

Frances Rutherford Lecture Award 2015: Possibilities for the future: Doing well together as agents of change.

Abstract:

None of us can predict with certainty what the future holds. However, as an agent of change, occupational therapists will not only strengthen the profession, they will make a significant difference to the health and well-being, and occupational outcomes of the people and communities we serve. I suggest The challenges ahead include: how and where we practice, what we need to do how to be more responsive in the bi-cultural context, how to educate the next generation of occupational therapists, how to support and develop leaders, and how to build a stronger profession. Our success in this new and the changing world will require reform, responsibility, and innovation. “He waka eke noa” - we are all in this same boat together.

Key words: occupational therapy, change agents, transformational change, bi-cultural context, leadership, workforce, role

*Ko Taranaki te Manunga*

*Ko Te Henui te awa*

*Ko Shaw Saville Line te waka*

*Ko Newcastle Upon Tyne, England, Geordie toku iwi*

*Ko Reed toku hapu*

*Ko Heather Clark toku whaea*

*Ko Doug toku matua*

*Ko Ngamoutu ahua*

*Ko Kirk toku ingna*

## Introduction:

I would like to first of all acknowledge Francis Rutherford, after which this award is named. The Frances Rutherford Lecture Award was established in 1983, to recognise the contribution that Frances Rutherford made to occupational therapy. Born in Masterton in 1912, Frances Moran Rutherford completed a Diploma in Fine Arts at Canterbury University in 1945. She wanted to study occupational therapy in New Zealand but was not admitted because of her disability (poliomyelitis) and so she went to England and enrolled in the Liverpool School of Occupational Therapy, graduating in 1952. On her return to New Zealand ??Miss Rutherford worked in Masterson as an artist and occupational therapist until 1955 when she took up a position at the New Zealand Occupational Therapy Training School in Auckland. In 1959 she took over the role of Principal and stayed in this role until 1972 when the school closed. Frances Rutherford, who was recognised as an artist and an occupational therapist, passed away in 2006.

*“I alone cannot change the world, but I can cast a stone across the waters to create many ripples”* (attributed to Mother Teresa)

In this lecture I want to cast a stone and create ripples. To do that, I draw on the innovations and words of wisdom from past and present leaders in our profession and challenge you to think about your role as an agent of change. None of us can predict with certainty what the future holds, what the next big government move will be, or where the new jobs will come from, but we can spark creativity and imagination in our profession.

In Aotearoa the leadership of women like Frances Rutherford and Hazel Skilton means we have a strong past to build on. To move the profession forward, we need to take risks, to do things differently, to go outside our comfort zone, and put trust in the next generation of occupational therapists. We need to reset where we are going, to strengthen and build partnerships outside the profession, and new alliances for progress. But we must be clear of the purpose behind what we are doing, not to do things for the

sake of the profession, our goal is to improve the health, well-being, and occupational outcomes of people and communities and indeed the whole nation. We must never forget the things we have struggled and fought for, while looking forward. However, our success in this new and changing world will require reform, responsibility and innovation.

Have no illusions about the work ahead of us. We are a small profession and reformation will not be easy, it will take time. As a profession we like to talk, to analyse and critique the details, and consider the consequences of our actions. From time to time I have heard people from outside the profession say “what you do is good, stop talking about it and just get on and do it”. Perhaps these words should be heeded and we should just get on with it!

From the earliest days of our founding, occupational therapy has been a story of ordinary people who dare to make a difference, of imagining a different world. We may have differences, but we all believe in what occupational therapy has to offer. We may have different backgrounds and world views, but we need a strong and vibrant profession that can make a difference, where anything is possible!

I believe there are some key questions that face the future of the profession in terms of:

- How we support and develop fearless leaders;
- How and where we practice;
- How we maintain and develop a culture of research
- How we educate the next generation
- How we build a strong workforce
- How we continue to be responsive to Māori

I believe these five/six questions are relevant to the future. They provide a clear framework to think about how you might become a change agent. Rogers (1987) described a change agent as a person that takes professional and in some instances, personal responsibility to transform the profession, to do something differently, to be innovative or in some way improve the profession.

Do we need answers to these questions? Yes we do! Especially if we are going to be a strong, vibrant profession that makes an authentic difference in the world ??of health care.

Responsiveness to Māori:

From a phenomenological perspective the notion of responsiveness to Māori and the Treaty of Waitangi “calls me”. I grew up in a household of white middle class privilege. I was raised in New Plymouth underneath Mount Taranaki, I know I am home when I have the mountain in sight. In Auckland, where I now live, I look for the Mountain to the West, to the place where it should be. In a way the mountain connects me to home and family, to the place where I belong.

Before I worked at Auckland University of Technology I was employed by a mental health Non-Government Organisation in South Auckland, I had many conversations with one of the community support workers, a staunch Māori woman from Northland, she talked to me about the articles of Te Tiriti rather than the principles, and what Te Tiriti meant to her, her hapu and Iwi and she talked to me often about a model of shared governance for organisations. These conversations made me realise that the Treaty is a live document that impacts on how we are as kiwis.

In thinking about responsiveness to Māori I need to acknowledge two things, first that as a country it is unique that we have the Treaty of Waitangi, I have visited places like Australia and Canada where such a document either does not exist or if it does exist then it is not recognised in contemporary society and where indigenous peoples are immensely disadvantaged. The second thing I want to acknowledge ??is (are) the massive injustices that have occurred to Māori, too many to list here, except that I wasn't really aware of many of them. Growing up in Taranaki, there is a place called Parihaka, I didn't know it existed let alone what happened there, of the uprooting of people from their land and being interned in caves in the South Island, all because of the tactics of the people of Parihaka to disrupt land grabs through peaceful protest.

