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**Title:** Foundations of equitable speech-language therapy for all: the Treaty of Waitangi and Māori health

## **Abstract**

The delivery of health services, including speech-language therapy (SLT), is influenced by the culture of the healthcare discipline and the unique cultural, social and political history of the country. Among the multitude of terms referring to cultural competence and related concepts, it is timely for the SLT profession in Aotearoa (New Zealand) to determine a unified and strategic approach to cross-cultural service delivery. This article examines foundational issues to consider before establishing that approach. The Aotearoa context is strongly influenced by colonization, te Tiriti o Waitangi (the Treaty of Waitangi), immigration and questions of biculturalism and multiculturalism. Within this, issues arise because the Aotearoa SLT workforce is not representative of the population it serves. Because of te Tiriti, it is necessary to begin by addressing issues facing Māori, the indigenous peoples of Aotearoa. These include health inequities, racism, colour-blindness and white privilege. The Hauora Māori (Māori health) approach taken by medical schools in Aotearoa might be a suitable medium for SLT to address these issues. Ultimately the SLT profession, and individuals within it, need to develop a ‘critical consciousness’ (Kumagai and Lypson, 2009) through which they recognize the cultural, social and political context and search for innovative solutions.

**Key words:** speech-language therapy, cultural competence, health inequities, indigenous, Treaty of Waitangi/te Tiriti o Waitangi, Māori

Every country has a unique cultural, social and political history which shapes the context in which health services are delivered. At the same time, within a country every healthcare discipline has its own culture. This means that, while there are commonalities, speech-language therapy (SLT) practice in Aotearoa (New Zealand) is different from that in Australia and, within Aotearoa, SLT practice is different from that of other disciplines such as nursing or psychology. Nowhere is the cultural, social and political context more significant than in cross-cultural service delivery and cultural competence. The SLT profession in Aotearoa does not have a unified or strategic approach to this issue, although the unique context suggests that it should be a priority. However, establishing an approach to cross-cultural service delivery and cultural competence is no simple matter.

There is a plethora of terms to refer to notions related to cultural competence, each with a distinct political, social and educational standpoint. Each of these terms has a distinct meaning and history and, if used, must be chosen carefully in full understanding of what it represents. Terms include, but are not limited to, cultural competence (Cross, 1989), cultural awareness (Farrelly and Lumby, 2009), cultural humility (Tervalon and Murray-Garcia, 1998), cultural diversity (Bentley et al., 2008), cultural sensitivity (Nursing Council of New Zealand, 2011), cultural safety (Ramsden, 1990), multicultural competence (Downing Hansen et al., 2000), transcultural nursing and culture care (Leininger, 1978, Leininger, 1991), cultural respect (Thomson, 2005), cultural security (Farrelly and Lumby, 2009), cultural literacy (Ewen, 2011), cultural training (Spencer et al., 2008) and critical consciousness (Kumagai and Lypson, 2009).

Perhaps it is timely for the Aotearoa SLT profession to create a new and unified strategic approach for cross-cultural service delivery, and strengthen the cultural responsiveness of the profession. Of all the approaches listed above, cultural competence and cultural safety may be the most relevant to current SLT practice in Aotearoa. Cultural competence because that is

the term used in the New Zealand Speech-language Therapists' Association (NZSTA) Programme Accreditation Framework (New Zealand Speech-language Therapists' Association Programme Accreditation Committee, 2011), and cultural safety because it was developed by Māori (Ramsden, 1990). We suggest that the lesser-known concept of critical consciousness (Kumagai and Lypson, 2009) is also highly relevant. Before adopting any approach, however, many foundational issues must be examined. This article aims to address those issues.

