Using this Resource Book for Readings

International documents –

International Federation on Ageing Declaration on the Rights and Responsibilities of Older Persons

United Nations Principles for Older Persons

The Treaty of Waitangi – Te Tiriti o Waitangi

New Zealand legislation and related codes –

Health and Disability Commissioner Act 1994 and Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996

Health and Safety in Employment Act 1992

Human Rights

Injury Prevention, Rehabilitation, and Compensation Act 2001 (formerly the Accident Rehabilitation and Compensation Insurance Act 1992); and the Accident Compensation Corporation (ACC)


Mental Health (Compulsory Assessment and Treatment) Act 1992

The Third Age

Diversional therapy

History of the New Zealand Society of Diversional Therapists

Occupational therapy

Occupational Therapy Code of Ethics

Competencies for Registration as an Occupational Therapist

Notice of Scope of Practice and Related Qualifications Prescribed by the Occupational Therapy Board 2004

Booklist and websites

Name ________________________________________________

Employer _____________________________________________

NZQA number _________________________________________

Date _________________________________________________

“All the answers in this workbook were completed by me.”

Signed _______________________________________________
Using this Resource Book for Readings

The National Certificate in Diversional Therapy (Level 4) contains eight unit standards taken from the Diversional Therapy Domain of the National Qualifications Framework (NQF). These eight unit standards, together with their NQF ID numbers, are:

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<th>Title of Unit Standard</th>
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<tr>
<td>5786</td>
<td>Develop, implement, evaluate, and adapt personal diversional therapy care plans</td>
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<td>Develop, implement, evaluate, and adapt diversional therapy group care plans</td>
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<td>Identify, implement, evaluate, and adapt diversional therapy activities for people with identified health conditions</td>
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<td>Describe the philosophy, purpose, and benefits of diversional therapy, and the role and skills of diversional therapists</td>
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<tr>
<td>25770</td>
<td>Research support services for diversional therapists and collate into a resource manual</td>
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Using this Resource Book for Readings

The Special Notes to these eight unit standards make reference to “legislation, codes and documents [that] must be complied with”, namely:

- International documents that establish principles for care of older persons.
- The Treaty of Waitangi.
- New Zealand legislation and related codes which are relevant to a diversional therapist working within health and disability services.

It is important that you familiarise yourself with these documents before starting on the learning activities. This Resource Book will help you with this familiarisation process, and contains information that will assist you to understand and interpret the requirements of these documents. You should understand the purpose of each document (why it was written and for whom); and the application of each document (how it relates to your work as a diversional therapist).

You will need to keep this Resource Book on hand as you work through each of the diversional therapy unit standards in the National Certificate in Diversional Therapy (Level 4). You might find it helpful to highlight key points for ease of reference later on.
International documents

New Zealand is a signatory to the United Nations Charter, as well as to a range of United Nations declarations on human rights. From time to time, the United Nations issues statements on the rights of different groups of people. Older persons are one of these groups, and the United Nations issued the United Nations Principles for Older Persons in 1991.

The United Nations Principles for Older Persons “address the independence, participation, care, self-fulfillment and dignity of older persons” including those in health care support services or facilities. These Principles were based on the International Federation on Ageing (IFA) Declaration on the Rights and Responsibilities of Older Persons.

This section of the Resource Book will outline the IFA Declaration on the Rights and Responsibilities of Older Persons first, followed by a summary of the United Nations Principles for Older Persons 1991. You will notice that the way the “Rights” of older persons are set out and worded in the IFA Declaration is almost identical to the way they are set out and worded in the United Nations “Principles”. The IFA Declaration adds another section, however, to do with how older persons can help themselves to live productive and fulfilling lives.

NB These “Rights” and “Principles” have been slightly paraphrased to promote ease of understanding.
International Federation on Ageing Declaration on the Rights and Responsibilities of Older Persons

The Rights of Older Persons

**Independence** – Older persons have the right:

1. Of access to adequate food, water, shelter, clothing and health care with the help of income, family and community supports.

2. To work and follow other income-generating opportunities free of any age-based barriers.

3. To retire and to participate in determining when and at what pace they withdraw from the labour force.

4. Of access to education and training programmes that improve literacy, enhance their employment prospects, and help with informed forward planning and decision making.

5. To live in environments which are safe and that can be adapted to their personal preferences and changing capabilities.

6. To live at home for as long as possible.

**Participation** – Older persons have the right:

7. To remain integrated and active participants in society, and to provide input into developing and implementing policies which directly affect their well-being.

8. To share their knowledge, skills, values and life experience with younger generations.

9. To seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.

10. To form movements or associations representing the interests of older persons.
International documents

Care – Older persons have the right:

11 To benefit from family support and care consistent with the well-being of the family.
12 Of access to healthcare that will help them maintain or regain optimum levels of physical, mental and emotional well-being, and to prevent or delay the onset of illness.
13 Of access to social and legal services that will help them to maintain independence and provide them with protection and care.
14 To utilise appropriate levels of institutional care which provide protection, rehabilitation and social and mental stimulation in a humane and secure environment.
15 To have their human rights and fundamental freedom respected when they are living in any shelter, care and treatment facility. These rights include full acknowledgement of their dignity, beliefs, needs and privacy, and their right to make decisions about their care and quality of life.

Self-fulfilment – Older persons have the right:

16 To pursue opportunities for the full development of their potential.
17 Of access to the educational, cultural, spiritual and recreational resources of society.

Dignity – Older persons have the right:

18 To be treated fairly regardless of their age, gender, racial or ethnic background, disability or other status, and to be valued independently of their financial circumstances.
19 To live in dignity and security and to be free of exploitation and physical or mental abuse.
20 To exercise self-determination in healthcare decision-making, including the right to die with dignity by accepting or rejecting treatments designed solely to prolong life.
Consistent with individual values, and as long as health and personal circumstances permit, older persons should try:

1. To remain active, capable, self-reliant and useful.
2. To learn and apply sound principles of physical and mental health to their own lives.
3. To take advantage of literacy training.
4. To plan and prepare for old age and retirement.
5. To update their knowledge and skills to enhance their employability if they want to remain in the workforce.
6. Along with other family members to be flexible in adjusting to changing relationships.
7. To share knowledge, skills, experience and values with younger generations.
8. To participate in the civic life of their society.
9. To seek and develop potential avenues of service to the community.
10. To make informed decisions about their healthcare and to let their doctor and family know their decisions about terminal care.
International documents

United Nations Principles for Older Persons

The United Nations Principles give priority attention to the situation of older persons. The Principles address the independence, participation, care, self-fulfilment, and dignity of older persons.

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and healthcare, aided by income, family and community support and self-help.

2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.

3. Older persons should be able to participate in deciding when and at what pace they withdraw from the labour force.

4. Older persons should have access to appropriate educational and training programmes.

5. Older persons should be able to live in environments that are safe and able to be adapted to personal preferences and changing capabilities.