Where I work at the Auckland University of Technology, I am employed by an institution that is subject to an Act of Parliament that mentions the Treaty of Waitangi. I

encounter formal strategy documents like Ka Hikitia – The Māori Education Strategy (Ministry of Education, 2013) which develops outcomes and reflects the Treaty in the Universities daily activities. I work in a context that has been shaped by a history of learning institutions grappling with the changing expectations of Māori in terms of educational success, economic contributions, and health outcomes, just as I am sure you do in your work place. These notions of success, contribution and outcomes are affected by the principles of the Treaty which were articulated in the 1988 Royal Commission on Social Policy. I also know that that the Treaty is present in my Being a Registered occupational therapist with an annual practicing certificate.

The Occupational Therapy Board of New Zealand (OTBNZ) (2015) has articulated that “Te Tiriti O Waitangi ??a effects all our lives and is essential for helping people participate in their desired occupation”. More specifically in competency two “Practicing appropriately for bicultural Aotearoa New Zealand” (p.3). The OTBNZ obliges occupational therapists to take into account the Treaty and work towards equal outcomes for clients.

As an occupational therapist and an occupational therapy educator I brush up against the Treaty when I encounter and talk about; health outcomes, preparing the future workforce, people’s occupations, and in the understanding of how our health and social care systems are designed and delivered. I am a person who believe in Pākehā decolonisation. I support the work of the Council of Occupational Therapy New Zealand Whakoara Ngangahu Aotearoa (OTNZWNA) for raising and addressing the question of how a mainly Pākehā organisation can become truly bicultural in a decolonised sense. As a person and as a member of the Association I encounter the Treaty not just as an historical event but, more importantly as a history of thinking and negotiation between Māori and Pākehā. I recognise the efforts of OTNZWNA in implementing a model of shared governance. As change agents they have a vision of how things could be, they have the conviction to recognise a different possibility for the future.

At home, I can see the Treaty at work in the conversations I have and in my self-care occupations (do I wash the tea towels with my undies), the necessity to try and be

proficient in Te Reo, and in my other occupations such as how local council and government behaves, or how I understand and do something about institutional racism. I would say all of these things come under the umbrella of the Treaty of Waitangi and what it means to be a Tauwi partner in the Treaty process. The Treaty isn't primarily for me, a process of redress between the Crown and Māori for historical and contemporary breaches, but rather it is short hand for a decolonisation process which sits in the here and now and which is future focused, where the task is to challenge the invisibility and power of Pākehā and Tauwi privilege.

The Treaty of Waitangi connects us to a history – not just to a signing in 1840, but a history of breaches, of Tauwi behaving badly, of principles generated at a specific moment in time from certain social and political conditions. I believe that to engage in a decolonisation process we need four things: a sense of responsibility to do things differently; patient Māori to explain how things really are; a reason to look back in history and to be clear what it is as a profession we bring to the table.

There isn't a lot of room for a Pākehā like me in the Treaty of Waitangi if we are talking about negotiation between the Crown and Māori. Obviously the Crown represents me and the Crown's actions have privileged me and my family. I believe a big part of decolonisation is linking our own history to the breaches of the Treaty – tracking our personal connection to a process in which Aotearoa starts off as Māori land and ends up as New Zealand, a quarter acre paradise.

We need to find a way to challenge the idea that the Treaty of Waitangi is a Māori issue, and that the idea that bi-culturalism is a Māori problem. Many of the organisations I have worked in have had Māori staff who run cultural sensitivity training or who are responsible for articulating what bi-culturalism means. This just lets most of us off the hook. Change is going to require Tauwi to step up and shrug off the invisible cloak of whiteness. Indeed our own regulatory authority has ensured that as a profession we need to be 'Practicing appropriately for bicultural Aotearoa New Zealand. This might be seen as a top down approach to making change happen, alternatively this should spur us on to show our leadership as individuals and as a profession. For some this might be to begin the conversation with others or, add to the impetus to keep the conversation going, but for all of us we should access the resources that already exist and the people

who are already committed to develop a blueprint for the way forward, to a place where we honour and accept differences and to a place where we can prosper as a profession and as a nation. To make some of this change happen we will need strong leadership, not just in relation to working towards an authentic bi-cultural nation but in the development of the profession as a whole.

#### Fearless Leadership:

We know that spending on health and social care in this country is stretched. The current government message is that there will be increasing demand for services which will need to be more innovative and flexible within the budget allocated. In a nut shell, the message is 'do more with less'. This message exists in a context of many demographic and financial challenges: an increasing ageing population; an increase in migrants; increasing incidence of long term health conditions and the associated complexity of multiple conditions; over representation of Māori in negative health statistics and social factors linked to income.

Perhaps it is time to really think about how occupational therapy can drive innovation and the delivery of high quality responsive services that are developed around the needs of people and their families. The broader social and political context is changing rapidly around us, but are we changing in response to these wide-ranging health and social issues or are we happy to keep doing what we have always done?