In this article we discuss the many factors that need to be considered when determining the best approach to cross-cultural practice for SLT in Aotearoa. We begin by describing the Aotearoa context, which is strongly influenced by colonization, te Tiriti o Waitangi (the Treaty of Waitangi, hereafter te Tiriti), immigration and questions of biculturalism and multiculturalism. We then examine the Aotearoa SLT workforce and issues that arise because the workforce is not representative of the population it serves. Because of te Tiriti, we argue that it is necessary to begin by addressing issues facing Māori, the tangata whenua (people of the land) or indigenous peoples of Aotearoa. We introduce some of the inequities facing Māori along with racism, colour-blindness and white privilege. This is followed by a discussion of relevant documents from the NZSTA and the reasons behind the need for a unified and strategic approach to cross-cultural practice. We suggest that the Hauora Māori (Māori health) approach taken in medical schools in Aotearoa might be suitable for SLTs. This all leads to the conclusion that the SLT profession, and individuals within it, need to develop a 'critical consciousness' through which they recognize the cultural, social and political context and search for innovative solutions (Kumagai and Lypson, 2009).

This article initiates a discussion on this important but complex topic. We acknowledge that there are many other related topics that remain to be explored but are not covered in this article. These include:

- The application of te Tiriti and concepts of Hauora Māori in SLT services for Māori;
- Determining the most appropriate overall approach to cultural competence for the SLT profession in Aotearoa and how to apply this in practice;
- A model of practice for speech-language therapists (SLTs) working with immigrant groups;
- Issues surrounding working with bi- and multilingual clients, non-English-speaking clients and working with interpreters;
- Cultural safety for SLT students within the SLT training programs;
- Establishing professional competencies and evaluating cultural competence (or related concepts) in SLT students and the workforce.

## **The Aotearoa context**

### **Te Tiriti o Waitangi**

Fundamental to the Aotearoa context is te Tiriti o Waitangi, signed in 1840 by representatives of the British Crown and more than 500 Māori chiefs. Differences between the te reo Māori (the Māori language) text and the English text led to different understandings of the meaning and implications of te Tiriti (Orange, 1997). In the first two articles of the English text rangatira (Māori chiefs) ceded ‘sovereignty’ to the British Crown but retained ‘full exclusive and undisturbed possession’ of land, forests, fisheries and other property. In the first two articles of the te reo Māori text rangatira ceded ‘government’ (kāwanatanga) of their lands but retained ‘entire supremacy’ (tino rangatiratanga) of land, settlements and all personal property (taonga) (English translation from Coleman, 1865). Article three of both texts states that the Crown gave Māori protection and the same rights as British subjects.

Recently the Waitangi Tribunal published a report stating:

We have concluded that in February 1840 the rangatira who signed te Tiriti did not cede their sovereignty. That is, they did not cede their authority to make and enforce law over their people or their territories. Rather, they agreed to share power and authority with the Governor. They agreed to a relationship: one in which they and Hobson were to be equal – equal while having different roles and different spheres of influence. In essence, rangatira retained their authority over their hapū (sub tribes) and territories, while Hobson was given authority to control Pākehā (Non-Māori) (Waitangi Tribunal, 2014, p. xxii)

This report was highly significant, conclusively acknowledging the enduring authority of Māori in Aotearoa and their rightful position as tangata whenua and Treaty partner.

Te Tiriti has also been recognized as the ‘foundation for good health in New Zealand’ (Department of Health, 1986, p. 2). Because SLTs are health practitioners, te Tiriti is also the foundation for SLT. There is no room for debate around whether or not SLT as a profession accepts te Tiriti or wishes to integrate it into practice. Although te Tiriti is an integral part of SLT practice in Aotearoa and SLT training programmes are required to teach students to apply it clinically (New Zealand Speech-language Therapists' Association Programme Accreditation Committee, 2011), the application of te Tiriti in clinical practice is broad and can be difficult to identify. The profession as a whole has no guidelines for the application of te Tiriti, an area that has been examined in some detail by allied disciplines such as Nursing (Nursing Council of New Zealand, 2011) and Physiotherapy (Physiotherapy New Zealand, 2004).