6. Older persons should be able to live at home for as long as possible.

Participation

7. Older persons should remain integrated in society; participate actively in developing and implementing policies that directly affect their well-being; and be able to share their knowledge and skills with younger generations.

8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.

9. Older persons should be able to form movements or associations of older persons.
International documents

**Care**

10 Older persons should benefit from family and community care and protection in accordance with each society’s system of cultural values.

11 Older persons should have access to healthcare to help them maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.

12 Older persons should have access to social and legal services that will help them to maintain independence and provide them with protection and care.

13 Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation, and social and mental stimulation in a humane and secure environment.

14 Older persons should have their human rights and fundamental freedom respected when they are living in any shelter, care and treatment facility. These rights include full acknowledgement of their dignity, beliefs, needs and privacy, and their right to make decisions about their care and quality of life.

**Self-fulfilment**

15 Older persons should be able to pursue opportunities for the full development of their potential.

16 Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

**Dignity**

17 Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

18 Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their financial circumstances.
The Treaty of Waitangi – Te Tiriti o Waitangi

“The Treaty of Waitangi is regarded as the founding document of New Zealand. In signing the Treaty the Crown agreed that, within our society, the values and traditions of both cultures (Māori and British) would be reflected in society’s customs, laws, practices and institutional arrangements. There was also an agreement to share control of resources and decision-making. The Treaty guarantees Māori equal status and power within New Zealand society, and it also legitimates the rights of Pākehā New Zealanders.

This concept was explained by Judge Eddie Durie at his Waitangi Day address in 1989:

‘The Treaty of Waitangi is not just a Bill of Rights for Māori. It is a Bill of Rights for Pākehā too. It is the Treaty that gives Pākehā the right to be here. Without the Treaty there would be no lawful authority for the Pākehā presence in this part of the South Pacific. The Pākehā are the Tangata Tiriti, those who belong to the land by right of that Treaty.’

The provisions of the Treaty require that the Crown and its agents respect the principles of the Treaty. These principles, as enunciated by the Royal Commission on Social Policy, are partnership, protection and participation. The Treaty has been promoted as a suitable framework within which to consider social and economic development, which includes health.
The Treaty of Waitangi – Te Tiriti o Waitangi

**Partnership** refers to an ongoing relationship between the Crown, its agencies and Iwi. It means that Māori need to share in decision making about the nature of their health services, with this leading to increased Māori control over their own health.

**Protection** creates an obligation for the Crown to actively protect Māori and their interests. In health, this is about health promotion and preventive strategies, and it implies the State will seek out opportunities to enhance Māori health.

**Participation** is about equality of opportunity and outcomes, and emphasises positive Māori involvement in health care services at all levels.”


The following web page provides a series of Frequently Answered Questions about the Treaty of Waitangi, and links to a series of informative booklets and pamphlets prepared by the State Services Commission: http://www.nzhistory.net.nz/politics/treaty/treaty-faqs#WherecanIobtainprintedbookletsabouttheTreaty
The New Zealand Parliament has legislated to recognise people’s basic rights. There are now many different statutes and codes that are designed to protect the rights of New Zealand citizens, including people receiving support through health and disability services.

The **Health and Disability Commissioner Act 1994** and its associated regulations are the benchmark for health professionals who are providing services to people accessing Ministry of Health and regional health and disability funded services, i.e. most residential and community health support services.

The **Health and Safety in Employment Act 1992** is designed to promote the prevention of harm to all persons at work and other persons in (or in the vicinity of) a place of work. The Act promotes health and safety management, in particular through promoting the systematic management of health and safety; and defining hazards and harm (including work-related stress) in a comprehensive way. The interests of both workers and older people are promoted through the establishment of safe and healthy workplaces.

The **Human Rights Act 1993** was designed to protect people from discrimination. It provides remedies if people are discriminated against on prohibited grounds such as age, gender, family status, race, political opinion, and health or disability conditions.

The **Injury Prevention, Rehabilitation, and Compensation Act 2001** (formerly the Accident Rehabilitation and Compensation Insurance Act 1992) establishes a scheme to assist people who require rehabilitation or support following injury that results from an accident. The statute is the governing legislation for the Accident Compensation Corporation.

**Privacy and confidentiality** legislation and associated codes are relevant to all people providing services and support to people who are using a health and disability service.

The **Mental Health (Compulsory Assessment and Treatment) Act 1992** was passed following revision of an earlier Mental Health Act. The new Act included provisions to ensure that mental health service users had their rights recognised and respected.

Most of the legislation has an impact on how we support people in our workplaces.
New Zealand legislation and related codes

Health and Disability Commissioner Act 1994 and Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996

The Health and Disability Commissioner Act 1994 established the office of the Health and Disability Commissioner, who has a number of responsibilities in relation to health and disabilities consumers, namely:

• To promote and protect the rights of consumers who use health and disability services.
• To help resolve problems between consumers and providers of health and disability services.
• To improve the quality of health care and disability services.

The Code of Health and Disability Services Consumers’ Rights Regulations 1996 issued under the Act is the key document for workers providing health and disability services. The following excerpt is taken from the website of the Health and Disability Commissioner:

“The Code of Health and Disability Services Consumers’ Rights became law on 1 July 1996 as a regulation under the Health and Disability Commissioner Act. It confers a number of rights on all consumers of health and disability services in New Zealand and places corresponding obligations on providers of those services…

Application of the Code is very wide and extends to any person or organisation providing…a health service to the public or a section of the public, whether that service is paid for or not. With regard to disability services, it extends to goods, services and facilities provided to people with disabilities for their care or support or to promote their independence, or for related or incidental purposes. Unlike health services, disability services do not have to be provided to the public in order to be covered by this legislation.”
“The Code therefore covers all registered health professionals, such as doctors, nurses, dentists, etc, and in addition brings a level of accountability to all those who might be considered outside the mainstream of medical practice, e.g. naturopaths, homeopaths, acupuncturists etc. As well as applying to individual providers, the Code also applies to hospitals and other health and disability institutions and allows the Commissioner to enquire into systems issues across professional boundaries. It does not extend to purchasing decisions or confer entitlement to any particular service.

The obligation under the Code is to take ‘reasonable actions in the circumstances to give effect to the rights, and comply with the duties’ in the Code. The onus is on providers to show that such action has been taken. The Code does not override other legislation, and nothing in the Code requires providers to act in breach of a duty or obligation imposed by any enactment, or prevents a provider doing an act authorised by another enactment.”
New Zealand legislation and related codes

**Under the Code:**

Consumers have rights, and providers have duties:

- Every consumer has **rights** in the Code.
- Every provider is subject to the **duties** in the Code.

Every provider must take action to:

- Inform consumers of their rights.
- Enable consumers to exercise their rights.

**Rights of Consumers and Duties of Providers**

Clause 2 of the Code details the ten rights of consumers and the duties of providers as follows:

**Right One – The right to be treated with respect.**

- Every consumer has the right to be treated with respect.
- Every consumer has the right to have his or her privacy respected.
- Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.