I believe that strong leadership is needed to take the profession to a new and different future. Not only in terms of shaping how the profession might look, but in providing leadership for different models of health and social care planning and service delivery based on our core philosophical assumptions and values about health, occupation and participation. This is likely to include a paradigmatic shift away from an over-reliance on hospitals and professional interventions to employing strategies to manage demand, prevent dependency, and support people and their families to live healthy fulfilling and meaningful lives at home, or in a homely setting for as long as possible. As occupational therapists we bring an exclusive perspective to the planning and delivery of health services. We are uniquely placed to exploit our expertise by implementing an

‘enabling’ approach that will bridge medical and social models of service delivery. We have the potential to influence planning and delivery so that health services take an asset based approach, focus on self-management, develop resilience and independent living, and that are meaningful and culturally sound. We have the capacity to take a lead in working with, and across, disciplines and agencies.

It has been said that as a profession we don’t have strong leadership and this is usually followed by ‘but that’s because we are a female dominated profession’. It is time to cast that myth aside. If we are to become agents of change then we must put aside that kiwi notion of the tall poppy syndrome, “a social phenomenon in which people of genuine merit are resented, attacked, cut down, or criticised because their talents or achievements elevate them above or distinguish them from their peers” (Pile & Roberts, 2014, p.??).

We have high expectations of people in leadership positions. It is no easy task balancing organisational expectations and personal interests of team members, as well as being authentic, visionary, and empowering. Leaders are expected to know who they are, to know their own strengths, beliefs and values. In and of itself leadership is no easy occupation!

Past Frances Rutherford Lecture Award recipients, have each in their own way been fearless leaders, they have provided guidance to the profession and have been agents of change. They have challenged us to reflect on and consider occupational therapy practice in Aotearoa New Zealand and covered varied topics such as quality assurance (Boyd, 1990); resource management (Goeder, 1992 ); partnerships (Gordon, 1994 ); occupation (Wilson, 1996 ); caring (Wright-St Clair, 2001 ); identity (Henare, 2003; and evidence from the past (Hocking, 2005);); inclusion (Simmons Carlsson, 2009); and the multiple worlds that span practice (Hopkirk, 2013).

At this point I should lay claim to being pro-feminist. The reason for doing so is because I want to revisit the point made earlier, that it is often heard that the reason we don’t have many leaders in occupational therapy is because it is a female dominated profession. The fact that the profession is female dominated in Aotearoa can’t be



disputed, in 2014 92.2% of occupational therapists with an Annual Practising Certificate were female and 7.8% male. (Occupational Therapy Board of New Zealand, 2015).

leadership starts with you and me, not only those in elite positions. Many of our leadership texts and our role models in society have taught us to think about leadership as being patriarchal, hierarchical, competitive, heroic and individualistic. Our deeply held societal gender roles of men aligns and supports the belief that men can, and will be, more effective leaders. Up until recently much of the existing literature on leadership has been written by men and studies men in leadership roles. This doesn't mean that women and members of under-represented groups don't also practice hierarchical leadership, but there is a growing body of evidence to say that women think differently about leadership.

I contend that the notions associated with feminist leadership have much to offer. Feminine leadership is often defined by behaviours that are presumed to characterise women (passive, emotional, sensitive, accepting, and dependant). This definition fails to recognise the inherent power differential based on societal oppression that disproportionately affects women compared to men. It is a leadership style that fails to recognise diversity among women relying instead on perceived attributes and stereotypes.

Feminist leadership on the other hand is grounded in a set of assumptions and values while also paying attention to historical and contemporary circumstances that have created power inequalities and oppression of women and other under-represented groups. Barton (2006) identified some common central points of agreement in relation to feminist leadership, despite the differences amongst feminist theories. These central points include equality of representation and empowerment that are relevant to leadership. There seems to be a link between the notions that underpin the concepts of feminist leadership and occupational therapy, such as attending to issues of social justice, focusing on equality, empowerment, collaboration, fairness and balance, and being cognisant of larger issues of oppression and community development.

In an historical analysis of the medical and nursing professions, Clark (2010) identified the implications for occupational therapy becoming a powerful and confident profession. Her analysis suggested that nurses have actually been an oppressed group (Sieloff, 2004; Brady, 2007), demonstrating behaviours that characterise all groups in highly sub-ordinated circumstances, such as being; hierarchical and competitive; manipulative; exercising lateral violence; failing to support one another in times of conflict; disrespecting students, referred to as “eating the young” (Sieloff, 2004, p. 247); discrediting the values and norms of the profession and being fearful of confronting those with organisational power.

When using the word ‘power’ Clark does not associate this with the opposite of caring or being associated with domination, but as a gender neutral term that assumes occupational therapy as a powerful profession that uses its power for the public good. Being a powerful profession requires; strong leadership in health care delivery systems; educational programmes that prepare graduates for leadership roles; and strong representation in the policy arena, and where leadership skills would be sharpened in all practitioners. Clark points out that “occupational therapy practitioners must develop and project confidence in order for our profession to optimally meet our clients’ needs and further the public good” (p. 268).

Lacking strong leadership will mean our profession will not become widely recognised in government or the health and social care sectors or with the people and communities that need our services to prosper. Lacking strong leadership will mean we do not develop our research capacity to gain research grants and produce outputs that will ensure that our profession is evidence based. Lacking strong leadership will mean we will not be able to develop a diverse workforce or secure resources to implement interventions. The risk is that without strong leadership we will not thrive, we will stay much the same, and we won’t achieve our goals in this changing and technologically advanced world of health, and this may catastrophically limit our ability to meet society’s occupational needs.