Discussions on the application of te Tiriti often centre on principles, although Māori tend to prefer to focus on the articles of te Tiriti itself (Durie, 1998). There are many principles of te Tiriti from different sources such as the Waitangi Tribunal, Court of Appeal and the Royal

Commission on Social Policy (Durie, 1998). Probably the principles best known in SLT are those of The Royal Commission on Social Policy (1988) – partnership, participation and protection. For discussions on the application of the principles of te Tiriti in clinical practice (albeit not specific to SLT) see Nursing Council of New Zealand (2011) and Durie (1998).

The provisions of Article Three, in which Māori are promised protection and the same rights as British subjects, are clearly important to SLT practice. Article Three provides for rights such as receiving a service in one's own language and worldview and attaining equitable health outcomes. This clinical application of te Tiriti is currently challenging due to a severe lack of Māori assessments and therapy materials (Brewer et al., 2015) and few Māori SLTs (which will be addressed later in the article), but nonetheless very important.

### **Biculturalism and multiculturalism**

Another factor that shapes the cultural, social and political context in Aotearoa is more recent immigration. The 2013 census (Statistics New Zealand, 2014) revealed that 25.2% of people living in Aotearoa were born overseas, with the largest immigrant group coming from Asia. This means that, although they are the tangata whenua, Māori are one of many minority groups in Aotearoa. There is, however, one major difference. Cultural groups who have arrived in Aotearoa as immigrants have another homeland in which their language and customs still exist, often as the 'mainstream' culture. In contrast, for Māori Aotearoa is the homeland. There is no other country in which te reo Māori is an official language and nowhere at all that te reo me ona tikanga (the language and its associated customs) are 'dominant' or 'mainstream'.

In discussions about te Tiriti and immigration the terms 'biculturalism' and 'multiculturalism' are often used. These words have multiple interpretations (Sullivan, 1994). At the root of biculturalism is the fact that te Tiriti created a 'partnership' between the Crown

and Māori. This concept of partnership was initiated by the Waitangi Tribunal in their 1985 Manukau Harbour Report (Temm, 1990) and reinforced by the Waitangi Tribunal in 2014. In this partnership, guaranteed by te Tiriti, Māori are not one of many minority groups but ‘all other cultures are acknowledged and greeted by the Tangata Whenua’ (Ramsden, 1990, p. 2).

In contrast to biculturalism, multiculturalism acknowledges the multiple cultural groups present in Aotearoa as all of equal value (Polaschek, 1998). This is appealing, given the long history of immigration to Aotearoa. However, multiculturalism has been criticized for not taking into account power, social, psychological, and economic differences and the circumstances (such as colonization and racism) that have shaped them (Polaschek, 1998, Brascoupé and Waters, 2009). In addition, for Māori multiculturalism creates ‘the danger of **being defined** as a minority group in New Zealand’ (Ramsden, 1996, no page number) rather than in partnership.

Based on the principle of partnership arising from te Tiriti, our preferred approach is biculturalism, defined as a partnership between tangata whenua (the descendants of the chiefs who signed te Tiriti) and tauiwi (the descendants of the settlers at the time of the signing of te Tiriti and all subsequent immigrants) (Sullivan, 1994). This Māori/Tauiwi partnership (rather than a Māori/Pākehā partnership), includes all people in Aotearoa while acknowledging the Treaty-given rights of Māori as tangata whenua (Sullivan, 1994).

## **Colonialism**

Undoubtedly the strongest cultural and political influence in Aotearoa is that of Great Britain. This influence was cemented early on with the English Acts Act (1854), in which all English laws became effective in Aotearoa. Ramsden (1996, p. 27) observed that ‘in analysis of power structures New Zealand remains a monoculture’. She pointed out that, although Aotearoa is multicultural, the only group with any power is the dominant ‘Anglo-derived’



group. Although Ramsden made this statement nearly 20 years ago, there is little to indicate that the situation is significantly different today, as suggested by Ward and Liu (2012, p. 63):

New Zealanders accept both biculturalism and multiculturalism in principle; however, there are limits to the extent to which New Zealanders of European descent are prepared to relinquish privilege to meet bicultural and multicultural ideals.

