Occupational Therapy in Aotearoa : Part 2 The Steps to Biculturalism

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This article outlines the professional response demanded of occupational therapists practising in New Zealand, if they accept the challenge of fulfilling the requirements of the Treaty of Waitangi. A description of biculturalism is given, suggested steps towards biculturalism are outlined, and finally, current constraints to and resources for bicultural practice are identified and acknowledged.

The challenge to occupational therapists practicing in Aotearoa in the 90's is to fulfil the requirements of the Treaty of Waitangi. Part 1 of this article (Henare, 1992) raised questions about the adequacy of current occupational therapy practice, knowledge base, and recognition of the impact of therapist's own cultural background. In addition, compliance with the Occupational Therapy Board's Competencies for Practice, and the stated goals of the Schools of Occupational Therapy was questioned. Part 2 follows this up by describing the journey towards becoming bicultural.

Three phases can be identified in the journey to biculturalism: the acknowledgement phase, the training phase and the negotiation phase. Each phase has a number of steps. To miss one step invites failure to understand fully. There is no comprehensive blueprint but rather a map. How long it takes depends on the travellers (Smithies, 1990). This article combines information from the work of Irihapeti Ramsden (1989), the Rowan Partnership (1990), and Ruth Smithies (1990), to provide a map for occupational therapists in New Zealand. But first, the goal needs to be defined.

Biculturalism implies that there are two distinct sets of cultures. In this context, one is the culture of the indigenous people, the Maori or Tangata Whenua, within which there are differing tribal tikanga (customs). That the Maori people are indigenous means that they did not replace or incorporate another culture when they arrived here. It also means the Maori culture can only be found in this country.

The other cultural set was established through a process of colonisation. The Pakeha or Tauiwi (foreign) culture from Britain became the dominant one, from which the rules of society and society's institutions were taken (Smithies, 1990). The word Pakeha does not include everyone of the settler group. It applies to those of Western European descent. The term Maori was determined after arrival of Pakeha and means 'normal'. The word that is now most frequently used to include all settlers is "Tauiwi". The term literally means "tau" to stay or settle and "Iwi" people or tribe. There are many peoples of many races who comprise Tauiwi.

Being bicultural indicates an ability to be "at home" in two cultures. It implies an understanding of and respect for a culture other than the one in which the person was born and raised. Many Maori are bicultural, keeping their own distinct culture, while they have been forced to also function in the dominant Pakeha one. This same phenomena also applies to many people from other cultures who have settled in New Zealand, especially those from the Pacific. Therefore, to become bicultural is primarily a challenge to Pakeha (Smithies, 1990).

Biculturalism occurs where there is dual cultural development and practice. The people from each set of cultures have an obligation to ensure that neither absorbs the other, so as to destroy the rightful place of each set of this dual heritage. Bicultural development strives for a society in which these two sets of cultures have an equitable say in the development of policies and setting of priorities, a recognition of both languages and cultures, and a fair sharing of power and resources.

Biculturalism differs from assimilation or integration, in that the two cultures live along side each other. At its core, biculturalism means recognition of Maori as Tangata Whenua with a right, as enshrined in the Maori language version of the Treaty of Waitangi (Te Tiriti o Waitangi), to their own language and cultural self determination.

According to Puao-te-ata-tu (cited by Abbott & Durie, 1987), biculturalism "involves understanding and sharing the values of another culture ... means that an institution must be accountable... for meeting (client) needs according to their cultural background..." and includes "...the sharing of responsibility and authority of decisions with appropriate Maori people" (p. 20).

Multiculturalism

There is much debate about the position of other cultures. Maori and Tangata Whenua, people of the land. That is an indisputable fact of New Zealand's history. The Tauiwi arrived many hundreds of years later. Maori signed a treaty, Te Tiriti o Waitangi, which gave Pakeha permission to share in the hospitality of this land. But this is a basis for biculturalism only. What of all the other cultures? It is argued that New Zealand is currently a plural society. That is, it contains many different cultures which do not have an equitable say (Smithies, 1990). Achieving biculturalism is seen as a step towards becoming a multicultural society, that is, a society in which many distinct cultures are supported by the State to pursue their various cultures.

