed)*

Thanks! Please return this Response Form to:
Carolyn Simmons Carlsson, Ministry of Education, Special Education, Auckland City District, PO Box 26 408, Epsom, Auckland
Telephone: 09 623 3970 extn. 741 Fax: 09 623 3981
email: carolyn.simmonscarlsson@minedu.govt.nz

Appendix 11: Invitation Letter to Participants

AUT
AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

LETTER TO PARTICIPANTS

Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens. A descriptive study.

24th November 2003

Dear GSE Occupational Therapists and Physiotherapists

I am writing to see if you would be willing to participate in the above study, which is part of a Master of Health Science degree at the Auckland University of Technology.

I hope to identify, make visible, and write about the 'culture of practice' that is embedded in the practice of Ministry of Education - Special Education Occupational Therapists and Physiotherapists. So I am looking for OTs and PTs who are able and willing to volunteer to be interviewed, and who meet the following criteria, to be considered for participation:

- OTs/PTs who are employed with and have worked for a minimum of one year with the organisation, and who are working more than .2 FTE (more than one day a week)
- they will have previously worked in the health sector
- they will have worked for more than 2 years with children and young people
- they will provide services to regular school settings (inclusive schools)

What is the purpose of the study?
Overall, I am interested in looking at the 'culture of practice' that MoE-Special Education OTs and PTs may have, and exploring whether such a culture exists within the context of organisation and the SE 2000 legislative framework from your perspective. I am seeking to gain the 'insider's view of the group's meanings and understandings of our philosophical underpinnings of practice; how and why we practice the way we do; and in relation to key components of integrated effective service provision. I enclose the *Information Sheet* and *Consent Form* which will provide you with more detail on the study.

What is required?
Please read the enclosed *Information Sheet* and *Consent Form.* If you are willing and interested in volunteering to participate in this study please indicate this by filling in and returning the *Response Section* attached to this letter, by email, fax or post (see contact details at end of letter). I will use this information to purposively select participants to interview. Interviews will be carried out during December 2003 - July 2004.
Participants will engage in a confidential, semi-structured, audiotaped interview lasting a minimum of 1 hour, and no more that 2 hours with myself, the researcher. I will transcribe the interview material myself. I will then ask you to check your transcript for accuracy and amendments, or both, and I will analyse the data myself. Confidentiality will be maintained by giving individual codes to identify your data and material. Names will not be used. Explicitly, no student, school, school staff, family/*whānau*, colleague, or other agency will be identified in this project.

When I have written a draft description of the group's culture of practice, I will give this draft to two therapists (one OT and one PT) who are pioneers and leaders in the field of MoE-SE service provision. This will allow them to comment and provide me with "experts in the field" perspectives of my findings.

Are there potential benefits?
I anticipate a range of benefits from this study to a wide group, including the participant, the organisation, and the wider community. These are outlined in detail in the enclosed *Information Sheet.*

Are there risks?
No risk or harm to the participants, nor the organisation, students, schools, families/*whānau*, school staff, colleagues, and any other agency is foreseen in this study.

What should you do if you are interested in participating?
If you are willing to participate please indicate this by filling in the attached *Response Section* and return it to me within 1 - 3 weeks on receipt of this invitation. This will allow me to make contact with you to arrange a time to go over the *Information Sheet,* and *Consent Form* as well as answer any questions and arrange an interview time. Many thanks.

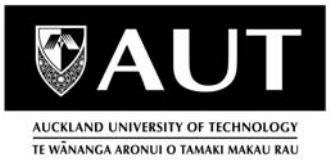
Yours sincerely

Carolyn Simmons Carlsson
Researcher
Telephone: 09 623 3970 extn. 741 Fax: 09 623 3981
Mobile:
E-mail: carolyn.simmonscarlsson@minedu.govt.nz
Mail to: MoE-Special Education, Auckland City District, PO Box 26 480, Epsom Auckland

This project has been reviewed and approved by the Ethics Committee of the Auckland University of Technology
AUTEC reference number: 03/176

IF YOU ARE INTERESTED AND WILLING TO PARTICIPATE IN THIS STUDY PLEASE RETURN THE ATTACHED *RESPONSE SECTION* WITHIN 1 - 3 WEEKS

Appendix 12: Typist Transcript Confidentiality Form



TYPIST CONFIDENTIALITY AGREEMENT

Title of Project: Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens: A descriptive study.