This serves as a reminder that, despite Te Tiriti and a large immigrant population, discussions of biculturalism and multiculturalism are still largely in the domain of political and philosophical ideals rather than everyday life.

### **Cross-cultural practice in SLT**

Alongside the political and social context it is pertinent to consider the SLT workforce and issues of cross-cultural service provision. In cross-cultural settings even well-meaning clinicians can inadvertently contribute to health disparities (Burgess et al., 2004). In a particularly revealing article from the United States (Lurie et al., 2005), cardiologists reported whether they believed clinically-similar patients received different care based on their race or ethnicity. Participants were asked if this discrimination happened in healthcare in general, in cardiovascular care, in their hospital and for their own patients. While one third of respondents believed patients received differential care by race/ethnicity in healthcare in general, only 12% believed such discrimination happened in their hospital and merely 5% observed it in their own practice. The anomaly of these findings demonstrates how difficult it is to see ethnicity-based discrimination in one's own practice, even when aware of it in general.

In Aotearoa, SLT is not a registered health profession under the Health Practitioners Competence Assurance Act 2003 (HPCAA). Because there is no registration process there

are no definitive data about the number of SLTs practising in Aotearoa, or the ethnic and cultural make-up of the profession. Some data are available from the NZSTA, the professional body for SLT in Aotearoa. Membership of the association is optional so any demographic data collected from the association is not necessarily representative of the profession.

Insert Table 1 about here

Table 1 contains the available data about the ethnic make-up of the SLT profession compared to the 2013 New Zealand Census (Statistics New Zealand, 2014). NZSTA (2015) is the membership data available from the NZSTA in 2015 (personal communication, NZSTA, 28 May, 2015). It is not compulsory for members to state their ethnicity so this data only includes the subset of members who provided this information. Young (2012) includes the demographic information collected in a nationwide survey of SLTs titled 'Speech and Language Therapists and Issues with Cultural Competency in New Zealand'. There are several issues with this table:

- It is considered best practice to use the New Zealand Census question to allow comparisons between data sets; however, in this case each of the three sources used different ethnicity categories;
- NZSTA 2015 and Young 2012 only allowed one ethnic group per person, while the census allows multiple ethnicities;
- 53.5% of Māori and 37.2% of Pacific people identify more than one ethnicity (Statistics New Zealand, 2014). It is likely that, when forced to make a choice, some Māori and Pacific NZSTA members/survey participants prioritized their other ethnicity;

- The ‘other’ group in NZSTA 2015 and Young 2012 is large. This is likely to include people from Asia who are not Chinese or Indian (e.g., Korean, Filipina) and people from the Middle East, Latin America and Africa.

While imperfect, these statistics suggest that the Aotearoa SLT workforce does not reflect the population of Aotearoa, with large discrepancies for Māori, Pacific and Asian peoples. The clinician/client mismatch is likely to be greater than these statistics show because Māori and Pacific peoples have higher than average rates of overall disability (Statistics New Zealand, 2013).

Beyond ethnicity to linguistic ability, Young (2012) revealed a mismatch between the languages spoken by SLTs and the languages spoken by the people on their caseloads. The most common languages spoken by SLTs were English, French, German, Māori and Japanese. The most common languages of their clients were English, Māori, Samoan, Hindi, Tongan, Mandarin and Cantonese. The ethnic make-up of Young’s survey participants was very similar to the NZSTA ethnicity figures, suggesting that the sample was representative of NZSTA members. This linguistic, and most likely cultural, mismatch has also been demonstrated in Australia (Williams and McLeod, 2012).

While it is important to work towards a more representative SLT workforce, that is not the be-all-and-end-all. SLTs will always need to be skilled at providing a culturally competent and safe service. Even when SLTs work with clients who share their ethnic background, other cultures impact the therapeutic relationship such as those of age, gender, sexuality, religion and the cultures of the health system and the discipline of SLT.