**Right Two – Right to freedom from discrimination, coercion, harassment, and exploitation.**

- Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.
New Zealand legislation and related codes

Right Three – Right to dignity and independence.
• Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

Right Four – Right to services of an appropriate standard.
• Every consumer has the right to have services provided with reasonable care and skill.
• Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
• Every consumer has the right to have services provided in a manner consistent with his or her needs.
• Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
• Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Right Five – Right to effective communication.
• Every consumer has the right to effective communication in a form, language and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
• Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.
New Zealand legislation and related codes

Right Six – Right to be fully informed.

- Every consumer has the right to the information that a reasonable consumer, in the consumer’s circumstances, would expect to receive, including:
  - An explanation of his or her condition.
  - An explanation of the options available, including an assessment of the expected risks, side effects, benefits and costs of each option.
  - Advice of the estimated time within which the service will be provided
  - Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval.
  - Any other information required by legal, professional, ethical and other relevant standards
  - The results of tests
  - The results of procedures.

- Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer’s circumstances, needs to make an informed choice or give informed consent.

- Every consumer has the right to honest and accurate answers to questions relating to services, including questions about:
  - The identity and qualifications of the provider
  - The recommendation of the provider.
  - How to obtain an opinion from another provider.
  - The results of research.

- Every consumer has the right to receive, on request, a written summary of information provided.
New Zealand legislation and related codes

Right Seven – Right to make an informed choice and give informed consent.
- Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or common law, or any other provision of this Code provides otherwise.
- Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.
- Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent to the extent appropriate to his or her level of competence.
- Where a consumer is not competent to make informed choices and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where:
  - These services are in the best interests of the consumer.
  - Reasonable steps have been taken to ascertain the views of the consumer.
- Every consumer may use an advance directive in accordance with common law.

Right Eight – The right to support.
- Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer’s rights may be unreasonably infringed.
Right Nine – Rights in respect of teaching and research.
- The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching and research.

Right Ten – The right to complain.
- Every consumer has the right to complain about a provider in any form appropriate to the consumer.
- Every consumer may make a complaint to:
  - The individual or individuals who provided the services complained of.
  - Any person authorised to receive complaints about that provider.
  - Any other appropriate person, including an independent advocate provided under the Health and Disability Commissioner Act 1994.
- Every provider must facilitate the fair, simple, speedy and efficient resolution of complaints.
- Every provider must inform a consumer about progress on the consumer’s complaint at intervals of not more than one month.
- Every provider must comply with all the other relevant rights in this Code when dealing with complaints.
- Every provider, unless an employee of a provider, must have a complaints procedure which ensures that the complaint is acknowledged in writing within five working days of receipt, unless it has been resolved to the satisfaction of the consumer within that time period.
Where do you, and the people you work with, find the information from the previous pages in your workplace/service setting?
The Health and Safety in Employment Act 1992 is designed to promote the prevention of harm to all persons at work and other persons in (or in the vicinity of) a place of work, including health care support services and facilities.

The Act promotes health and safety management, in particular through systematic management of health and safety issues; and by defining hazards and harm (including work-related stress) in a comprehensive way. The interests of both workers and older people are promoted through the establishment of safe and healthy workplaces.

The legislation was designed to ensure that:

1. As far as is reasonably practicable, workplaces, machinery, equipment and processes under an employer’s control are safe and pose no risk to health.
2. Adequate measures (including first aid arrangements) are established to deal with emergencies and accidents.
3. Arrangements exist for workers and their representatives to co-operate with their employer in health and safety matters; to be involved in work organisation; and to be provided with the information and training that they need to perform their work safely.
4. Occupational health and safety measures do not involve any expenditure for workers.

In your workplace there will be a staff member who is the appointed health and safety officer.

Your workplace policies and procedures will explain your responsibilities relating to health and safety; how particular situations are to be dealt with; and the processes for documenting and reporting potential hazards and any workplace accidents.
New Zealand legislation and related codes

The Health and Safety in Employment Act 1992 is the law that covers your safety at work.

Under this Act, you have a number of duties and rights. Your organisation also has rights and duties.

The Act’s main aim is to stop people getting hurt at work. This could be physical or mental harm. For example, physical harm could be hurting your back while working, while mental harm could be witnessing an accident that really upsets you.

The Department of Labour, Occupational Safety and Health Service is the government department that makes sure people follow the Health and Safety in Employment Act.

Your duties under the Health and Safety in Employment Act are:

- To take all practicable steps to make sure you are safe at work.
  This means you shouldn’t do anything that is unsafe such as using an iron with a frayed cord. It also means you must wear and use any personal protective clothing supplied to you, such as gloves, aprons and hoists.
- To make sure other people do not get hurt because of something you do or forget to do.
  This means that you must not do anything that could hurt the people you are supporting. For example, if you have just mopped the kitchen floor you must let people know that the kitchen floor is wet.

The Health and Safety in Employment Act covers

- Employers – your organisation or the people who employ you.
- Employees – you and your work colleagues.
- Visitors – people who visit your workplace.

Support workers work in a variety of settings, including the community and in people’s homes. These settings are your workplaces and the Act covers you in all of these places.

Your organisation has policies and procedures about health and safety. If you have not already been given a copy of them you should ask your supervisor for them.
New Zealand legislation and related codes

Human Rights

The New Zealand Bill of Rights Act 1990
The New Zealand Bill of Rights Act 1990 is intended by Parliament to: “affirm, protect, and promote human rights and fundamental freedoms in New Zealand”; and “affirm New Zealand’s commitment to the International Covenant on Civil and Political Rights” (New Zealand Bill of Rights Act 1990).

The Act places limitations on the actions of those in government (including the legislature, government departments, the judiciary, state owned enterprises and local authorities) that might interfere with the rights of individuals, companies and incorporated societies.

What are the Rights?
The rights protected by the Bill of Rights Act are summarised as rights relating to the life and security of the person, democratic and civil rights, non discrimination and minority rights, search arrest and detention, criminal procedure and the right to justice.

The following is an extract from the Law Access website (http://www.lawaccess.lsa.govt.nz/default2.aspx), explaining the rights protected by the Bill of Rights Act.

“Life and security of the person
The New Zealand Bill of Rights protects the following rights -

- **life** – everyone has the right not to be deprived of life.

- **cruel treatment** – everyone has the right not to be tortured or be given cruel, degrading or disproportionately severe treatment or punishment.

- **experimentation** – everyone has the right not to be subjected to medical or scientific experiments.

- **medical treatment** – everyone has the right to refuse medical treatment.”
New Zealand legislation and related codes

“Political and other democratic rights

The New Zealand Bill of Rights protects the following rights –

- **voting rights** – everyone who is 18 or older has the right to vote and to stand in Parliamentary elections.
- **political action** – everyone has the right to freedom of expression, freedom of association (that is, to meet with whoever they want), and freedom of peaceful assembly (that is, to demonstrate lawfully about political or social issues).
- **religious rights** – everyone has the right to freedom of thought, conscience and religion.
- **minorities’ cultural rights** – minorities have the right to enjoy their culture, practise their religion and use their language.
- **discrimination** – everyone has the right not to be discriminated against on the grounds of their sex; marital or family status; religious or ethical belief; colour, race, ethnic or national origins; disability; age (unless they’re under 16); political opinion; employment status; or sexual orientation.
- **immigration and travel** – New Zealand citizens have the right to enter and leave New Zealand and move within it freely. Non-citizens who are legally in New Zealand have the right to live in and move freely within the country, and the right not to be expelled from the country arbitrarily. Every person in New Zealand has the right to leave the country as they wish.”