Possibilities for practice in the future:

In Aotearoa New Zealand there is a slow but paradigmatic shift underway in terms of the way health services are planned and delivered. This includes a move away from the over-reliance on hospitals and professional interventions to home based and self-management services. These changes are being driven by the Primary Health Care Strategy (Ministry of Health, 2001), Better, Sooner, More Convenient Health Care in the Community (Ministry of Health, 2011), Whanau Ora (Best Practice Advocacy Centre, 2011), and the World Health Organizations Framework on Action: Interprofessional Education and Collaborative Practice (2010). In concert the current government has paid particular attention to ‘work’ through the Social Security (Benefit Categories and Work Focus) Amendment Act 2013. This Act aims to: modernise the welfare system by embedding a work focus throughout the benefit system, and tackling long term benefit dependency.

Based on an analysis of these documents and what might in my opinion might be a sensible direction for the profession, I have identified some of the possibilities for future practice. Conceivably Some of the ideas capitalise on what is already happening and developing that ??potential; capacity, some of the ideas challenge us to consider where best to practice to ensure the most advantageous outcomes for the population; finally, the ideas call on us to consider how the next generation of occupational therapists are prepared. Need a sentence to lead into the next paragraph

### **Primary health care**

A major focus of current health care policy is to keep people healthier in the community for longer. This obliges us to consider where and how we position ourselves in an approach to health care which aims to create “an environment where health professionals in the community are actively encouraged to work with one another, and with hospital based clinicians to deliver care in a co-ordinated and co-operative manner” (Ministry of Health, 2011, p. 3). It is necessary to grapple with where should we be based to ensure we are well positioned to support people to stay in their own communities?. Have the days of being in an acute hospital environment or in a hospital based rehabilitation setting passed? How do we need to reframe where some

occupational therapists are working to clearly position occupational therapists on the continuum of primary and tertiary care?

The reason We can make significant contribution to: the reduction of unnecessary hospital admissions, reshaping care, and enabling independent living because we:

- are strongly placed to support self-management and enablement and to drive inter-professional working at the point of care
- are focused on “enabling”. An ethos rooted in a person-centred approach that sits on the continuum between medical and social models of care
- are more strongly focused on a resilience and asset based approach that builds personal capabilities and community know-how and
- have the ability to proactively plan for the transition from home to hospital and home again – focused on retaining capabilities and resilience and planning support that is embedded in the local community

To achieve these things it will be necessary to reframe concepts of occupational therapy so that they are strongly relevant to primarily health care, community development, and population based health. For example of this is the work of Catherine Fink (“Occupational therapists improving” 2014) from Christchurch who has been working to improve the interface with general practitioners (GPs). Fink highlights the importance of establishing effective relationships with GP’s and practice nurse, being clear about occupational therapy services that could be provided to a particular population, giving a clear rationale supported by evidence, and ensuring the service is cost effective.

The Primary Health Care Strategy (Ministry of Health, 2001), highlights three key levels of health care provision: improving, maintaining and restoring health. Improving health involves health promotion, education, counselling and helping people to adopt healthy lifestyles. Maintaining health and independence involves preventing the onset and progression of disease and disability, and restoring health and independence covers a wide range of services, usually hospital based.

As a profession I assert that Traditionally, we have focussed on maintaining and restoring health with less emphasis on improving health. Therefore a challenge exists in the context of Better, Sooner, More Convenient Health Care in the Community (Ministry of Health, 2011). How can we demonstrate our commitment to improving the health and well-being of people in Aotearoa New Zealand?. Many in the profession have identified the need to be more involved in health improvement activity (Frenchman, 2014; Tse, Penman & Simms, 2003; Tse, Wilson, Wright-St Clair, & Ford, 2003). I would argue that we are not particularly clear on our role in terms of health prevention and promotion from an occupational perspective, nor have we sought to collaborate with our health promotion colleagues. Despite a holistic approach and a bias toward every day activity, occupational therapy continues to emphasise its involvement in a problem focused framework and, in the prevailing medical model.

The bias towards the medical model has been, and is still, reinforced by funding. Nonetheless the primary health care strategy clearly intends for allied health practitioner services including occupational therapy to be readily available. Few GPs understand what an occupational therapist could offer in a primary health care environment (reference needed). Familiar concepts such as resilience and a whole person view of performance and life skills are key in primary health care models. Especially as increasing numbers of people are coping with long term conditions and communities are seeking sustainable futures. Reframing concepts of occupational therapy so they are strongly relevant to primary health care, community development and, population health ??is essential .

## **Work**

The current focus on ‘work’ is supported by a growing evidence base that shows being in work is good for health (reference needed). Worklessness for example will likely have a negative impact on the person out of work. It also has a significant impact on their children and families (NHS Lanarkshire, 2011). OTNZWNA is a signatory on the Australian and New Zealand Consensus Statement on the Health Benefits of Work (The Australasian Faculty of Occupational and Environmental Medicine, 2011). This consensus statement highlighted the fact that employability status correlates highly with perceived well-being while low levels of job satisfaction (or no work) has close links with increased reported illness, disability and health problems.

The focus on work is a platform occupational therapists could capitalise on. The Accident Compensation Corporation is already strongly focused on early return to work after accident or injury. Similarly, the Ministry of Health and the Ministry of Social Development both have an agenda related to the value of work. The recently introduced Health and Safety at Work Act 2015 has a much stronger focus on safe work environments and work practices. Occupational therapists are well placed could be the principal profession to make accurate work capacity assessments, intervene through vocational rehabilitation activities, co-ordinate packages of care and advise colleagues across the spectrum of age groups, conditions and life stages.

### **Youth mental health**

Lastly I wanted to address is the role of occupational therapy in youth mental health. In 2012 the Prime Ministers Youth Mental Health project was launched. This \$62 million package was the result of intensive work following a report from Chief Science Advisor (Office of the Prime Ministers Science Advisory Committee, 2011) which indicated that more than anyone else, young people will determine the future shape and prosperity of New Zealand. The report indicated that one in five of our young people will experience some form of mental health issue during the crucial time that they are transitioning to adulthood.