## **Inequities in SLT for Māori**

The Health and Disability Commission Code of Rights states that people receiving a health or disability service have the right to be treated with respect and without discrimination. A cultural safety approach is one way of realizing this. Cultural safety aims to shift the power in a clinical relationship to the patient rather than the practitioner. It is measured by how safe the patient feels. The clinician does not focus on learning the patient's cultural practices but thinks about their own cultural practices and own biases and how these might impact the provision of care (Ramsden, 1996). While not all health disparities are due to unsafe service provision, health disparities in Aotearoa are a good indication that health services are not currently culturally-safe. Māori face many inequities in health status, with higher rates of hospitalization and mortality from illness and injury and lower life expectancy compared to non-Māori (Robson and Harris, 2007). While factors such as socioeconomic status and genetics have an impact, they do not fully account for the differences (Robson and Purdie, 2007, Pearce et al., 2004). Many factors are at play in these health inequities, including society, policy and the individual clinician (Curtis et al., 2010). SLTs in Aotearoa have reported that they want to provide a culturally-safe service for Māori but they face many barriers in doing so (Brewer et al., 2015).

Ramsden (1990, p. 2) interpreted these health disparities as demonstrating that Māori 'have voted with their feet when it comes to the health service'. People will not continue to attend appointments if they do not feel culturally-safe. Therefore, as well as measuring outcomes we can gauge cultural safety by looking further up the chain at how many Māori use the service. There is no data to determine how many Māori receive SLT in the public health system, or whether Māori have equitable access. Given that Māori aged 35 years and over are hospitalized with stroke at twice the rate of non-Māori (Ministry of Health, 2010) and Māori have above average rates of disability (Statistics New Zealand, 2013), a reasonable number of Māori requiring SLT input can be expected, even in areas with a relatively small Māori

population. This, coupled with SLTs' anecdotal report (McLellan, 2013), suggests that in many areas of Aotearoa Māori are under-represented on SLT caseloads. Acceptability is but one of several service access barriers and responsibility falls on the SLT profession and service providers to collect accurate data and investigate the reasons behind any under-representation.

## **Racism**

While generally considered abhorrent, racism has been shown to contribute to health inequities for Māori (Harris et al., 2006). We are not aware of any formal accounts of racism in SLT service delivery in Aotearoa but there is some evidence that it is present (McLellan et al., 2014). Racism is often referred to as having three levels – institutionalized, personally mediated and internalized (Jones, 2000). Institutionalized racism is defined as 'differential access to the goods, services, and opportunities of society by race' (Jones, 2000, p. 1212). The health disparities outlined above are clear evidence that institutionalized racism exists in Aotearoa. Personally mediated racism is equally evident but difficult to pinpoint. It includes prejudice (making assumptions about people's ability or actions based on their race) and discrimination (treating people differently based on their race) (Jones, 2000). While most healthcare professionals would be personally and professionally opposed to overt prejudice, they might not recognize the subtle ways in which their behaviour portrays prejudice (Curtis et al., 2010). Internalized racism is when the recipients of institutionalized and personally mediated racism accept the 'negative messages about their own abilities and intrinsic worth' (Jones, 2000, p. 1213). An example of this is where Māori patients make no attempt to control their health condition because they have been led to believe that poor health is inevitable in their family.

The following example (from McLellan et al., 2014) illustrates the subtle interplay between institutionalized and personally mediated racism in SLT, and their impact on the patient's experience and outcomes. It involves Makere, a Māori elder and fluent speaker of te reo Māori, who acquired aphasia through stroke. Makere's son and daughter described the language therapy Makere received. At first her preferred language was not recognized. The SLT provided flash cards in English, did not recognize when Makere named the picture correctly in te reo Māori, and prompted her to provide the English word. This is an example of both institutionalized racism (there was no provision for therapy in te reo Māori) and personally mediated racism (not valuing Makere's preferred language). Then the whānau arranged for an interpreter to come to therapy sessions. However, the interpreter was unable to make explicit to the SLT Makere's worldview so her answers appeared to be incorrect. 'The concepts that the speech therapist was looking at were, um, Mum was translating them into a Māori framework and then replying in that framework, but I can see that it would be interpreted as a cross' (McLellan et al., 2014, p. 534).