This summary of the Act shows that the Bill of Rights has particular importance to the diversional therapist who is providing leisure activity programmes. A diversional therapist frequently needs to advocate on behalf of people who experience discrimination on any of the grounds listed above.

The remainder of the New Zealand Bill of Rights Act explains in detail:

- Your rights when arrested.
- Rights when charged with an offence.
- Criminal procedure.
- Right to justice.

The full text of the Act can be viewed on www.hrc.co.nz/home/hrc/humanrightsenvironment/humanrightsinnewzealand.
New Zealand legislation and related codes

**The Human Rights Act 1993**

The Human Rights Act 1993 was designed to protect people from discrimination. It provides remedies if people are discriminated against on prohibited grounds. The following is a summary of the prohibited grounds of discrimination in the Act:

- Sex, which includes pregnancy and childbirth, and sexual harassment.
- Marital status.
- Religious belief.
- Ethical belief.
- Colour.
- Race.
- Ethnic or national origins.
- Disability, which means:
  - Physical disability or impairment (e.g. respiratory conditions).
  - Physical illness.
  - Psychiatric illness (e.g. depression or schizophrenia).
  - Intellectual or psychological disability or impairment (e.g. learning disorders).
  - Any other loss or abnormality of psychological, physiological, or anatomical structure or function (e.g. arthritis or amputation).
  - Reliance on a guide dog, wheelchair, or other remedial means to assist safe movement.
  - The presence in the body of organisms capable of causing illness (e.g. HIV/AIDS or hepatitis).
- Age.
- Political opinion.
- Employment status.
- Family status.
- Sexual orientation.
People are protected from unlawful discrimination in certain areas of their lives, including:

- Government or public sector activities.
- Employment.
- Access to education.
- Access to public places, vehicles and facilities.
- Provision of goods and services.
- Provision of land, housing and accommodation.
- Industrial and professional associations, qualifying bodies and vocational training bodies.
- Partnerships.

(Acknowledgements: Human Rights Commission Facts Sheet #02 – What is the Process for Dealing with Disputes?)

An older person receiving services from a health or disability service could be discriminated against (either by the service provider, or by other people or organisations), on the basis of one or more of the prohibited grounds in the Act.

The Human Rights Commission (which functions under the authority of the Human Rights Act) is able to accept complaints and take action to resolve examples of unlawful discrimination.


One of the Commission’s functions under the Human Rights Act is to:


The Commission carries out this function through its Te Mana i Waitangi project.

New Zealand legislation and related codes

Injury Prevention, Rehabilitation, and Compensation Act 2001 (formerly the Accident Rehabilitation and Compensation Insurance Act 1992) and the Accident Compensation Corporation ACC

Section 3 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 sets out the purpose of the legislation as follows:

“The purpose of this Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social, and personal costs), through –

a) establishing as a primary function of the Corporation the promotion of measures to reduce the incidence and severity of personal injury:

b) providing for a framework for the collection, co-ordination, and analysis of injury-related information:

c) ensuring that, where injuries occur, the Corporation’s primary focus should be on rehabilitation with the goal of achieving an appropriate quality of life through the provision of entitlements that restores to the maximum practicable extent a claimant’s health, independence, and participation:

d) ensuring that, during their rehabilitation, claimants receive fair compensation for loss from injury, including fair determination of weekly compensation and, where appropriate, lump sums for permanent impairment:

e) ensuring positive claimant interactions with the Corporation through the development and operation of a Code of ACC Claimants’ Rights:

f) ensuring that persons who suffered personal injuries before the commencement of this Act continue to receive entitlements where appropriate.”

NB. The special notes in these unit standards refer to the Accident Rehabilitation and Compensation Insurance Act 1992. That Act has been replaced by the Injury Prevention, Rehabilitation, and Compensation Act 2001.
In summary, the accident compensation scheme was established to provide a “no fault” scheme, whereby people who are injured as the result of an accident do not need to go to court to prove that someone else is liable to pay damages to compensate them for the injury they have suffered (e.g. an employer for a workplace injury, or the driver of a car that injures the claimant in a car accident). The Act covers earners and non-earners in different ways, and replaces the former “worker’s compensation” system.

The Accident Compensation Corporation (ACC) has a responsibility to promote measures to reduce both the number and seriousness of personal injury accidents (i.e. “the fence at the top of the cliff”). It also has a responsibility to focus on the rehabilitation of people who are injured as the result of an accident, and restore to the greatest practicable extent the person’s health, independence and participation (i.e. “the ambulance at the bottom of the cliff”).

ACC also has a responsibility to ensure that a person who is injured as a result of an accident receives fair compensation for loss from injury (again, “the ambulance at the bottom of the cliff”). This compensation may take the form of weekly compensation (e.g. payment of ongoing compensation in the form of a percentage of the worker’s average earnings in the period leading up to the accident), and/or lump sum compensation for permanent impairment (e.g. loss of a limb). Provision is also made to compensate dependent family members where the person they are dependent upon dies as a result of an accident.

Further information can be found on the ACC webpage: http://www.acc.co.nz/index.htm

Please note that ACC claimants have rights that are defined in the Code of ACC Claimants’ Rights, which can be read either on the ACC website (above) or at: http://www.lawaccess.lsa.govt.nz/Lrm_V2.aspx?BookId=62&ChapterId=5.


Please remember:
ACC does not provide services, or funding for services and equipment, for consumers who experience disabilities that result from illness, age related conditions, or congenital conditions.
The privacy of people in relation to their personal information is seen to be a fundamental right in New Zealand. People receiving health and disability services are particularly vulnerable to breaches of their privacy because of the intimate nature of the personal information they are required to disclose to service provider staff.

The primary forms of protection of people’s privacy in relation to their personal information are as follows:

- Legislation (e.g. the Privacy Act 1993).
- Codes of practice (e.g. the Health Information Privacy Code 1994).
- Ethical codes of professional associations (i.e. the codes of ethics for occupational therapists, social workers etc).

This section of the Resource Book will deal with the Privacy Act 1993 and the Health Information Privacy Code 1994 (2008 Revised Edition). Please note that whilst the unit standard special note only refers to the Privacy Act, the Health Information Privacy Code (set up under the Act) will provide you with the most relevant guidance for your work, so you need to be familiar with both pieces of legislation.

One of the main purposes of the Privacy Act 1993 is to promote and protect individual privacy. The Act is primarily concerned with ethical and safe practices in relation to personal information.

