Occupational Therapy in Aotearoa : Part 1 The Challenge

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Health professionals in Aotearoa are questioning their practice and knowledge base in relation to fulfilling the requirements of the Treaty of Waitangi, as Maori concepts of health are recognised and Department of Health commitments are actioned Occupational therapists are challenged to recognise their own cultural background - both personal and professional. Questions are raised about the extent to which we comply with the Occupational Therapy Board's competencies for Practice, and the stated goals of both Schools of Occupational Therapy.

Practice as a health professional in Aotearoa New Zealand in the 1990's provides a great challenge, as we consider the relevance and competence of our practice to maori clients and practitioners. Recent discussion and increased understanding of the history of this country, and acknowledgement of the differences between maori and western views of health and illness, lead us as a profession to question our practice and our knowledge base in relation to the tangata whenua.

Historical Perspective

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Maori and ·· ·rown. On an individual level, it can be said that the Treaty partners were in fact Maori and Tauiwi.

Implicit in the Treaty were the concepts of equity, partnership and economic and cultural security, all of which contributed importantly to hauora (spirit of life/health). Poor standards of maori health may therefore be regarded in part as non-fulfilment of these Treaty concepts and obligations (Pomare and de Boer, 1988).

Partnership implies that both Maori and Tauiwi have gifts to give and receive from one another, and that nationhood is best served when both partners are valued and respected and share fairly in decision making and the resources of the nation. Alternatives to partnership are entrenched separatism on the one hand and assimilation and homogeneity on the other. Partnership is the preferred option (Smithies, 1990).

The emphasis, for those of us who work in the health professions, is that of partnership in health care. That is, "Value for Money" for all those who require the services of the health system.

Health Concepts

In recent years, a maori concept of health has been emphasised and health authorities are being urged to rethink basic attitudes to health and health care along cultural and ethnic lines. Tribal authorities have been advocated as custodians of maori health, and more emphasis on culture as a component of health has been recommended for the curricula of training health professionals (Maori Health Advisory Committee, 1988). The Department of Health has made a commitment to the development of a bicultural health system and workforce and has emphasised the implications and importance of the Treaty of Waitangi as a basis of partnership in health between maori people and others in New Zealand. There have been strong calls too for more effective involvement of maori people in health planning, a critical factor if the health needs of many maori people are to be adequately met (Pomare and de Boer, 1988).

As we know, european colonisation of New Zealand led to the rapid submergence of Maori health values in favour of western thinking and practices. The spiritual basis for health was replaced by scientific method. The authority of the elder was challenged by the health professional. The role of the family in community health care was undermined by institutional care. Western psychological theories and therapies alien to maori thinking were introduced. For example, bonding a child to its biological mother has been a western preoccupation for years. Maori practice bonds the child to the land, where ritual burying of the placenta symbolises the formation of a unique relationship, and provides nourishment, security, anchorage and shelter (Durie, 1985). Ongoing maori efforts to reclaim their land can thus be seen as a positive mental health measure.

Another example is embedded in pakeha mental health theorists' advocacy of independence. They equate health with self determination, and maturity with self sufficiency. These are, however, unhealthy concepts to maori, as they elevate the individual above the family.

Durie (1985) also describes environmental pollution as a mental health problem. He describes it as a deterrent to good mental health in that it is an assault on the mind, and claims it may even be a cause of mental ill health.

Health Care Challenges

Maori concerns regarding health issues are beginning to be heard. In the submission by the New Zealand Board of Health Standing Committee on Maori Health to the Minister of Health, in July 1988, the following challenges for achieving a Bicultural Health System were made:

1. that the three articles of the Treaty of Waitangi be regarded as the foundation for good health in New Zealand,
2. that maori tribal authorities be regarded as the proper trustees for maori people,
3. that resources be made available to those authorities to enable them to include health in their own development programmes. Improvements in maori health are likely to come about through whanau, hapu and iwi development,
4. that maori health issues can only be addressed by the involvement of a greater number of maori people in the delivery of health care and the setting of priorities,
5. that for maori people the health team must have the support of the maori community and must include both western-trained health professionals and people trained in maori schools of learning, and
6. that training programmes reflect the bicultural nature of New Zealand society. If teaching institutions are unable to adequately prepare people, they should contract out to those organisations equipped to do so (Maori Health Advisory Committee, 1988).

These challenges are consistent with the World Health Organisation (WHO) objective of "Health for All" by the year 2000, which emphasises the need for consumer partnership in clinical, management and planning situations. WHO states that health can only be achieved if people are actively involved in decisions that effect their own health and health care. Implicit in this are notions of cultural difference in health perspectives, social organisation and management styles (Durie, 1987).

Occupational Therapy

So where does occupational therapy fit in this picture? Occupational therapy is a health profession. It is practised in the health institutions of Aotearoa, in educational institutions, in voluntary agencies and in private practices. How do we implement the principles of biculturalism in our practice, or do we?

Occupational therapy evolved from the belief in the therapeutic worth of occupation. Adolph Meyer made his first references to the therapeutic uses of occupation in 1893 in America. "The proper use of time in some helpful and gratifying activity appeared to me a fundamental issue in the treatment of any neuropsychiatric patient" (1922, p. 639). He also described, in 1902 at McLean Hospital in Massachussets how "Mrs Meyer.... may have been one of the first, if not the first to introduce a new systematized type of activity into the wards of a state institution" (1922, p. 639).