Here again, ensuring that children have the best possible start in life is an area where occupational therapists could have more responsibility. We know that in Aotearoa New Zealand far too many children are living in poverty or, are victims of domestic violence or sexual abuse. One goal focus of the Prime Ministers Project is to make primary health care services more youth friendly. If we believe that participation in occupation and occupational development are key, then how might we ensure that this agenda and its significance is raised within the primary health care sector? How do we ensure that there is public awareness of the significance of participation in occupation as a contributor to healthy development and successful life transitions which include capacity building of families and communities? We could for example, advocate for primary health care occupational therapists to assess occupational needs or develop and promote low cost and free activity ideas for youth and parents or have a stronger focus on listening to youth and supporting and facilitating purposeful activity opportunities in

local communities which are focused on meaningful life skills. Carolyn Lotawa (2015) provided an example of how this could be put into action. She works with children and uses skateboards as a therapeutic tool to enable participation, improve balance and change behaviours.

Part of realising the possibilities for the future will also be producing evidence that supports what it is we do. Therefore it is essential to consider is how we let our colleagues beyond occupational therapy know about our evidence base to ensure we are positioned where we can have more impact.

Research:

To be agents of change we need to have and use evidence to support goals. Research is hard currency for government departments, funders, and ensures our voice is heard. Here I would like to share some of my research story.

Not long after I started at AUT I attended a workshop on having an academic career, facilitated by Professor Anne Cusick. At the time I had just started my doctorate. During the workshop one of the things that came to the fore was that completing a doctorate was the beginning of a research career. Anne likened a doctorate to a builder completing their apprenticeship. I thought having a doctorate would be the pinnacle of my career only to be told it was actually the beginning of my academic career. I would like you to think about how you might become more involved in research. My basic premise is that if I can do it anyone can, it takes commitment, brain power, but mainly it takes perseverance.

My research question came from practice. Working in mental health I saw how people who were acutely unwell were quite different when they were part of the occupational therapy programme. For instance, they came to the kitchen and cooked or they spent time playing scrabble with me. In summer I organised a weekly BBQ for lunch, the clients cooked and made the salads, and the staff joined in. , the system managed to cancel the catering for lunch for 24 people, the BBQ was lit with a generous dousing of methylated spirits. I noticed that when the clients engaged in these ordinary everyday activities, the 'engagement in doing' seemed to make a difference. The chaotic and

disorganised person was able to come up with words on the scrabble board, the man who was aggressive as a result of his drug induced psychosis was calm and relaxed helping to make the salads, the person in a manic state was great at getting everyone organised. I didn't understand how or why but there seemed to be something in this occupational therapy business. Postgraduate study in occupational science got me to wondering about the meaning of occupation, the more I read the harder it seemed to find an explanation.

The next step was working out how to uncover the meaning of occupation, it was not about measuring meaning as such, it was about understanding what the lived experience was like for people. That question led me to a hermeneutic phenomenological study (Reed, Hocking, & Smythe, 2011). As part of the study 12 participants were recruited through informal professional and personal networks. They represented a range of the adult population from a large Aotearoa New Zealand city and ranged in age from 27 to 67. There were 5 men and 7 women and they had each experienced an occupational disruption which included a change of job, retirement or the way in which occupations were normally carried out. Occupational disruption was a way to begin the conversation. The unstructured interviews were audiotaped and transcribed verbatim. Themes began to emerge through the process of analysis and from there, three essential themes came to the fore: the call, Being-with, and possibilities.

The study revealed that the meaning of occupation lies in the complex interconnectedness between the person, the world, and others in the world. Three essential themes emerged: Each of the three themes was informed by philosophical underpinnings that exposed different aspects of the meaning of occupation. The findings were not a complete picture. By necessity, the themes presented here are in a linear format, they are conceptualised as representing an inter-connected whole and might provide you with a framework to help understanding the meaning you or your clients ascribe to their occupations.

#### The call

In this life, it is the care and concern that we have for others or things in the world, that calls us to action. The call itself is complex. It may come from within or be external to



us. According to the participants, it is what they care about, or what concerns them, that gives their occupations meaning. Care and concern often puts their occupations in conflict with one another and so the call that is most pressing is responded to. A call can show itself in many different ways; as responsibility, angst, loss or excitement

In our dealings with the world, concern shows itself as “producing something, attending to something and looking after it, making use of something, giving something up and letting it go, undertaking, accomplishing, interrogating, considering, discussing, determining... All these ways of Being-in have concern as their kind of Being” (Heidegger, 1927/1962, p. 83). The occupations that we engage in have care at the heart of them, yet in our actions or activities concern becomes an outward showing of that care. The things that matter to us show up when we care. Caring allows us to see the world and others around us. Responding to things in the world means that at different times and in different contexts the call changes. The meaning of occupation shows itself in what people care about and what calls them to action. Care calls for engaged action and attentiveness.

### Being-with

The second theme, Being-with, comes to light as a fundamental part of being human. From the participants’ stories, occupation done with others gives a sense of connection and it is through the connection that occupations come to have meaning. Occupations performed alone, but would preferably be done with others, becomes a task to be completed; it can be lifeless and empty. Through occupation an avenue to Be-with others is created and therefore meaning is revealed that is more than the occupation itself. The multitude of combinations of occupations and who we engage with, in those occupations, is immense. This in turn influences the meaning of each and every occupation. Being-with, from the participants’ experience, shows itself along with other notions such as intimacy, obligation, sharing an interest, or being wanted.