The Privacy Act gives the Privacy Commissioner the power to issue codes of practice that become part of the legal framework for privacy protection. The key code of practice for people working within health and disability services is the Health Information Privacy Code 1994. The Code extends the Act by providing specific rules and guidance on the handling of personal information within health and disability services.
New Zealand legislation and related codes

Privacy Act 1993
The Act contains twelve information privacy principles dealing with:

- How we collect information.
- How we hold/store information.
- How we share information.
- Unique identifiers.
- An individual’s right to access his/her personal information.

The main requirements of each privacy principle may be summarised as follows:

Principle 1
Personal information must not be collected by any agency unless:

1. The information is collected for a lawful purpose connected with a function or activity of the agency.
2. The collection of the information is necessary for that purpose.

(This information covers a person’s medical/care notes, client history, holistic assessment information, and information about the person’s activities and interests.)

Principle 2
Where an agency collects personal information, the agency must collect the information directly from the individual concerned; or if the agency believes on reasonable grounds that non-compliance is necessary to collect this information:

1. That the individual concerned authorises collection of this information from someone else.
2. That compliance is not reasonably practicable in the circumstances.

(This provision covers gathering information from next of kin when a person has a communication impairment, or can no longer provide information due to the impact of dementia or traumatic brain injury.)
Principle 3
Where an agency collects personal information directly from the person concerned, the agency must take such steps as are reasonable to ensure that the person concerned is aware of:

1. The fact that information is being collected.
2. The purpose for which the information is being collected.
3. Who will see and use this information.
4. The person’s right of access to, and correction of, personal information provided.

(This provision spells out the agency’s responsibility to inform the person of the reason for collecting information and how it will be used; and to explain the person’s right to see this information if he/she so wishes.)

Principle 4
Personal information must not be gathered by an agency:

1. By unlawful means
2. In a way that intrudes upon the personal affairs of the individual concerned to an unreasonable extent.

(This provision is about the “need to know”: many areas of a person’s private life, work or business may have no relevance to the person’s present situation and should not be recorded.)

Principle 5
Any agency that holds personal information must ensure that the information is protected by such security safeguards as it is reasonable (in the circumstances) to put in place. These safeguards should provide protection against:

1. Loss of information.
2. Access, use, modification or disclosure of information, except with the authority of the agency that holds this information.

(This principle is about keeping personal information in a secure appropriate place, and establishing who has the authority to access this information.)
New Zealand legislation and related codes

**Principle 6**
Where an agency holds personal information in such a way that it can be readily retrieved, the individuals concerned are entitled to:

1. Obtain from the agency confirmation of whether or not the agency holds such personal information.
2. Have access to that information.

(Workplace policies and procedures will explain the process for a resident/person to have access to the information held in his/her care plan and – where applicable – a diversional therapy plan/programme.)

**Principle 7**
Where an agency holds personal information, the individual concerned is entitled to:

1. Request correction(s) to the information.
2. Request that there be attached to the information a statement of the correction(s) sought but not made.

(Workplace policies and procedures should explain this process and specify who has the authority within the workplace to deal with access to personal information.)

**Principle 8**
An agency that holds information must not use this information without establishing the purpose for which it is to be used. The agency must also ensure that the information is accurate, up to date, complete and relevant; and not misleading in any way.

(For the diversional therapist, Principle 8 relates to what he/she writes in the care plan or diversional therapy plan and how regularly this information is updated.)

**Principle 9**
An agency that holds personal information must not keep that information longer than is required for the purposes for which it may be lawfully used.

(Information about people who are no longer in a workplace/service cannot be kept. Workplace policies and procedures explain what must happen to this information.)
Principle 10
An agency that holds personal information for one purpose must not use this information for any other purpose.

(In a diversional therapy context, the diversional therapist cannot use information gathered from a person for his/her social history in a reminiscence session or for other purposes, without the consent of the person concerned.)

Principle 11
An agency that holds personal information must not disclose this information to another person, body or agency, unless the agency believes on reasonable grounds that the disclosure of information is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned (or of another individual).

(This principle applies where a person may be at risk of self harm, or of causing harm to others. This situation must be reported – and workplace policies and procedures should explain who you report to and how this is to be done.)

Principle 12
An agency must not assign a unique identifier to an individual unless assigning that identifier is necessary to enable the agency to carry out its functions efficiently. An agency that assigns unique identifiers to individuals must take all reasonable steps to ensure that unique identifiers are assigned only to individuals whose identity is clearly established.

(In a diversional therapy context, if a person has removed his/her unique identifier wristband, the diversional therapist must not re-attach the wristband. The removal of the wristband must be reported in accordance with the workplace’s policies and procedures.)
New Zealand legislation and related codes


The Health Information Privacy Code 1994 is the Code to be followed by agencies (and agency employees) delivering health and disability services. The Code follows the broad outlines of the Privacy Act, but it is tailored to the specific requirements of health and disability services and the needs of people to whom they provide services. Your employing agency has an obligation to ensure that its policies and procedures in relation to personal information are consistent with the Code. It is also obliged to provide training for its employees so that they understand their obligations.

The following is an extract from the Foreword to the Code, written by Marie Shroff, Privacy Commissioner (2008 Edition, p 2.):

“Nearly every interaction with an agency generates information. Mostly that information will be trivial (though even trivial data can reveal a surprising amount about the person to whom it relates). When it comes to health information, though, there is little we would consider to be trivial. Because of this, we are used to information about our health being treated in particular ways.

We expect it to be considered as confidential, because in all likelihood it was collected in a situation of confidence and trust. We want it to be treated as sensitive, because it may include details about our body, lifestyle, emotions and behaviour. And we accept that a piece of information may have ongoing use if it becomes clinically relevant in the future, long after it was initially collected.

This code of practice recognises those expectations that health information should be treated differently. It applies specific rules to agencies in the health sector to better ensure the protection of individual privacy. With respect to health information collected, used, held and disclosed by health agencies, the code substitutes for the information privacy principles in the Privacy Act.”
New Zealand legislation and related codes

“The rules in the code might be summarised as follows:

1. Only collect health information if you really need it.
2. Get it straight from the people concerned.
3. Tell them what you’re going to do with it.
4. Be considerate when you’re getting it.
5. Take care of it once you’ve got it.
6. People can see their health information if they want to.
7. They can correct it if it’s wrong.
8. Make sure health information is correct before you use it.
9. Get rid of it when you’re done with it.
10. Use it for the purpose you got it.
11. Only disclose it if you have a good reason.
12. Only assign unique identifiers where permitted.

Put like that, the rules can be seen for what they are – a straightforward and sensible blueprint for the management of people’s information. There are, of course, many important complexities that need to be understood; the rules themselves should always be studied carefully before attempting to apply them.

These rules are enforceable by complaining to my office, and then, if necessary, to the Human Rights Review Tribunal. There may be financial and other consequences for agencies that breach the rules, so it is important that they are studied and complied with by those working in the health sector.”
New Zealand legislation and related codes

The following is an extract from the Introduction to the Code (2008 Edition, p 3):

“The code applies to health information relating to identifiable individuals. This means that while it covers, for example, information about an individual’s medical and treatment history, disabilities or accidents, contact with any health or disability service providers and information about donations of blood or organs, it does not apply to anonymous or aggregated statistical information where individuals cannot be identified.