Developmental Process

Partnership indicates persons

associated with others in a business in which risks and profits are shared. It involves co-operation and interdependence between two or more distinct people or groups. To achieve true biculturalism and partnership, will be a developmental process. As mentioned earlier, this has three phases.

1. The acknowledgement phase
This incorporates the recognition of the need to explore issues of the Treaty and of biculturalism. It involves the issues of acknowledging and respecting our own values and cultural beliefs, awareness of cultural difference, and an acknowledgement of the existence of racism. According to Ritchie (1992),

> the recognition of ethnic difference has become an increasing requirement everywhere.... In every large nation state, and many small ones, what has come to be called the 'fourth world' status of ethnic minorities has become the focus of political activity. Fourth world cultures are forced by circumstances to seek to assert their identity while submerged within some wider culture...(p.7).

2. The training phase
Smithies (1990) describes several areas of training and knowledge gathering; the Treaty of Waitangi, our history, Maori values, and Maori culture. The Rowan partnership model (Rowan Partnership Workshop, 1992), adapted from the work of Irihapeti Ramsden, demands:

> treaty and biculturalism training for policymakers at least... (and) ... treaty and biculturalism training for all new and existing workers. With Tauiwi trainers for Tauiwi workers, and Maori trainers for those who identify as Maori. Cultural awareness training as a follow-up, not as a substitute (page not numbered).

This raises questions for occupational therapy. Have the policy makers been on these courses? The Occupational Therapy Board? The staff of the two schools, the Advisory Boards, the NZAOT Council? How many practising occupational therapists have attended a Treaty of Waitangi workshop, or a workshop on understanding racism?

I would emphasise the importance of ongoing learning, as one attendance at one workshop does not make an expert. In James Ritchie's (1992) book "Becoming Bicultural" he describes a number of principles that he uses as a Pakeha to assist understanding. He has labelled them with Maori headings. The one that fits here is "Whakakitenga - never presume to understand" (p. 63). There is always more to know, the task of understanding is never complete. From my own experience of the last 23 years living in a bicultural family I know that I will never fully understand. From the training we move to the first steps of action and negotiation.

3. The negotiation phase
The first step involves policy commitment to the Treaty of Waitangi, e.g. mission statement, aims and objectives, etc. As previously mentioned both Schools of Occupational Therapy have these statements. All Health Services have, through the Department of Health Memoranda. Yet, does the New Zealand Association of Occupational Therapists? We should have policies and actions consistent with a commitment to the principles of the Treaty.

In 1990, as Convenor of the Working Party on Cultural Perspectives within NZAOT, I advertised for people to participate in this working party. Only Beth Gordon came forward. Together we prepared a discussion document for the Association in October 1990. As yet I have received no feedback on the issues raised in the paper. Is that a measure of the real commitment to biculturalism of the profession? The first recommendation of the discussion paper stated that:

> When the Association is formulating policy, preparing submissions, discussing issues related to the practice of occupational therapy it seeks the advice of an advisory group or network of Maori who have knowledge in the relevant area of concern (p. 2).

Where else might we need policy or mission statements of commitment to the Treaty? In private practice? In the New Rehabilitation Institute? The Education Subcommittee of the Occupational Therapy Board proposed inclusion of Treaty and bicultural material in the information kit forwarded to foreign occupational therapists seeking registration in New Zealand.

One caution to note at this stage is that it is easy to stop there, and say we have made a commitment to Treaty issues and biculturalism, once policies are written. These statements are tokenism without action and changed practice. What else do we need to do as a profession to address the policy issues relating to biculturalism?