Our modern theorists are also mainly from America. They include Mary Reilly, Anne Cronin Mosey, Gary Keilhofner, Lorna Jean King, Jean Ayres and Claudia Allen. The values and principles they espouse, and which we have adopted, come from the western academic world.

Furthermore we ourselves come mainly from a western heritage. During a series of workshops I have run with students and therapists around the issues of culture, time has been spent establishing who we are and where we come from. Over 95% of therapists who attended these workshops had their origins in Great Britain. We bring our heritage of values and experiences with us. It is important that we acknowledge our origins, and understand the influence they have on our practice.

Our Challenge

The challenge for us is that we are practising our profession in a country that has begun to acknowledge its bicultural history. At the recent opening of the Occupational Therapy School on the Akoranga campus of the Auckland Institute of Technology a very strong public statement was made, both in the design of the building and in the speeches, stating a commitment to biculturalism. There are two challenges to the profession which arise from those public statements. The first is related to the training and skills of the therapists who will emerge from that school. Will they match up to the promise of that occasion? How will we measure that? The second challenge is to a profession which has considerable work to do, to bring its own skill and competency level in the area of biculturalism to appropriate standards and demands of the health system moving towards the year 2000.

As a professional group, we have documented our intention to achieve this. In the document 'The Competencies for Registration as an Occupational Therapist' of the New Zealand Occupational Therapy Board (1990), it is stated that the occupational therapist as clinician can:

- professionally present, record and report client information relevant to the receiver with cultural sensitivity,
- select, analyze, structure, synthesise, adapt and grade activities achieving client/media match considering client's age, gender, culture, interests, values and social roles,
- attend to the safety of the client and therapist with regard to cultural sensitivity,
- recognise and respect the uniqueness of the individual, and work with this to achieve therapeutic goals
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As a communicator, the occupational therapist is considered competent if able to;

- demonstrate a range of communication skills and techniques in specific occupational therapy situations and modify communication while maintaining professional integrity demonstrating cultural sensitivity and awareness,
- use non racist language, and
- facilitate the teaching learning process in a variety of occupational therapy settings providing a learning environment that takes account of the learner's cultural and social environment. etc.

The Otago Polytechnic Charter states ".. the Otago Polytechnic's acceptance of its responsibility to ensure that resource allocation, policies

and practices operates in ways consistent with the principles of equity, relative needs and the Treaty of Waitangi (Otago Polytechnic School of Occupational Therapy, 1991). The Auckland school states in its Programme Philosophy that graduates are prepared for practice in New Zealand's bi-cultural society, in accordance with the Treaty of Waitangi, (Auckland Institute of Technology School of Occupational Therapy, 1992).

Do we as practising therapists meet these competencies and skills? There is no specific New Zealand data, but also no evidence to suggest that we do better than therapists in the U.S.A.

Blatant examples of cultural bias, against both black therapists and black clients, occurred so frequently within occupational therapy that the black therapists formed the Black Occupational Therapists Caucus (Lowery & Scott, 1991). As a response to the need for cultural sensitivity in occupational therapy practice in America, cultural competencies are being considered. A suggested format is put forward by Folks and People (1991) of the Eastern Michigan University Occupational Therapy Programme. These competencies are presented below.

Cognitive Domain

1. The culturally skilled therapist will understand sociopolitical systems operating in the United States with respect to treatment of minorities.
2. The culturally skilled therapist will have specific knowledge about the similarities and differences between whites, african americans, hispanics, native americans and other racial/ethnic groups.
3. The culturally skilled therapist will be aware of the institutional barriers that prevent or discourage members of minority groups from using rehabilitation services.

Affective Domain

1. The culturally skilled therapist is aware of and sensitive to his or her own cultural heritage and sensitive to the need to value and respect diversity.
2. The culturally skilled therapist is aware of his or her own values and biases and how they may affect the therapeutic relationship with minority consumers.
3. The culturally skilled therapist is sensitive to circumstances, socioeconomic factors, political factors, racism etc. that may dictate referral of minority consumer to a minority therapist.

Psychomotor Domain

1. The culturally skilled therapist will be able to generate a wide variety of verbal and nonverbal responses that will facilitate the consumer's involvement.
2. The culturally skilled therapist will be able to send and receive both verbal and nonverbal messages accurately and appropriately. (Folks & People, 1990).

I do not know how we match against this list of competencies or the competencies of the New Zealand Occupational Therapy Board. I do not know if we support, or have moved towards the commitment made by the two Schools of Occupational Therapy. Our challenge however is clear. As James Ritchie (1992) states:

> The tide has turned. We face a future in which maori people will assert their rightful place in this society, with or without non-maori help. They are fashioning a thoroughly modern, totally viable maori lifestyle in which the rest of us may participate, if we wish. Between their world and the majority culture we also must fashion the bicultural world in inter-connections and common pathways and understandings, but we will not be successful in this until the maori world is respected, is resourced, is in good health and strength and is in a true state of equity. There are many reasons why some people may want to block, delay or deny maori progress. Some are simply threatened by changes which are going faster that they can tolerate. Some fear loss of property, or of position, power or control. Some are encumbered with the accumulated baggage of their personal, familial or cultural past with encrusted prejudices that they will not abandon or even put up for scrutiny. When the time has come for change, not to change is disruptive and distressing. When people cannot rid themselves of habits that cripple their functioning we term them neurotic and suggest they need help. The same is true in social matters. There is a marvellous feeling of release when you no longer have to support systems that you know are unjust, when you have found your therapy and others support you in it... (pp. 10-11).

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