Project Supervisor: **Principal Supervisor: Clare Hocking**
Tel: 09 917 9999 extn. 7120
E-mail: clare.hocking@aut.ac.nz

Supervisor: Valerie Wright-St Clair
Tel: 09 917 9999 extn. 7736
E-mail: valerie.wright-stclair@aut.ac.nz

Researcher(s): **Carolyn Simmons Carlsson**
Tel: 09 623 3970 extn. 741
Mobile:
Home:
E-mail: carolyn.simmonscarlsson@minedu.govt.nz

I understand that all the material I will be asked to transcribe is confidential.

I understand that the contents of the tapes can only be discussed with the researchers.

I will not keep any copies of the transcripts, nor allow third parties access to them while the work is in progress.

Typist's signature: .....

Typist's name: .....

Typist's Contact Details: .....

.....

Date: .....

Fee: ..... Number of tapes: .....

Number of interviews: .....

Approved by the Auckland University of Technology Ethics Committee November 2003
AUTEC Reference Number 03/176
Student No. 9815071

Appendix 13 Cultural Constructs Framework – Example of Working Tool

Using Cultural Constructs (Cultural / Anthropological Interpretations) to Analyse the Data

Going from *What*? & *How*? … to answering *WHY*?

Note to self:

- Situate the defining characteristics of culture that I will use in the study to help build a platform for my comparative analysis
- Look for bulleted points => culturally flavoured themes and subthemes

Cultural Anthropology – or Social Anthropology (UK/EU)

- the study of contemporary human societies and of the underlying patterns of human culture – involved detailed exanimations of individual cultures (*ethnography*) and the analysis and interpretation of data to discern cultural patterns (*ethnology*)
- ethnography = writing about people
- ethnology = ethnographers study and *describe* going beyond descriptions to *interpret* or *explain* the data to uncover the general patterns and rules that govern social behaviour

(Bates & Fratkin, 1999, p. 8)

GUIDE: HOW IS OUR CULTURE CONSTRUCTED?

CULTURAL CONSTRUCT (from literature)	Examples of Emerging Themes & Subthemes
New Beginnings / Birth into A Culture How / why have we been **thrown together**? **Points of entry** - how did we become "**born**" into MoE – our **stories**? What are the **positions we knew first**? Has our new **context** played a role – what and why? How / why have we found our way – **navigating a new cultural context**? How have we **adapted to** our **new** circumstances/**environment**? We are **striking out in new directions** – invention, discovery, innovation – new solutions to ways of behaving – now shared. What is the **culture of the "society" / organisation** we have been born into?	Coming together – new beginnings Finding each other Journeys towards the dream of inclusion Thrust into SES / SE legislative framework Landing in a new land Conforming to SES/GSE/MoE culture
Learning Our Culture / Becoming ENCULTURATED How are we **enculturated** – how does it start/occur? How do we **learn** / **teach each other** our culture? How do we **transmit** our culture from **new person to new person** and **what** do we transmit? How/what do we **enculturate each other** – **share** experiences – allow observation of practice? How do we **render each other fit for living** in the company of others? How do we **sustain/maintain order /** cultural cohesion/unity/solidity/pulling together/harmony to **avoid** than **cultural breakdown**? How does enculturation occur **unconsciously**? How do we **learn how to act and think** and **speak** the **socially appropriate way**; do things at culturally prescribed times; do things in culturally appropriate way? What **variations** are there in the process of enculturation – differences in perceptions of the culture? What are the **rules** and do we/how **break them – why**? How do we **adjust the rules to fit our individual** circumstances? **Adapting to our environment / MoE-SE** – in order to cope? (Special ed	Growing up together. Joining. Cultural fit The practice – context fit Settling in the groove – conforming to SES/GSE culture The new generation