Using the Rowan model, the next steps to action are:

- Commitment to search for bicultural goals and procedures. Such commitment involves resources, funding, time, action, and evaluation.
- Openness to biculturalism as a condition for prospective students. This is an issue for the polytechnics to determine, when they recruit prospective students and for therapists when recruiting staff. There have been few Maori therapists trained. According to Jamieson (1988), by 1988 approximately 15 people who identified as Maori had graduated in occupational therapy. This step looks at both the attitudes of those recruited, the openness to recruit Maori, and the skills to recruit and support them through the programme.
- If necessary appoint consultants to assist with the next stages. Professor Pomare, Dean of the Wellington Clinical School, indicated the frustration felt by Maori when anything to do with Maori issues were left to the few Maori staff to deal with. This is experienced as imposition and an excuse to do nothing. He quoted an example of a very effective Maori health committee where some research was required. A Pakeha researcher was asked to join the committee. Over time he was educated into the Maori way of approaching meetings,

with karakia, consensus decision making etc. and by sitting back, listening and learning he has become an advocate for Maori amongst his Pakeha colleagues. Alternatively, a negative experience was recounted where a Maori committee was set up by a Pakeha body, who then proceeded to criticise the Maori committee for doing things differently.

Ritchie (1992) gives us some advice regarding Maori structures. He describes the principles of Kotahitanga, Puta Noa and Rangatiratanga. "Kotahitanga: The ideal of Maori political process is achieved through consensual discussion. By this everyone is brought together, all personal differences of opinion are aired and, even if they cannot all be incorporated in the final decision, given respect" (p. 57). "Puta Noa: Seek rest and contentment. When things are done correctly, according to nga tikanga, the rules of custom, there is a sense of closure, of completeness. Things have been done well" (p. 59). "Rangatiratanga: Maori society is hierarchically organised and so is the authority within it" (p. 56). Authority, decision, action are all structurally organised around status. There is nothing comparable in Pakeha society. This is one of the most important principles.

• Tentative approaches to Tangata Whenua and other Maori interests. A statement of intent to act in good faith as allies; checking to see if there is Maori interest in a regular relationship, either for consultation on the organisations' programmes and plans which touch on Maori concerns, or for negotiation and accountability about the organisation's internal procedures as they affect Maori. If there is willingness for a long-term relationship, check all appropriate channels to identify how Maori partners will be appointed. Remember, negotiations are with the Tangata Whenua of the specific area. Structures, needs, and protocols will differ for each iwi.

• If there will be a long-term partnership:

- work out how and where meetings will be held with both partners. Negotiate a planning process which will assure Maori partners that their views will be represented in decisions, and check whether they need resourcing to be able to be involved.
- negotiate the guiding principles of partnership, including accountability, equity, goals, and how conflict will be managed if it arises, to meet the needs of the organisation and its Maori partners, and
- within the agreed principles, start negotiating specific agreements on the factors that will create a bicultural organisation. The Rowan model thus outlines a process of undertaking a commitment to biculturalism, ensuring that each of the participants is open to the principles of biculturalism, consultation with Maori, and negotiating the procedures to be followed.

One successful example of this process has been the Women's Refuge Collectives, which have, over time, established a bicultural organisation and a model which works. They began the process from the top, and have within their core group equal representation of Maori and non-Maori. They have established Maori and non-Maori houses in a number of areas. Their training is done separately, with separate training manuals and setting up manuals. Racism training is required for all workers who are part of the collective. Where there are not separate houses, there are two collectives for the one house, Maori and non-Maori. The fundraising is split 50/50 with the two groups. It is the structure that dictates practice. This is not always easy, and for some groups it has been a real struggle, but they have a commitment. The AGM is run with a day meeting beforehand for each caucus from which items are brought to the joint AGM. Constant evaluation occurs to ensure the principles are being met.