The code applies to all agencies providing personal or public health or disability services from the largest hospitals through to sole health practitioners. It covers, for example, primary health organisations, district health boards, rest homes, supported accommodation, doctors, nurses, dentists, pharmacists and optometrists. It also applies to some agencies that do not provide health services to individuals but that are part of the health sector, such as ACC, the Ministry of Health, the Health Research Council, health insurers and professional disciplinary bodies.

Health agencies and individual practitioners will need to ensure that their internal operational procedures comply with the code, for instance in the design of computer systems and the use of forms and internal procedures relating to the collection, use and disclosure of health information. Staff briefing or training will be an essential element of operational procedures. Compliance with privacy obligations is an integral part of good information handling procedures, and is closely linked to good clinical practice.

A number of health agencies and practitioners subject to this code must also comply with the Code of Health and Disability Services Consumers’ Rights and their own professional ethical obligations. In many cases these ethical requirements may be even more stringent than the legal obligations imposed by this code.”
New Zealand legislation and related codes

“The principles of informed choice and consent relating to autonomy, responsibility and accountability should also be borne in mind in the provision of health and disability services. Those principles accord with many of those expressed in this code. However, there is an important distinction between the need to obtain informed consent and the obligation for health agencies to be open about the purpose for which they collect and hold health information. Guidance on that code and matters of informed consent can be obtained from the Health and Disability Commissioner’s office.”

The Commentary to Clause 4 of the Code explains (at p 11):

“The code applies only to health information about identifiable individuals. Health information, as defined in the code, includes disability information (for instance, information collected as part of a needs assessment process). Incidental information obtained in connection with the provision of health services and that identifies the individual is also covered. The code does not apply to employee information. However, the health sector must comply with the provisions of the Privacy Act as it relates to employee information. Employees may exercise their rights, for instance to seek access to their personnel records, under the relevant parts of the Privacy Act…

The main agencies to which this code applies are those providing health or disability services such as health professionals, hospitals, ambulance services and rest homes. Also covered are agencies that no longer provide health services, but still hold information from the time when they did…”
New Zealand legislation and related codes

A health agency is responsible for the actions of those working for it, whether paid or unpaid, except where the person concerned was clearly acting outside his or her authority or instructions. Health agencies need to train their workers in their responsibilities under the code – it is possible that both agency and worker will be liable for an interference with privacy.”

Summary
As an employee of a health or disability service, you are required to follow the requirements of the Health Information Privacy Code 1994.

The simplest way to remember the main points from the Health Information Privacy Code 1994 is to recall the words of the Privacy Commissioner in her Foreword:

“The rules in the code might be summarised as follows:

1. Only collect health information if you really need it.
2. Get it straight from the people concerned.
3. Tell them what you’re going to do with it.
4. Be considerate when you’re getting it.
5. Take care of it once you’ve got it.
6. People can see their health information if they want to.
7. They can correct it if it’s wrong.
8. Make sure health information is correct before you use it.
9. Get rid of it when you’re done with it.
10. Use it for the purpose you got it.
11. Only disclose it if you have a good reason.
12. Only assign unique identifiers where permitted.”

It is recommended that you obtain and read a copy of “On the record – A practical guide to health information privacy” (2nd ed.) from the Office of the Privacy Commissioner. It is available at: http://www.privacy.org.nz/assets/Files/2206963.pdf. This resource outlines each of the rules in the Code, with examples that demonstrate how the Code should be applied by workers in health and disability services."
Think about the role and responsibilities of the diversional therapist when planning and providing activities for people accessing a health care service or facility.

Consider the rights of the older person as set out in the International Federation on Ageing Declaration on the Rights and Responsibilities of Older Persons.

Think about the 12 principles in the Privacy Act 1993 and the requirements of the Health Information Privacy Code 1994 as they relate to the personal information of people receiving health and disability services.

Now complete the questions below, explaining how a diversional therapist could ensure that people’s rights are respected when planning and running a programme of activities.

**Right 8 (Participation)** of the International Federation on Ageing Declaration on the Rights and Responsibilities of Older Persons states that older people have:

“The right to share their knowledge, skills, values and life experience with younger generations.”

How could the diversional therapist ensure that people in the programme have the opportunity to do this if they choose to?
The International Federation on Ageing Declaration on the Rights and Responsibilities of Older Persons (Section 16) states that older people have the right:

“To pursue opportunities for the full development of their potential.”

How could a diversional therapist assist a person to achieve his/her potential?
The International Federation on Ageing – Declaration on the Rights and Responsibilities of Older Persons Section 17 states that an older person has the right:

“To access the educational, cultural, spiritual and recreational resources of society.”

How could a diversional therapist ensure that a person had access to his/her cultural resources?
The Privacy Act 1993 and the Health Information Privacy Code 1994

What are the important points in the Privacy Act 1993 and the Health Information Privacy Code 1994 that you would explain to a person before recording his/her personal details or social history?
Where would you interview a person for his/her personal details or social history?

Where would you keep the person’s personal details or social history?
New Zealand legislation and related codes

Mental Health (Compulsory Assessment and Treatment) Act 1992

The Mental Health (Compulsory Assessment and Treatment) Act 1992 was passed following a review of earlier legislation. The new Act included provisions to ensure that people using mental health services have their rights recognised and respected.

What are Patient Rights?

Right One: The right to information
Right Two: Respect for cultural identity
Right Three: The right to an interpret
Right Four: The right to appropriate treatment
Right Five: The right to be informed about treatment
Right Six: The right to refuse video recording
Right Seven: The right to independent psychiatric advice
Right Eight: The right to legal advice
Right Nine: The right to company
Right Ten: The right to have visitors and make telephone calls
Right Eleven: The right to send and receive mail

Please note that these rights are in addition to the rights that the person has under the Code of Health and Disability Services Consumers’ Rights.

The Act sets out eleven patient rights. These rights apply as soon as a person becomes a patient or proposed patient under the Act. A person becomes a proposed patient when an application is made to have that person assessed under the Act. The person becomes a patient during the first period of assessment.
Right One – The Right to Information

Once you become a patient under the Act, you have a general right to information. This information includes:

- A statement listing your patient rights.
- Information about your legal status. In other words, whether you are:
  - Under compulsory assessment or treatment (meaning you must receive treatment); or
  - Not under compulsory assessment or treatment (meaning you are free to go).
- Information about your treatment, including any likely side effects and the expected benefits of the treatment.
- Information about your rights to have your condition reviewed.
Right Two – Respect for Cultural Identity

This is a very important right. Many inquiries have found cultural insensitivity in mental health services. This right acknowledges that different cultures have different needs and beliefs, and that these needs and beliefs must be taken into account when you are being assessed or treated under the Act.