Relationship can dramatically change the experience of ‘being there’ as the ‘other’ draws out a different ‘self’ and opens particular interests. As an occupation, a walk is not simply a walk. Who one walks with gives meaning and significantly shapes the experience.

## Possibilities

The third theme that emerged from the participants' stories points to the meaning of occupation being connected to 'possibilities'. As people continue on the journey of who it is they are becoming, their occupations show others what it is they are capable of and how they conform, or not, to what others dictate is acceptable. Through occupations people become aware of the possibilities that open up to them and those that close down. Occupation allows individuals to show themselves as being open to different things, having stamina or pushing boundaries. The meaning of occupation also shows itself in the way that occupation connects the past and present with the future. What we have done in the past influences what we do now, which in turn will influence what we do in the future. Each of these experiences will have meaning connected to it, as people traverse the continuum of time.

## The inter-connected interplay

The study revealed that the meaning of occupation is shaped by the dynamic interplay between the call, Being-with, and possibilities. The meaning of occupation is transactional, it is influenced by the world around us and the people and things we associate with in our world. Being-with is connected to the call, and to possibilities, in the sense that the call is shaped by what people care about, which is informed by what they know from society and others around them. This in turn allows others to respond appropriately to who they are. In the response from others, possibilities can open up or be closed down, fuelling or stifling the call to an occupation.

Need a sentence to round off the topic of your research and lead into the next topic.  
How does your research have relevance to this paper?

In Aotearoa New Zealand we have very few active occupational therapy researchers. To achieve some of the possibilities for the future I have mentioned we need more nationally generated research and evidence. This is made more difficult in a competitive research funding environment. We have some successes which we need to build on and celebrate, for example Wright St Clair has been working with a team at the University of Auckland on a cohort study as part of the 'Life and Living in Advanced Age' study

(Hayman et al., 2012), which aims to establish predictors of successful advanced ageing which includes engagement in activity. Sutton has worked on projects with interprofessional colleagues to develop evidence on the implementation of sensory modulation in mental health services (Sutton, Wilson, Van Kessel, & Vanderpyl, 2013), and O'Sullivan (2011) has called for changes in approach to the care of people with dementia. Perhaps we need to consider how we engage in research in our own work place, how we raise research questions, who we partner with, and how we make sure we use evidence to inform our practice.

While exploring possibilities for the future and taking on the challenge as change agents we must consider what the professions workforce looks like and what might it look like in the future.

#### Maximising workforce engagement and development

Occupational therapy was once seen as a way to rehabilitate and occupy soldiers disabled as a result of war, or to provide people living in asylums with activities to occupy their time. However, systems of health have moved on as health needs have changed, buzzwords have come and gone. Changes in the health workforce are not just happening within occupational therapy, nurses are now able to prescribe medications and physiotherapists and podiatrists will likely to be able to do so in the future.

Psychologists are training other health workers to deliver services that were traditionally the realm of the psychologist. The health and social care context is obviously changing too, but we are not yet well positioned as a profession to contribute to these changes.

We have limited research data that provides ongoing intelligence and analysis of the occupational therapy workforce. We are unable to undertake annual workforce modelling or project workforce requirements to meet service needs which involve stakeholders from the likes of higher education, health, insurance providers, corrections, or social care providers.

Table 1 gives an overview of the occupational therapy workforce between 2010 and 2014 (Occupational Therapy Board of New Zealand, 2015; 2014; 2013; 2012, 2011).

There has been limited growth, we are simply maintaining the status quo even though the population is increasing.

***Insert Table 1 about here***

Population projections (Statistics New Zealand, 2010) out to 2026, indicate that 16.2% of the population will be Māori, 15.8% Asian and 9.6% Pacific. If we make an assumption that the occupational therapy workforce should be representative of the population, based on current numbers we would need an additional 303 occupational therapists who identify as Māori. There has been a minor shift in where occupational therapists are employed, from the District Health Board environment to private practice. The future will likely involve more occupational therapists who are private practitioners, small business owners or sub-contractors rather than employed by large organisations. Developing and supporting practitioners to be small business owners, who can successfully bid for and contract their services to Primary Health Organisations, Iwi, other businesses, or community organisations is essential for the future.

The Ministry of Health (2014) identified the need to “continue to expand the opportunities for health professionals to work at the top of their scope in a team practice environment” (p.21). I do not believe we have a clear understanding of as a profession what it means to practice at the top of our scope. The time seems appropriate to have that discussion. To ensure occupational therapy is a key player at the decision making table we need to have a workforce that will underpin sustainable and affordable services at all levels. This could include; developing and strengthening consultant led services; developing a specialist scope of practice; recognising research as a viable career option, and introducing more assistant and assistant practitioner roles. A change in the makeup of the workforce has the potential to shift tasks between professions and could lead to non-medically directed pathways of care. For example, occupational therapists leading the assessment and co-ordination of primary health care services for individuals and their families. In a worst case scenario, occupational therapy is not even considered a viable or relevant health profession.

In addition I do not believe we have really thought about how we might use technology to provide equitable access to high quality and effective occupational therapy services inclusive of advice and information to support self-management through mobile phones, apps, websites or telehealth. The nature of employment is also changing, our next generation of occupational therapists will have different experiences to ours in their careers. They may well have ten careers in their lifetime, be burdened by student debt, be faced with the likelihood that technology will replace part or all of their roles. Consequently, they may be challenged with less secure work and income.