On reviewing where occupational therapy and therapists are on this journey, the obvious answer is that we are at different stages, with the majority at the awareness and training stages, and very few at the negotiation stage. My assumption is that the schools are at the negotiation stages, and the Association at the training stage. How do we move on from here and what will get in our way?

Constraints to Bicultural Practice

This section identifies constraints to bicultural occupational therapy practice, possible resolutions and ways forward. I have identified several constraints. You may know of others. These are our own attitudes and racism; lack of knowledge about our history, the Treaty of Waitangi, Maoritanga etc.; our educational processes; constraints of time and energy; uncertainty about how to move forward; management; and resources. A discussion of each of these constrains is presented.

1. Our own attitudes and racism

How do we recognise our own racism? Because the dominant culture in this country is Pakeha, many of us do not realise the extent of our own conditioning. We may not understand that the values and beliefs system we operate by are from a specific cultural set of values, an ideology that is hidden. These values are not from a universal divine law. No structure or institution in Aotearoa/New Zealand is value free or neutral. What is right and wrong has been defined from a cultural perspective. For most of us that is European. That is not to say it is wrong or right, but we need to recognise it for what it is. Those who are from a different culture will feel alientated by the system and find it hard to understand that they will be judged in ways that are incomprehensible to them. Those of you who have travelled to a non-English speaking country where the system is different from your own, may have experienced the feeling of frustration, alienation, and even fear when you do not feel familiar with or understand what is required.

Ritchie (1992) identified the principle of "Te Hara - the infliction of Western cultural values on the people has done enormous damage to their cultural integration" (p. 61). He acknowledges that personal guilt is not necessary. We did

not personally cause the pain, but he advises that we must not compound the harm or increase the pain by any personal action, or by any collective action that we are able to influence.

New Zealand suffers from two forms of racism: personal and institutional. Personal racism occurs when individuals see themselves as superior to Maori. It is manifested in disparaging comments, jokes, and subtle discrimination. Institutional racism is present in most of the institutions of our society. These, until recently, were completely modelled on Western thinking. Pakeha hold the power, and determine the structure, policies, and practices of schools, hospitals, government departments, courts, welfare etc. Pakeha have even taken over the pronunciation of Maori words (Smithies, 1990). Changes are beginning. As the saying goes "if you are not part of the solution you are part of the problem". We see racism in its most violent form in South Africa, and in Bosnia, Hezegovena. We saw it in Nazi Germany. We are not so blatant in New Zealand. Our racism is often more covert, which makes it harder to identify, but the hurt that can be perpetuated on those who are the recipients is just as devastating and demoralising.

How do we change our attitudes? Some of the answers have already been identified in the previous section and include attending workshops and seminars, reading books, learning about the issues, listening to Mana News and Maori television programmes, building contacts with Maori people, and listening, most of all listening.

2. Lack of knowledge about our history, the Treaty of Waitangi, Maoritanga etc.
Again, this has been addressed already. The solutions are readily available to all of us.

3. Educational processes
This is an issue which, again, has been partly addressed. The two occupational therapy schools appear to have taken on board the requirements of training health professionals to meet the needs of a bicultural society. There are clear guidelines given in the document of December 1986 from the Standing Committee on Maori Health to the then Board of Health (Durie, 1986).

This commitment must be used as a conscious basis to development of the curricula. In a study undertaken in 1987 (Abbott & Durie) the content of psychologists' training was analyzed to identify the Maori cultural content, and the number of students and teachers with Maori ancestry. There was very limited input in four courses and none at all in the other five. The point was made that the psychology degree structure was based on the English model, with particular input from America in relation to the content.

The issues around incorporating Maori content into health curricula can cause bitter debate, as was shown through the article in Metro recently which looked at the nursing curriculum and examination process (du Chateau, 1992), and the issues of cultural safety raised by Irihapeti Ramsden et al. (1992).