policy; organisation; physical environment) How do we **change** and what events **trigger** it? (restructure) How do we **change** and **adapt to new circumstances**? What adjustment benefits in the practice context does the process of adaptation bring? How does our **adaptation allow** us as a group to **fit the particular conditions of our environment** / circumstances? How do we **interact internally** and change – interact externally? How does our culture **motivate us to stay in** it – to survive as a culture?	
Pursuing the Cultural Fit - Adapting to Survive **What events / circumstances** is our cultural shift/adaptation a **response** to? How have we **produced our culture**? How have we **threaded together our sense of who we are, what we do and how we practice and use** to shape our culture? Are we are **sub-culture of our professions** or have we become part of the education culture? Have we adapted and changed in order to **survive,** gain **stability** and **continuity**? Have we **adjusted beneficially** to the available environment or is it fraught with **tensions**?	Enculturation
Cultural Relativism **Learning to recognise our culture** through the position we knew first - looking back from where we stand to look forward Are we **using the strategy of cultural relativism to develop understanding** of our new **sub-culture**? Do we **examine** our culture in its own terms and according to its own standards or do we cling to past norms - tensions? Are we still **judging** our sub-culture **by the standards of our 'other'** (professional history) **culture**? (eg. medical/impairment focus)	A foot in two worlds.
What's Our Social Structure? What is our **social structure** (relationships)? What /how have we developed to be **held together?** How are we **bound together**? What is our common **identity**? What are our **core shared** ideals, attitudes, values, beliefs? What are our **"right ways of doing things"**? What do we hold to **be "good" and desirable**? What are our **"should happens"**? What are our **norms**? What are our **predictable behaviours**? How do we **express our knowing** what to expect / how to respond appropriately / how to use objects & understand symbols? What matters **concern** us? What is of **common interest** to us? What is our **distinctive practice** "lifestyle"? What **lies beneath** our behaviour and is reflected? How do we **order our existence**? How do we **collectively experience** our **environment**?	[0] Core values / beliefs? Inclusion; inclusive practice; collaborative consultation Enable learning/participation Observers; educators; change Inclusive behaviours Inclusion; participation; learning; belonging What is our end? "Inclusionists"?
What's Our Language - Speaking "MoE-ese" What are our shared **common meanings** and **understandings**? How do we **symbolise, articulate** and **store** our culture? How do we **transmit** our culture through language (verbal / written / actions) – so it is shared? What do we **express** – without uncomplicated explanations or digressions – **meanings known to us**? How do we **substitute words for objects** How do we **communicate** our ideas, emotions, desires through language? What are our **arbitrary symbols** / what do they **represent**? Over time? How do we argue that our **new solutions to our contextualized**	The symbolic language that we speak Making sense of nonsense Speaking "MoE-ese" Knitting networks and building relationships – linchpins in our social structure.