These two interchanges are racist, although not overtly so. There was no deliberate personal insult. Indeed the SLT involved would likely be horrified to discover how her actions were perceived. As Camara Jones (2000) stated, 'personally mediated racism can be intentional as well as unintentional, and it includes acts of commission as well as acts of omission' (p. 1213). The clinician omitted recognizing or valuing Makere's world view and language. As a result Makere did not receive a culturally-safe service. Institutionalized racism made it acceptable for the clinician to deliver a culturally unsafe service. In addition, provision of a substandard SLT assessment (not assessing Makere in her preferred language) was a breach of Article Three of te Tiriti and the principles of partnership, participation and protection. While the therapist was oblivious to this racism, Makere and her whānau were acutely aware.

The result was that Makere became ‘very much disinterested’ in aphasia therapy (McLellan et al, 2014 p.534).

Experiences like this contribute to the overall health inequities for Māori because they provide a substandard service that gives unsatisfactory outcomes and gives Māori no incentive to engage in therapy. As documented by Ramsden (1992, p. 22), ‘It cannot be stressed strongly enough that it is a combination of the attitudes of health professionals, poverty, and poor information in delivery (e.g., health education and promotion) which cause many Māori to avoid the formal health service’.

## **Colour-blindness and white privilege**

Similar to racism, but even more difficult to recognize, is the concept of white privilege. By its very nature white privilege is invisible to the people who benefit from it.

New Zealand, through its colonial history, has been designed primarily to benefit Pakeha. Maori were required to fit into Pakeha culture and systems. All our basic institutions functioned on the assumption that being Pakeha was ‘normal’ and that there was only one way to make decisions, one way to deliver justice, health and education, one approach to conservation, and only one language that mattered... The result is that the infrastructure of New Zealand society is structured to deliver white privilege (Consedine and Consedine, 2012, p. 219)

Describing Aotearoa in the 1960s and 70s, Greenwood and Wilson (2006, p. 85) wrote of the country being projected as a ‘homogenous British-based entity’:

we had the overseas reputation of being racially harmonious and inclusive in our vision. Most Pakeha of the time were convinced that that was indeed the practice. People frequently boasted of being colour blind – unaware of ethnic or cultural

differences and undiscriminating in allowing everyone the same opportunities.

Embedded was a warm, well-meaning unawareness of the possibility of other cultural needs and desires.

The authors went on to explain that this vision benefitted members of the majority group who enjoyed being in a powerful position without being obviously privileged. This attitude persists widely today. For example, many Pākehā nurses are unaware that they have a culture, instead considering themselves 'normal' (Wepa, 2005).

A related attitude of 'colour-blindness' is evident in healthcare, and not always perceived as negative. Family doctors report striving for colour-blindness, believing that 'family medicine is and should be culturally neutral' (Beagan and Kumas-Tan, 2009, p. e21). A recent survey assessed perceptions of racial privilege in SLT and audiology students in the USA (Ebert, 2013). Two questions had a response option of 'I do not pay attention to [racial] differences', allowing participants to profess to be colour-blind. An average of 22% of the white participants selected the 'colour-blind' option. In open-ended questions students' perceptions ranged from denial that white privilege exists, through limited awareness of white privilege, to developed awareness. While individual intentions may be benevolent, on the whole 'colour-blind' attitudes are damaging. The above scenarios all fit into what has been called 'the normalization of the dominant culture through political and social systems' (Borell et al., 2009). The 'invisible and unquestioned' privilege this normalization provides members of the dominant group must be addressed if the bicultural partnership inherent in te Tiriti is to be achieved.