The other issue around training is that of Maori trainees. The number of Maori graduates from the various health professions have been very limited. Up to 1987 there had been no clinical psychologist graduates. In 1986, 2.3% of all physiotherapy and occupational therapy graduates were Maori. Social workers had a better representation with around 17%, while medical graduates were around 2% (Abbott & Durie, 1987).

What affects the recruitment and retention of Maori students? Firstly there is the applicant pool. The majority of Maori children leave school without formal qualifications. In 1985, there were only 438 Maori in 7th form. While this has changed in recent years, the numbers are still small and the requirements of Maoridom for tertiary qualifications mean that this pool is spread over a large number of professions.

The second area is how students are treated and supported during their training. In a report of a hui at Waikohatu Marae Rotoiti, in 1989, on Cultural Considerations in Health, the experience of students in the medical school was recounted. Students talked of having to deal with the competitive spirit of fellow students, and to the hostility meted out to those selected under the preference scheme. Some dropped out, some became radicals, some suppressed their Maoriness, some 'partied' to cope. The students identified the need for support, both in numbers and in facilities. The advent of Maori liaison officers has helped with the support issues. Students also need to be present in sufficient numbers to support one another. They must be protected from the racism of other students during racism education sessions, and not be expected to provide the Maori expertise for everyone else. They may need whanau support at interview, as happens with the Teachers College interview system.

Affirmative action selection programmes must be in place. Professor Eru Pomare mentioned the criticism from others who see affirmative action as lowering the academic standards. He indicated that research showed that if a student had a B-average they could achieve at Medical School. The other end of this issue is the enormous pressure on Maori students selected, as they receive frequent comment from other students about only being there because of the affirmative action scheme. Consequently, many feel they have to perform extra well to justify their selection. The issues of cultural safety do not just pertain to clients but also to Maori health professionals training and working in the current system (Pomare, 1992, personal communication).

The other criticism related to affirmative action is that there will be fewer places for Pakeha students. That means that some will miss out. I remember having a heated conversation with a therapist about the fact that her daughters had missed out on a place in an educational course because they were not Maori. That is the reality of resource sharing, someone will miss out. In the past, for a range of reasons, it has been Maori who missed out. Now in order to redress the imbalance and ensure there are Maori trained to work with Maori, some Pakeha will miss out.

In a study done by Dr. E. K. M. Douglas for the Wanganui Area

Health Board in 1989, it was identified that three occupational groups had the greatest representation of Maori workers - nursing, hospital cleaners and domestic staff, and cooks and catering staff. In all other areas-managerial, charge or supervisory positions, medical, pharmacy, and health professionals there were few Maori staff.

We need to improve our efforts to recruit Maori trainees. How does the message of occupational therapy as a career possibility get to young Maori? Positive approaches to Queen Elizabeth college, Te Aute college, Hato Paora, Hato Hohepa, and to the coeducational colleges in predominantly Maori areas need to be made. Representation to the groups working with Maori to encourage young Maori into health careers also needs to be made. We need to ensure that occupational therapy is portrayed on the Workforce video. These are the initiatives we can undertake.

4. Time and energy
When things get difficult for me, I frequently make the excuse that I don't have time. The reality in health practice today is that too much is being asked of us. Time can be an excuse to avoid those things in the 'too hard' basket. At Wellington Psychiatric unit, we have a cultural committee which monitors the cultural issues affecting the service. We are an ad hoc body, with no managerial recognition, but we have committed time to meeting within work hours because we believe it is the very least we can do in cultural terms. How could you organise your time, to give time to cultural issues?

5. Uncertainty about how to move ahead
As we all know some of our best learning has been when we made a mistake. Perhaps it is better to try something than not to try at all. Again, citing the Adult Mental Health service in Wellington, we began this process with an iwi contract for a Maori person to work with the service. For a variety of reasons the first experience was not a positive one for either party to the contract. The important thing was not to say it doesn't work, but to evaluate the project and try again. This has happened, and the contract is doing well the second time around.