The Act says you must be treated with:

- Proper respect for your cultural and ethnic identity, language and religious or ethical beliefs; and
- Proper recognition of the importance to you of your ties to your family, whānau, hapū, iwi and family group. For some people, having family or whānau involved in their care and treatment will be very important to their well being.

This right could also include:

- Having the opportunity to speak in your own language.
- Having people from your whānau and/or culture involved in your care and treatment.
- Health professionals understanding and taking into account your cultural beliefs when looking at diagnosis and treatment options.

The Ministry of Health recommends that every non-Pākehā admitted for assessment under the Act be given the opportunity to have a cultural assessment if he/she wishes.
Right Three – The Right to an Interpreter
If you are being assessed or treated under the Act and English is not your first or preferred language, you have the right to an interpreter.

Even if you can speak and understand English you can ask for an interpreter if you would rather communicate in another language, for example Māori or New Zealand Sign Language.

Right Four – The Right to Treatment
Whenever you are being assessed or treated under the Act you have a right to appropriate treatment – treatment of a professional standard that will benefit your condition. The treatment does not have to cure your condition but should at least relieve your symptoms or stop you from becoming more unwell.

If you are being treated in hospital you must be given the same level of treatment and care as a patient being treated for a physical illness.

Right Five – The Right to be Informed about Treatment
Before any treatment is started you are entitled to receive an explanation about the benefits and likely side effects of that treatment.

Even when your consent to that treatment is not required you must still be given information about it. The information should be in a form that you can understand and should be repeated if necessary. The Ministry of Health suggests that information be provided both verbally and in writing.
New Zealand legislation and related codes

**Right Six – The Right to Refuse Video Recording**
Your responsible clinician can only tape or record any part of your treatment if you consent to this process (this condition applies to video and audio recording). If you are too unwell to consent, your principal caregiver could provide consent on your behalf.

Taping or videotaping your treatment without your consent may also be a breach of your rights under the Health Information Privacy Code.

**Right Seven – The Right to Independent Psychiatric Advice**
If you are being assessed or treated under the Act and you are unhappy with your diagnosis or treatment you can ask an independent psychiatrist for a second opinion.

If you want a second opinion you can choose the psychiatrist (provided he/she willing to see you). Usually the hospital will be able to provide someone within its own service to give you a second opinion. If you want a second opinion from an independent psychiatrist you may have to pay. The hospital must allow the second psychiatrist to visit you.

**Right Eight – The Right to Legal Advice**
You have a right to a lawyer to give you advice about the Act and to represent you at hearings, reviews and appeals. If you don’t have a lawyer, staff at the hospital or a district inspector should help you find one.
New Zealand legislation and related codes

Right Nine – The Right to Company
When you are being assessed or treated under the Act you have a general right to the company of other people.
You can only be isolated or put into seclusion if this is necessary for your treatment or safety, or for the protection of others.

Right Ten – The Right to Have Visitors and Make Telephone Calls
You have the right to visitors and to make telephone calls. For example, if you are in hospital for compulsory assessment you may need to contact family or friends to make personal arrangements.

Right Eleven – The Right to Send and Receive Mail
While you are a patient under the Act you have the right to send and receive mail.
Hospital staff should not open your mail.
The Third Age


“The Third Age refers to the developmental life stage that Peter Laslett (1991) defined as beginning with retirement and ending with dependence. Laslett’s four ages of human experience defined by task, agenda, and perspective rather than by age, suggest a ‘radical revision of our attitude to ageing and achievement’. Among Laslett’s four ages, the third is most notable because it has not been previously identified or defined.

Current population studies highlight the discrepancy between the traditional retirement age of 60-65 and the reality of continued health and vitality well into their 80s (Laslett 1991, 1997). The Third Age releases older adults from the burden of work and frees them to follow their dreams, to choose a more satisfying type of work, or to find creative and meaningful leisure pursuits. Older theories of adult development focus on acceptance of loss and preparation for death. Laslett’s Third Age offers a positive and hopeful outlook to today’s retirees.”

<table>
<thead>
<tr>
<th>Age</th>
<th>Description</th>
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<tbody>
<tr>
<td>First Age</td>
<td>Childhood, dependency, socialisation, education, little responsibility.</td>
</tr>
<tr>
<td>Second Age</td>
<td>Maturity, independence, familial and social responsibility, earning a living.</td>
</tr>
<tr>
<td>Third Age</td>
<td>Retirement, crown of life, personal achievement and fulfillment.</td>
</tr>
<tr>
<td>Fourth Age</td>
<td>Dependency, disengagement, physical frailty, spirituality, preparing for death.</td>
</tr>
</tbody>
</table>
Diversional therapy

History of the New Zealand Society of Diversional Therapists

The following excerpt (pages 53 to 60) is taken from *The History of the New Zealand Diversional Therapy Society* (Christchurch: The New Zealand Society of Diversional Therapy Inc, 2005). The excerpt has been lightly edited for purposes of consistency of language, style and formatting within the various sections of this Resource Book for Readings.

During 1989 and 1990 various diversional therapists from the Waikato, Rotorua and Tauranga areas met to discuss how diversional therapists “fitted” into the system of providing motivational and recreational activities for people (particularly elderly people) who were in care.

These discussions resulted in a special meeting being called at Waiairiki Polytechnic, Rotorua in June 1992. Thirty-one people attended this meeting, at which two key proposals were presented:

• That an Incorporated Society be formed to work towards promoting the interests of diversional therapists.
• That a training course be established to provide a recognised qualification for diversional therapists.

It was felt that these steps were needed because there were many people performing the same tasks with and for clients. But these people held different titles; worked from different job descriptions; received different treatment and acknowledgement in their workplaces; and were generally uncertain as how best to direct their efforts.

The proposals were accepted, resulting in the New Zealand Society of Diversional Therapists becoming officially registered on 18 September 1992 as an Incorporated Society under the Incorporated Societies Act 1908.

Strong support from Manawatu Polytechnic and tutor Judith Beaver resulted in a forum being convened in Palmerston North in late September 1992. From this forum a steering committee was formed with the purpose of developing a national body, which would seek representation from all regions of New Zealand.

The first national seminar and AGM were held in Hamilton on 27 February 1993. At this seminar, the Society’s first membership badge was presented.
Diversional therapy

This interpretation of this badge is as follows:

We strive:
- For better quality of life for older adults.
- For our own satisfaction in a job done to the best of our abilities.
- To improve constantly on what we have done.

Rays of the sun:
- We try to spread “sunshine.”

Tree branches:
- We provide an umbrella for all to shelter under.

The roots:
- We are influenced by our roots, where we have come from and what we have done. We also need to recognise where our clients have come from and what they have done.

An important task for the Executive Committee elected at this seminar was to form an advisory group of selected health professionals representing all areas of the industry, as required by the New Zealand Qualifications Authority (NZQA). The purpose of this advisory group was to lead the development of a national training course. This group first met in December 1993.