practices are "good' and proper?	
<u>Our Raison D'Etre as a Group / Community</u> To **what end** do we practice? What or where are our **variations** / **differences**? **Individual variations**? How do we express the variety **of ways that we practice and do things**? What **meanings** do we give these variations / differences?	The end is inclusion / participation Unitedly diverse Straddling two worlds of practice – medical model : education model
<u>Grappling the Divide/Rift/Discord</u> Are we a **sub-culture** of our main professions? What is our **distinct identity** within the dominant culture? Are we / am I **ethnocentric**? What are our **expressions of ethnocentrism**? How do we speak about our culture from an ethnocentric position? Thinking related to our culture being *the* way of practice and that other ways of life are strange / ? inferior? What is our **starting point** – the **position we know first** – that we compare other culture with what we already knew about our culture? Do we try to not be / avoid being **ethnocentric**? Is our culture that of the **dominant group**? Are we **trying to be** or are the dominant voice/group? Are we seen as / held up / perceive ourselves as the "**index culture**" for other groups by MoE/ourselves? - set the standards – measured against Are we attempting to **assert** "global cultural dominance" aka **hegemony** (domination/control/supremacy/power/authority)	Ruptured / falling-out / estrangement / disharmony / dissonance Splitting off from health Distancing medical model Doing it "our way" … but is it the right way? Standing in two worlds – health-ed? Looking back.
Is our culture an **integrated culture**? What elements are integrated, or at least approximated – social – political – economic – physical? How do we **express internal integration** – the linking of the many domains with each other? (SE policy – inclusion – what we do – what student wants) What are the **harmonies** / **disharmonies**? Are there **strains** on our culture – what might this mean for the culture?	

(Sources: Bates & Fratkin, 1999; Cockerham, 1995; Haviland, 1999; Miller, 1999)

Appendix 14: Face-to-Face Interview Guide

INTERVIEW GUIDE

NB. Consent Form

I'm interested in getting at **the 'heart' of the 'how and why' we practice** as GSE OTs/PTs. To help me understand your particular practice, could you start by telling me about the **range of client groups** you work with?

What do you think are the **most important aspects for behaving as an MoE-SE OT/PT** when providing services in regular schools? What kinds of things should therapists do? How did you reach those conclusions?

If you were asked to write a **'best practice guideline'** for therapists who work with **students and their families** in regular schools, what things would you include?

If you were asked to write a **'best practice guideline'** for therapists who work with **school staff** in regular schools, what things would you include?

Can you think of and describe a **scenario** when you felt that your **work was successful**? What did you **'do'** that made you **think/know** that it was successful?

What do you **believe** are the **most important practice attitudes, beliefs, and values** to have in this work setting? How did you come to that understanding?

Can you think of a time when you felt you were **not practicing in line with those attitudes, beliefs, and values**? Can you describe what was happening?

What do you think **influences**, **hinders**, or **enables** your work in this setting?

Prompt questions if these topics have not come up already:

Is the way you think about and practice now any **different** to when you worked in the **health sector** (or trained)? What are the **similarities / differences**? How did you come to **identify** these differences?

The **legislation** we work under **emphasises inclusion**. How do you **know when** you are practicing inclusion?

Can you tell me about the **way in which you work** with teachers and teacher aides?

How does the **environment** in which you **practice** influence you?

What would you consider to be **important aspects** when **working with Maori**?

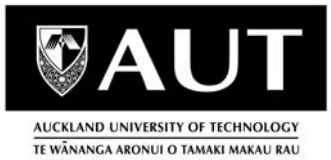
Concluding Questions

How would you **sum up what it is like to work** under the MoE-SE and the SE Policy?

if you could condense everything that we have covered what would you say is the **one thing you value the most in your work**?

Is there anything you would like to add / comment further on?

Appendix 15: Email Questionnaire



E-MAIL 'INTERVIEW' QUESTIONS

Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens: A descriptive study.

March 27 2005

Thank you so much for being willing to participate in the above study and consenting to being interviewed via email. Your data will be very helpful.

Would you describe for me:

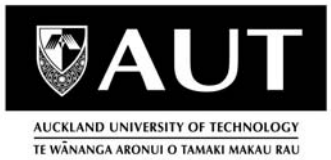
1. How you practice *inclusion* in your regular school settings?
2. How you team in the course of your work?
3. How you form relationships in relation to the work you do as an MOE-SE OT or PT?
4. How you collaborate during your practice in regular school settings?
5. How you share and pass on your knowledge about how to work as an MoE-SE Occupational Therapist or Physiotherapist to new OTs and PTs who have subsequently been employed in your district office?
6. How you work with:
    a. Students?
    b. Families?
    c. School staff?