6. Management
Unless management are committed to finding solutions, allocating resources, and providing training, time, and so on, the committed therapist can do little. Where management is dragging behind, therapists may need to be the people who challenge management to act differently.

8. Resources
Biculturalism calls for sharing of power and resources. How do we do that? This I believe, is often where 'the crunch' comes. We can talk about bicultural ideals, and we can agree in principle, but to make it happen, those with power and resources must share them with those who do not. It has become the fashion to give everything we do a Maori name, hence Te Tari Ora for the Health Department; but a change of name will not change the way in which the Department operates.

The Wellington Area Health Board has chosen to share its resources by contracting with local Maori groups to provide a Maori perspective on health. It is now into its third round of contracting with the regions' five major iwi groups as providers of health care to their people. This means handing over resources to the group to provide the services they see necessary, in the way they see as most appropriate. "Services run by iwi groups are far better accepted in the community and tend to carry through to the whole family instead of stopping at an individual level" (Wineera, 1992). The programmes include diabetes screening, hearing testing, immunization programmes, parenting education, programmes for the elderly, drug and alcohol research with young people, and a drop in centre for people with chronic psychiatric disability.

Wellington is by no means leading the move to bicultural health services. Other Boards have been prime movers in bicultural health delivery and the sharing of resources. Whai Ora, at Tokanui Hospital, is a Maori initiative in mental health. It is based on Maori values and systems. It aims to enhance the ability of clients to function at an optimal level, using interventions based on Maori values system, and uses whanau based community support networks.

In some areas, Maori have taken the initiative to train Maori in Maori Health initiatives. The Waahi Marae based health centre trains women from the local community to become Nga Ringa Aroha (those with loving hands). The training programme integrates Maori cultural values and beliefs, traditional Maori healing practices, and modern health promotion knowledge.

The Rotorua Health centre at Tumahaurangi Marae has an emphasis on a Maori perspective of health, health promotion, and disease prevention activities. Te Wananga o Raukawa, Otaki, offers a course in health studies which emphasises both traditional Maori and modern Western concepts of health. The health curriculum includes Te Reo (language), Nga Putake (foundation of health), Whanaungatanga (Family health), strategies for prevention, and planning for health and health promotion (Abbott & Durie, 1987).

Resource sharing is the bottom line. For me, the challenge came last year when the new Wellington District Community Mental Health Team was set up. The staff numbers had been set, but no provision had been made for Maori health workers in the service. The new Manager approached me and asked if I would be prepared to relinquish one occupational therapy position to provide a position for a Maori health worker. My initial reaction was "Why us?". On reflection, I realised that I was being asked to put my actions where my words had frequently been: sharing resources. This time it meant my resources. As the Minister of Health frequently tells us, there are finite resources. As that is the case, then we must be prepared to share them.

Other challenges will come in the form of institutional policy. For example, the Auckland Institute of Technology has established a policy requiring a staffing ratio of one Maori staff member for every six in each department. That is a major commitment of resources.

We must also be prepared to meet the cost of our own learning. If Maori people are asked to participate in policy groups and planning groups, can we pay them appropriate consultation fees? What resources are targeted by the New Zealand Occupational Therapy Association to Maori and bicultural issues? Allocation of resources is harder to do than writing a policy statement, because it calls for active commitment to the issue. Where is the Association on this issue?

I have attempted to identify some of the constraints to biculturalism. I know there are initiatives and attempts by therapists to find ways around the constraints. Let us, as a profession, share what we are doing, and support each other to make the necessary changes to our practice to provide value for Maori clients, and to move ourselves from a monocultural profession to a bicultural profession.

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Errata

The title of Wendy Hindmarsh's article, **Accessible Playgrounds,** published in NZJOT Volume 43, Number 2 was incorrectly spelt. Apologies from the editor and the proof reading team.

Clare Hocking, Editor.