## **The need for a strategic unified approach**

Taking into account the problems impacting Māori health and SLT service provision, it is clear that a strategic and unified approach to cross-cultural service provision is required, and



that first and foremost this should provide for Māori. The approach to cultural competence that the SLT profession selects, modifies or creates must be compatible with the cultural, social and political history of Aotearoa, and take into account existing NZSTA policies.

Professions that are regulated under the Health Practitioners Competence Assurance Act 2003 (HPCAA) are bound to standards of clinical competence, cultural competence, and ethical conduct (6s 118 (i)). Because SLT is not a registered health profession, SLTs are not covered by this act. The importance of cultural competence is recognized by the NZSTA. Principle 2 of the 'Principles and Rules of Ethics' (Professional Competence) states that SLTs will 'ensure they are current in their knowledge of evidence-based and culturally competent practice across different areas of professional practice'. Similarly the NZSTA (2012) Scope of Practice states that 'speech-language therapists working in New Zealand will need to act with cultural sensitivity in all aspects of their service provision' (p. 3).

The education of SLT students is monitored by the NZSTA Programme Accreditation Committee, using the Programme Accreditation Framework (New Zealand Speech-language Therapists' Association Programme Accreditation Committee, 2011). The 'Accreditation Standard for the Aotearoa/New Zealand Context' requires:

That the Programme reflects te Tiriti o Waitangi in its recruitment, curriculum and clinical education practices. This includes recognition of Māori as tangata whenua, and how this and the Tiriti apply to professional practices. The Programme needs to provide students with the best available evidence re: Māori responsiveness, practice, theory and intervention and show how these are woven throughout the Programme (New Zealand Speech-language Therapists' Association Programme Accreditation Committee, 2011, p. 12).

In addition, under the Programme Accreditation Framework all university SLT programs are required to teach cultural competency. To demonstrate this they must provide 'Evidence of how cultural competence is understood and communicated to students; both in specific focus and in general integration through the academic and clinical courses' (2.2.1) and 'Indications of how cultural competence is assessed in students' (2.2.3).

Although these documents appear to be comprehensive, there are problems. In the field of SLT there is very little research or recommendations to guide Māori responsiveness, practice, theory and intervention. Therefore, current 'best available evidence' is not necessarily helpful. Much work is required to create this 'evidence'. Although the terms 'cultural competence' and 'cultural sensitivity' have been used, there is no discussion of what they mean for the SLT profession in Aotearoa or how they should be applied. The interpretation and application will be unique because of the unique social, cultural and political situation in Aotearoa, and the distinctive culture of the SLT discipline.

## **Hauora Māori**

The SLT profession might benefit from adopting an approach to Māori health now taken in medical schools in Aotearoa. Traditionally, 'cultural' elements of the medical curriculum have been focused on Māori. This led to an expectation that Māori cultural teaching should expand to include other ethnic groups (Jones et al., 2010). More recently 'Hauora Māori' (Māori health) has been established as a subject in its own right. Hauora Māori includes elements of cultural competence and takes the perspective of Māori as tangata whenua (Jones et al., 2010). This approach is appealing because it upholds the partnership expected from te Tiriti and provides much-needed education about the multitude of factors that impact Māori health, but it leaves room for a broad teaching of cultural competence elsewhere in the curriculum.

*Te Ara* (University of Auckland, 2009) is the graduate profile in Hauora Māori for undergraduate programs of the Faculty of Medical and Health Sciences (FMHS) at The University of Auckland. This includes graduates in medicine, nursing and pharmacy, among other courses. *Te Ara* states that in respect to Hauora Māori, graduates of the FMHS will be able to:

- Engage appropriately in interactions with Māori individuals, whānau (extended family) and communities;
- Explain the historic, demographic, socioeconomic, and policy influences on health status;
- Explain how ethnic inequalities in health are created and maintained and how they may be reduced and eliminated;
- Identify approaches to reducing and eliminating inequalities including actively challenging racism;
- Explain the influence of one's own culture and that of the health system on patient and population health outcomes;
- Engage in a continuous process of reflection on one's practice and actively participate in self-audit in respect of the Treaty of Waitangi;
- Identify and address professional development needs as a basis for life-long learning about Māori health (University of Auckland, 2009).