Many thanks for your time. Do contact me if you have any questions or concerns. I look forward to your early response ☺

Carolyn Simmons Carlsson NZROT
Researcher
Telephone: 09 623 3970 extn. 741 (Ministry of Education, Special Education)
Mobile:
Afterhours:
E-mail: carolyn.simmonscarlsson@minedu.govt.nz

This project has been reviewed and approved by the Ethics Committee of the Auckland University of Technology
AUTEC reference number: 03/176

Appendix 16: Letter to Participants with Transcript



LETTER TO PARTICIPANTS RE: TRANSCRIPTS

Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens: A descriptive study.

24 May 2004

Dear

Thank you so much for being willing to participate in the above study and consenting to being interviewed. Your data will certainly be valuable to my study. As you know part of the study involves having the interviews transcribed. I have now had this done by a transcribing service to save time - a confidentiality agreement was signed by the transcriber. Your transcript is enclosed with this letter.

I would like to invite you to check your transcript for accuracy and amendments, or both. I have maintained confidentiality/anonymity by giving you an individual code to identify your data and material. Any names or potentially identifying information has been removed from the transcript.

You will notice that the transcripts have been typed up verbatim. This is a required part of the research. Please do not make any corrections to grammar, repetitions, and/or sentence construction, weird as it may read in places.

I look forward to getting your transcript back by: (*Date*). If I do not receive it by this date I will assume that you are happy with the content. I have enclosed a SAE for your convenience.

Again, many thanks for your time. Do contact me if you have any questions or concerns.

Yours sincerely

Carolyn Simmons Carlsson
Researcher
Telephone: 09 623 3970 extn. 741 (Ministry of Education, Special Education)
Mobile:
Afterhours:
E-mail: carolyn.simmonscarlsson@minedu.govt.nz

This project has been reviewed and approved by the Ethics Committee of the Auckland University of Technology
AUTEC reference number: 03/176

Appendix 17: Letter to "Expert-in-the Field"

RESEARCH PROJECT (Masters Thesis)

Exploring the culture of practice of Ministry of Education, Special Education Occupational Therapists and Physiotherapists through an ethnographic lens. A descriptive study.

To: (*Therapist*)
(***sent electronically via email)***

Date:

Dear (*Therapist*)

Following on from our discussion last month, I am writing to invite you to be part of this project by taking up a role of offering me your insights, thoughts and comments on my draft findings as an "expert-in-the-field".

I am excited that you are willing and able to do this. Thank you.

I will send you the draft sometime in (*month*) and would appreciate your being able to return the document to me within two weeks of receipt.

Hope that will be OK for you. If not let me know.

Many thanks.

Researcher:
Carolyn Simmons Carlsson
Tel: 09 623 3970 extn. 741
Mobile:
E-mail: carolyn.simmonscarlsson@minedu.govt.nz

Principal Supervisor:
Clare Hocking
Tel: 09 917 9999 extn. 7120
E-mail: clare.hocking@aut.ac.nz

Supervisor:
Valerie Wright-St Clair
Tel: 09 917 9999 extn. 7736
E-mail: valerie.wright-stclair@aut.ac.nz

This project has been reviewed and approved by the Ethics Committee of the Auckland University of Technology
AUTEC reference number: 03/176