As mentioned earlier the need to consider and plan for the future occupational therapy workforce is in the context of some large scale changes in health and social care. Some traditional roles may still exist, but there is potential to create roles in organisations that haven't previously employed an occupational therapist. For example in a Work and Income New Zealand office breaking the cycle of continual joblessness, or providing a service to fee paying older adults to maintain living in their own home, or to be researchers on large scale research projects. It is unclear how well prepared new graduates, and the current workforce, are to work in these diverse and less well established areas of practice. ?? It would seem the occupational therapy workforce must expand boldly and take employment in 'other' areas of practice, rather than just produce enough graduates to fill current vacancies and maintain the status quo.

## **Conclusion**

In conclusion it has been a pleasure to be the recipient of the 15<sup>th</sup> Frances Rutherford Lecture Award. My aim was to create some ripples and present a case for why we should take up the challenge of being agents of change.

As a profession we do big things!

I call on you to reflect on, and imagine possibilities for the future, and to consider your role as an agent of change in relation to some of the issues that face our profession as we transition to a new future. The challenges highlighted include: how and where we practice in the future, how we are more responsive in the bi-cultural context, how we educate the next generation of occupational therapists, how we support and develop

fearless leaders, and how we build a strong sustainable profession. These ??discussions ideas could serve to strengthen the profession and to make a difference to the health, well-being, and occupational outcomes of the people and communities we serve.

It is fair to say WE do big things!

The ideologies of occupational therapy endure and some say our star is in ascendancy (reference), it is time for us to flourish. Our ??professional future remains our choice. It is up to YOU to move it forward to a new, different, exciting and as yet unknown place. future and the state of the profession is strong.

Our success in this new and changing world of health care will require reform, responsibility, and innovation. So always remember “He waka eke noa” - we are all in the same boat together.

*Hei konei ra, ma te wa ka kite ano*

Key messages:

- In a changing world of health care, a range of possibilities are open to occupational therapy or should it be therapists?
- The challenges ahead include: where and how we practice, leadership, working in a bi-cultural context, developing evidence and a sustainable workforce;
- Becoming change agents will transform the profession and make a difference to the people and communities we serve.

Acknowledgements: My grateful appreciation goes to my colleagues in the Department of Occupational Science and Therapy at AUT for their ongoing support and wisdom. Special thanks to my friends and colleagues; Christine Rigby, Jenni Tregoweth, Renee Bradfield and Liz Mafile’o for their input into the draft of the lecture.

## References

- Author's name An everyday OT enabling participation in everyday life. (2015, July).  
OT Insight, 36(4), 4-5.
- Barton, T. R. (2006). Feminist leadership: Building nurturing academic communities.  
Advancing Women in Leadership, 22. Retrieved from  
<http://awljournal.org/index.html>
- Best Practice Advocacy Centre. (2011). Whanau ora: The theory and practice. Best  
Practice Journal, 37, 10-17. <http://www.bpac.org.nz/BPJ/BPJ.aspx>
- Boyd, M-A. (1990). Frances Rutherford Lecture: Quality assurance in occupational  
therapy. New Zealand Journal of Occupational Therapy 41(1), 61-63.  
<http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Brady, J. M. (2007). Nurse heal thyself: Personal power can create professional change.  
*British Journal of Anaesthetic & Recovery Nursing*, 8, 75-78. doi:  
10.1017/S1742645607000289
- Clark, F. A. (2010). Power and confidence in professions: Lessons for occupational  
therapy. Canadian Journal of Occupational Therapy, 77(5), 264-269. Doi:  
10.2182/cjot.2010.01.77.5.2
- Fink, C. (2014, March). Occupational therapists improving the interface with general  
practice. OT Insight, 35(2), 12-13.
- Frenchman, K. (2014). The health promoting role of occupational therapy in primary  
health care: A reflection and emergent vision. New Zealand Journal of  
Occupational Therapy 61(2), 64-69. Retrieved from  
<http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Gordon, B. (1994). Frances Rutherford Lecture: Partnerships: With aroha and integrity.  
*New Zealand Journal of Occupational Therapy*, 45(2), 5-10.  
<http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>

- Gordon, B., Riordan, S., Scaletti, R., & Creighton, N. (Eds). (2009). *Legacy of occupation: Stories of occupational therapy in New Zealand 1940-1972*. Wellington, New Zealand: Bookprint Consultants Ltd
- Gooder, J. (1992). Frances Rutherford Lecture: Resource management. *New Zealand Journal of Occupational Therapy*, 43(2), 4-9.  
<http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Harman, G. (2007). Heidegger explained: From phenomenon to thing. Chicago: Open Court
- Hayman, K. J., Kerse, N., Dyllal, L., Kepa, M., Wham, C., Wright-St Clair, V...Jatrana, S. (2012). Life and living in advanced age: A cohort study in New Zealand – Te Puawaitanga o Nga Tapuwae Kia Ora Tonu, LiLACS NZ: Study protocol. *Aquatic Biosystems* 12, 1-33. doi: 10.1186/1471-2318-12-33
- Health and Safety at Work Act 2015
- Heidegger M. (1962). Being and time (J. Macquarrie & E. Robinson, Trans.). Oxford: Blackwell. (Original work published 1927)
- Henare, D. (2003). Frances Rutherford Lecture: “It just isn’t me anymore”: Moving forward to a new identity. *New Zealand Journal of Occupational Therapy* 50(1), 4-10. <http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Hocking, C. (2005). The 2004 Frances Rutherford Lecture: Evidence from the past. *New Zealand Journal of Occupational Therapy* 52(1), 4-16.  
<http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Hopkirk, J. (2013). Frances Rutherford Lecture: E rua ngā ao, kotahi te taura tangata: Two worlds and one profession. *New Zealand Journal of Occupational Therapy* 60(1), 5-15. <http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>



Ministry of Education (2013). *Ka Hikitia: Accelerating success 2013-2017: The Māori education strategy*. Wellington, New Zealand: Author.