Although *Te Ara* was not written for SLT, it covers all the important elements of Hauora Māori and is likely to be largely applicable in SLT practice.

## **Conclusion**

The time has come to address issues of cross-cultural practice in the SLT profession in a strategic manner. In presenting the current and historical context this article has established the foundation on which such discussions can begin. In Aotearoa, which is strongly influenced by colonization and immigration, the bicultural partnership of te Tiriti acknowledges the unique place of Māori as tangata whenua, in relation to all migrant groups. Difficulties arise for Māori and migrant groups because the SLT workforce in Aotearoa is not representative of the population it serves. While there are many issues to address, we have demonstrated that it is necessary to begin with Māori, as tangata whenua. The concept of Hauora Māori is important in this discussion. By addressing Hauora Māori separately to cultural competence (and related terms) we acknowledge the unique position that Māori are in and the Treaty-based need to address inequities. At the same time, we acknowledge that cultural competence is a broad concept that is important for all people.

There are two areas that the SLT profession in Aotearoa must address most urgently. These are the application of te Tiriti and concepts of Hauora Māori in SLT services for Māori; and establishment of the most appropriate overall approach to cultural competence for the profession (possibly cultural competence or cultural safety) and how to apply this in practice. The way forward for both of these lies in developing a critical consciousness (Kumagai and Lypson, 2009). This is not something that one can attain in the same way as other clinical skills, it is:

the development of an orientation—a critical consciousness—which places [medicine] in a social, cultural, and historical context and which is coupled with an active recognition of societal problems and a search for appropriate solutions (Kumagai and Lypson, 2009, p. 782)

It is this change in thinking and knowing that is likely to be most successful in reducing inequities and making Aotearoa a world leader in culturally-safe SLT.

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**Table 1, Ethnicities of SLTs**

<b>Ethnicity</b>	<b>2013 Census</b>	<b>NZSTA 2015 (n=485)</b>	<b>Young 2012 (n=103)</b>
European	74.0%	84.2%	86.4%
Māori	14.9%	1.6%	1.0%
Asian (NZSTA = Indian + Chinese)	11.8%	4.5%	5.8%
Pacific (NZSTA = Samoan)	7.4%	0.5%	0.0%
Other	2.8%	9.2%	6.8%

**Caption:** Ethnic make-up of the Aotearoa SLT profession compared to the 2013 New Zealand Census (Statistics New Zealand, 2014). The 2013 Census data adds to more than 100% because people who reported more than one ethnic group are counted once in each group reported.

NZSTA = New Zealand Speech-language Therapists' Association

## **Glossary**

<b>Aotearoa</b>	New Zealand
<b>Hapū</b>	Sub-tribe
<b>Hauora Māori</b>	Māori health
<b>Kāwanatanga</b>	Government
<b>Māori</b>	The Indigenous peoples of Aotearoa
<b>Pākehā</b>	Non-Māori, usually used to refer to New Zealand Europeans
<b>Rangatira</b>	Chief or chiefs
<b>Tangata whenua</b>	The people of the land, refers to the Indigenous status of Māori in Aotearoa
<b>Taonga</b>	Property, treasure
<b>Tauīwi</b>	People who are not Māori
<b>Te Ara</b>	The path, track or course
<b>Te reo Māori, te reo</b>	The Māori language
<b>Te reo me ona tikanga</b>	The Māori language and its customs
<b>Te Tiriti o Waitangi</b>	The Treaty of Waitangi. Usually used to refer to the Māori language version of the Treaty
<b>Tino rangatiratanga</b>	Absolute sovereignty, self-determination
<b>Whānau</b>	(Extended) family