Appendix 18: Example of *A Priori* Excel Spreadsheet

FIRST CUT ANALYSIS		*A Priori* concept coding						Sub-Themes / Notions / Connections / Patterns						
Concepts & beginning interpretations / emerging themes / patterns														
Transcript	No.	01	02	06	07	08	12	13	Fieldwork Data p.					
	Colour Coding	Dark Yellow	Blue	Pink	Indigo	email	email	Red	OT/PT e-	presentations	literature about IS /	MoE / SE stuff		
Concept	Pseudo	Bonnie	Phillipa	Sandra	Deb	Tracey	Leanne	Cassie						
The client group - who do we work with?		ORRS - high / very high needs	ORRS + MPDC	ORRS MPC students etc.	ORRS & moderate contracts - so that would cover children with a huge range of impairments or disabilities	school staff students families	systemic work	neurological conditions, eg. CP / ASD / Aspergers / syndromes / myopathies / Duchenne / Downs Syndrome / intellectual disability / the whole range really ... the distinction is that they're all high needs or very high needs ...	students school staff teachers teacher aides principals systemic:	Referrals are accepted for students who qualify for ORRS funding and students who meet the Moderate Physical Disabilities Contract criteria	Students who have been verified under the Ongoing Reviewable Resourcing Schedule (ORRS) may access occupational therapy and physiotherapy services if required.	students; families; school staff; school system		
Content collapsed and hidden within spreadsheet for ease of working with														

Appendix 19: Elements of Consultation (Workshop Handout)

The Interrelated Themes of Consultation	
Knowledge • theoretical level • technical level • from basis of discipline specialisation	• standards of practice • frames of reference or theoretical approaches • evidence-based practice • practice settings and systems
Interpersonal Skills	• communication and active listening • clear communication without jargon • mutual respect • partnership • readiness and openess • acknowledge and accept diversity • leadership • negotiation • effective interviewing skills • education and training (coaching skills)
Diversity Readiness	• working with diverse communities • awareness of cultural influences • ecological practice (environmental influences) • resource systems • sensitive practices

Consultancy - Do's & Don'ts	
Do	**Do Not**
• keep a record of all contacts • recognise that you hold an equal position with the consultee socially, emotionally, administratively • evaluate client and system needs • promote learning by consultee and yourself • impart specialised knowledge • find solutions jointly (share responsibility for problem solving) • suggest changes that are palatable and realistic • enhance creative, self-directed implementing of your suggestions • listen and expect two-way communication • be task-oriented; delegate intervention strategies • recognise you are dealing with a whole social system • be non-threatening in your approach • consider *who* asked you to consult and *why* • solve a problem or crisis; recognise your involvement is likely to be temporary and the consultee may terminate your relationship at any time • recognise that a consultant's role may not establish deep personal relationships or provide deep personal gratification	• try to assume authority or take responsibility (which would be supervision, not consultation) • act patronizing, benign, or aloof • make unilateral decisions • expect consultee to modify behaviour to please you • teach/lecture, dictate, be authoritarian • ignore feedback • be solely student oriented • be an advisor who does not become involved in the social system • try to upstage the consultee or compete for attention • fail to obtain and maintain sanction from people who may have opposed your involvement • plan to stay in this position indefinitely

This material is adapted from the following sources: Dudgeon & Greenberg, 1998; Dunn, 1992; Hanft & Place, 1996; Giangreco, Edelman & Dennis, 1991; Kemmis & Dunn, 1996.

Therapy in Education – Promoting Effective Practices. Therapists Training Workshop Series I & II. Specialist Education Services, National Office, New Zealand.
Presented by Carolyn Simmons Carlsson & Pat Caswell, June 1999.

Appendix 20: GSE Service Pathway: Poutama

Reprinted with permission from: Dr Roseanna Bourke, Manager, Professional Practice, MoE-SE, November 9th 2005 (see correspondence below).

Chronological email correspondence regarding permission to reprint the GSE Service Pathway: Poutama

From: Champion Sally [mailto:sally.champion@minedu.govt.nz]
Sent: Wednesday, 9 November 2005 1:29 p.m.
To: Ford Jill
Subject: FW: MoE-SE Service pathway: Poutama

Hi Jill
I hope this is the right email address for the person who wanted the fern poster. See comments below – it just needs to be fully cited and sourced.