Ministry of Health. (2001). *The primary health care strategy*. Wellington, New Zealand: Author.

Ministry of Health. (2014). *Briefing to the incoming Minister 2014*. Wellington, New Zealand: Author.

Ministry of Health. (2011). *Better, sooner, more convenient health care in the community*. Wellington, New Zealand: Author.

NHS Lanarkshire. (2011). *A guide to health and employability in South Lanarkshire*. Lanarkshire, England: South Lanarkshire Council.

Occupational Therapy Board of New Zealand. (2011). *Annual Report 2010*. Wellington, New Zealand: Author.

Occupational Therapy Board of New Zealand. (2012). *Annual Report 2011*. Wellington, New Zealand: Author.

Occupational Therapy Board of New Zealand. (2013). *Annual Report 2012*. Wellington, New Zealand: Author.

Occupational Therapy Board of New Zealand. (2014). *Annual Report 2013*. Wellington, New Zealand: Author.

Occupational Therapy Board of New Zealand. (2015). *Annual Report 2014*. Wellington, New Zealand: Author.

Occupational Therapy Board of New Zealand. (2015). *Competencies for registration and continuing practice*. Wellington, New Zealand: Author.

Office of the Prime Ministers Science Advisory Committee. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence: A report from the Prime Ministers Chief Science Advisor*. Wellington, New Zealand: Author.

O'Sullivan, G. (2011). Ethical and effective: Approaches to residential care for people with dementia. *Dementia*, 12(1), 111-121. doi: 10.1177/1471301211421707

- Pile, C., & Roberts, T. (Eds). *Deus ex machina: The machine: The progression of secular socialism*. New Orleans, LA: Lanterns of Liberty.
- Reed, K., Hocking, C., & Smythe, L. (2010). The interconnected meanings of occupation: The call, being-with, possibilities. *Journal of Occupational Science*, 17(3), 140-149, doi:10.1080/14427591.2010.9686688
- Rogers, E. M. (1987). In J. G. Anderson & S.J. Jay. (Eds). *Computers and medicine: Use and impact of computers in clinical medicine*. (pp. 113-136). New York, NY: Springer- Verlag.
- Royal Commission on Social Policy. (1988). *The April Report*. Wellington, New Zealand: Author
- Sieloff, C. L. (2004). Leadership behaviours that foster nursing group power. *Journal of Nursing Management*, 12, 246-251. Doi: 10.1111/j.1365-2834.2004.00423.x
- Simmons Carlsson, C. (2009). The 2008 Frances Rutherford Lecture: Taking a stand for inclusion: Seeing beyond impairment. *New Zealand Journal of Occupational Therapy* 56(1), 4-11. <http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>
- Social Security (Benefit Categories and Work Focus) Amendment Act 2013. ??Source
- Statistics New Zealand. (2010). *National ethnic population projections: 2006 (base) – 2026 update*. Wellington, New Zealand: Author.
- Sutton, D., Wilson, M., Van Kessel, K., & Vanderpyl, J. (2013). Optimizing arousal to manage aggression: A pilot study of sensory modulation. *International Journal of Mental Health Nursing*, 22, 500-511. Doi: 10.1111/inm.1210
- The Australasian Faculty of Occupational and Environmental Medicine. (2011). *Australian and New Zealand consensus statement on the health benefits of work*. Sydney, Australia: Author.
- Tse, S., Penman, M., & Simms, G. (2003). Literature review: Occupational therapy in primary health care. *New Zealand Journal of Occupational Therapy*, 50(2), 17-

23. <http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>

Tse, S., Wilson, L., Wright-St Clair, V., & Ford, J. (2003). Challenges and opportunities: Occupational therapy and primary health organisations. *New Zealand Journal of Occupational Therapy*, 50(2), 24-27.  
<http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>

World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. Geneva, Switzerland: Author.

Wilson, L. (1996). Frances Rutherford Lecture: Occupational therapy – My occupation. *New Zealand Journal of Occupational Therapy*, 47(2), 5-13.  
<http://www.otnz.co.nz/public/publications/new-zealand-journal-of-occupational-therapy/>

Wright-St Clair, V. (2001). Frances Rutherford Lecture: Caring: The moral motivation for good occupational therapy practice. *Journal* 48(4). 187-199. doi: 10.1046/j.0045-0766.2001.00274.x

Table 1 Occupational Therapy Workforce

	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
<b>Total with an APC</b>	2166	2220	2264	2296	2331
<b>Female: Male</b>	1995:171 (8%)	2041:170 (8%)	2092:172(7 .6%)	2121:175 (7.6%)	2050:181 (7.8%)
<b>Ratio per 100,000 of population</b>	49.7: 100,000	50.6:100,000	51.3:100,000	51.6:100,000	51.6:100,000
<b>Main employer (with and without an APC)</b>					
<b>DHB</b>	No data	59%	53%	57%	51%
<b>Self employed</b>	No data	18%	16%	12%	15%
<b>Māori</b>	No data	62 (2.8%)	66 (3%)	62 (2.7%)	75 (3%)