-----Original Message-----
From: Kerry Sharon
Sent: Tuesday, 8 November 2005 5:05 p.m.
To: Champion Sally
Subject: FW: MoE-SE Service pathway: Poutama

Hi Sally,
Sorry I didn't see this from Roseanna. On the basis of Roseanna's comments please release the picture providing it is fully cited and sourced through a public document.
Thanks
Sharon

-----Original Message-----
From: Bourke Roseanna
Sent: Monday, 7 November 2005 8:59 a.m.
To: Ford Jill; Champion Sally; Kerry Sharon
Subject: RE: MoE-SE Service pathway: Poutama

Hi Jill, I see no reason why not if it is fully cited and if it is sourced through a public document. However, it is the SDSU manager. Sharon Kerry, who you need to check with as the work derived through that unit
Roseanna

-----Original Message-----
From: Ford Jill
Sent: Monday, 7 November 2005 8:51 a.m.
To: Champion Sally; Bourke Roseanna
Subject: FW: MoE-SE Service pathway: Poutama

Dear Sally and Roseanna,

Carolyn is one of our staff who is doing her Masters thesis on the culture of OT practice in GSE. She would like permission to use the slide of the client pathway from the service description? Can you give approval for this please? I think it would be appropriate and her material will be directly useful for our staff. Hopefully a copy will be available in the library once it is completed.

Jill Ford
Occupational Therapist
Professional Practice Advisor
Group Special Education
P O Box 30177

Lower Hutt
Ph 045703658
Fax 045703667
Cell 0274758402

-----Original Message-----
From: Kero
Sent: Sunday, 6 November 2005 12:17 p.m.
To: Ford Jill
Cc: Simmons Carlsson Carolyn
Subject: MoE-SE Service pathway: Poutama

Hi Jill

Do you know who/how I might get permission to use the picture of our service pathway in my thesis? It's the centre page in this and I would really like to be able to make it small and have it as an intro to one of my chapter "Inside the Practice Context" if possible:

Ministry of Education, Special Education. (May, 2005). *National service description: A national service description for special education services – Ministry of Education, Special Education (2005).* Wellington: Ministry of Education, Special Education.

This is really a great publication. Does every therapist have one – good induction resource.
Cheers
Carolyn

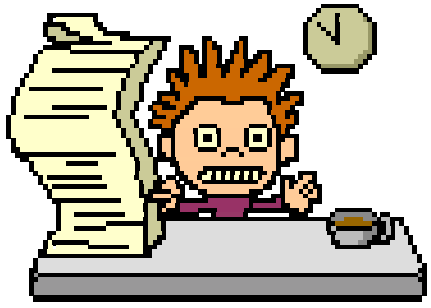
Appendix 21: Powerpoint Slide: MoE-SE Therapists' Culture of Practice

Appendix 22: Summary of GSE Fieldstaff Key Principles, Attitudes, Beliefs and Skills

The following points are summarised by the author of this thesis from: Ministry of Education. (2004c). *Professional practice in special education. Ministry of Education, Group Special Education*. Wellington, NZ: MoE, Group Special Education.

GSE specialist practitioners value and believe in:

- inclusive practice philosophy
- relationships and the building of relationships
- respecting others and their contexts and treating each other with dignity and honesty
- valuing the contribution of others and understanding others perspectives
- collaboration with others
- partnerships with clients
- communicating with others; listening and problem solving with others
- good, effective communication and interpersonal skills
- sensitive practice when working with others
- understanding that others have different ways of knowing/worldviews
- providing a culturally appropriate service
- their interventions being built upon positive foundations
- the child's voice being heard
- fostering independence in the students they work with in school systems
- being *whānau*-focused
- being family centred in their service provision
- evidence-based in their practice
- applying the ecological approach in their assessments and interventions
- using formal and informal assessment and naturalistic observations of students in school settings
- a strength-based approach to practice
- avoiding a deficit model of practice



Here endeth the text!