The Executive Committee also established a national quarterly newsletter for distribution to all members. This newsletter was intended to keep members informed of developments within the Society as well as to provide news of activities and events from regional support groups.

At this point, a definition of diversional therapy was written.

“Diversional therapy is a professional practice which recognises and facilitates purposeful recreational leisure and pleasure activities with individual client choice to increase the physical, intellectual, spiritual and emotional well-being of older people in supportive environments.”

During February and March of 1994 and 1995, seminars were again held in Hamilton. As a result of these seminars and with the continuing work of the Executive members, the year 1995 brought some significant changes to the Society.
Many issues were finalised, and progress was made towards establishing the professionalism of the Society and increasing awareness of diversional therapy as an active profession. The main achievements during this year included:

- Membership forms were formalised.
- A formal letterhead was approved and stationery printed.
- The *Code of Ethics* was approved, written up, printed and sent out to members.
- Publicity brochures and posters were printed and distributed throughout New Zealand.
- The *Standards of Practice for Diversional Therapists* was finalised
- The NZSDT became a member of “Enhancing Potential” Industry Training Organisation.
- Judy Cooper, President of NZSDT and members of the Executive continued to meet with representatives of polytechnics and education providers to discuss a NZSDT qualification for diversional therapists, and the delivery of the courses.

The Executive Committee reached the decision that the NZSDT should be responsible for an annual two-day conference, to replace the forum previously arranged by the Manawatu Polytechnic and the annual one-day AGM/seminar convened by the Society.

The first of these two-day conferences was held in Upper Hutt in March 1996.

Of significance at a later conference that year was the official announcement that the National Certificate in Diversional Therapy had been registered on the National Qualifications Framework on 20 August 1996.

Also of significance was approval of the following documents by the Executive Committee on 25 August 1996:

- Membership
- National Society’s responsibility to members
- Regional group
- Resource provision
- General
- Fundraising
- National newsletter
- Policy and procedure review
Another milestone was the production and availability of the NZSDT Members’ Handbook from April 1997. The Contents of this Handbook included:

- The Society’s philosophy
- The NZSDT’s role
- Members’ policy
- Members’ responsibilities
- Membership information
- The Code of Ethics
- The Standards of Practice of the New Zealand Society of Diversional Therapists
- The Constitution and Rules (which were amended in June 1998 and again in 1999)

By April 2000, the National Certificate of Diversional Therapy had increased from 91 to 121 unit standards at Level Four on the National Qualifications Framework. Also at this time the Society’s Patron, Judy Cooper, received the CNZM (Companion of the Order) in the Queen’s Birthday honours for her services to the elderly and to education.

At the 2001 conference in Wellington it was decided that trainees should be members of the Society for two continuous years before being eligible to access the qualified badge and certificate.

The 2002 conference in Christchurch saw the following changes:

- A contract which was signed by the Community Support Services Industry Training Organisation, Motivational Therapy NZ Ltd, and the Society in June 2001, was re-signed in April 2002.
- A five-year Strategic Plan for the Society was formulated and accepted by the Executive in December 2001.

A society website was launched in August 2001: www.diversionaltherapy.org.nz

This website address was later changed to: www.diversionaltherapy.net.nz
The Society's philosophy was amended to add the words “cultural”, “psychosocial” and “sexual.”

The Society’s Standards of Practice, Standard One added the following aim:

“The Diversional Therapist is accountable for ensuring that the physical, intellectual, psychosocial, cultural, spiritual, sexual and emotional needs are met”.

The Constitution included a new clause as follows:

**REGISTRATION**

**9. QUALIFIED BADGE/REGISTRATION**

1. The Qualified Badge belongs to the Society and shall be issued when all documentation is received and approved.

2. A Member may be issued with the Qualified Badge, which does not constitute Registration status.

3. Registration of a Qualified Diversional Therapist will be accepted in accordance with the procedure set out in the Registration Handbook which may be subject to change from time to time and will be published.

The rule book was numbered accordingly.

A Mission Statement was agreed upon: “To improve the Quality of Life of the People in our care through Diversional Therapy”.

Liability insurance was investigated and approved by the Executive for the Society.

The Society logo was registered as copyright for the Society.

A professional accountability document was drawn up and accepted by the Executive and distributed to all Members and interested groups.
At the conference convened at Wellington in May 2005 the following amendment was made to the Constitution:

a. A new executive shall be elected at each Annual General Meeting of the Society and shall take office at the conclusion of the meeting.

b. Nominations for the executive must be submitted in writing to the Secretary at least six weeks prior to the date of the Annual General Meeting.

c. The Secretary shall circulate the list of nominees to the Members four weeks prior to the Annual General Meeting.

d. In the event that insufficient nominations are received in writing 6 weeks prior to the Annual General Meeting and/or in the event that the persons nominated in writing 6 weeks prior to the meeting do not receive sufficient votes to be elected, nominations may be taken from the floor.

By December 2005, significant changes were being made to the national qualification. A report on the review of the qualification follows and is printed verbatim:

UPDATE ON QUALIFICATION REVIEW AND TRAINING Dec 2005

The review process is slowly winding down and after months of meetings, emails and phone calls we are coming to a stage where we now have some idea as to what our “new” qualification will look like and options available to Diversional Therapists. Your Diversional Therapy Standards Setting Team has been working very hard on your behalf, networking, re-writing unit standards and packaging. NZQA requirements have changed considerably since the last review a few years ago, which has made it a whole new ball game.

We hope to be able to publish details of the “new” Diversional Therapy Certificate in the first newsletter for 2006, and trust that you will all be happy with the changes that have been made, many of which we had no control over. Funding is no longer available for large qualifications like we currently have, but is this best for our candidates? A staircase qualification that is achievable and affordable for all is what we have been working on.
Some of you were, and still are, concerned that the qualification that we fought so hard for many years ago would be down-graded, and with it our unique identity. We can re-assure you that this has been foremost in our minds throughout the review process. Many of our “older” and now past members, fought long and hard to ensure there was a definite separation of your role from that of other workers. However, we also had a responsibility to ensure the packaging of any new qualification equipped you with the skills and knowledge to venture out of aged care if you so desired, and into other exciting areas.

Your “new” qualification will give you more choices and options. During the review process, and even prior to that, it was becoming very obvious that Diversional Therapists were being asked to work in other areas of disability, not only within residential care facilities but also in the community. This was a priority factor in packaging your “new” qualification.

The increase in people accessing training, the increase in qualified Diversional Therapists applying for registration, the increase in membership of the NZ Society of Diversional Therapists Inc, and the increase in attendees at our National Conference most definitely highlights industry support of your role and your training.

2005 has seen a steady growth of Diversional Therapists working outside aged care facilities. We now have Diversional Therapists in day cares, working in head injury organisations, working with the intellectually disabled, working with the physically disabled, and those with mental health problems. The focus is slowly shifting to the community and we have several Diversional Therapists working in this area.
Support workshops for candidates in training with CSSITO and professional development workshops to support those who are qualified and in training, continue to be much sought after. 2005 has seen over twenty specialist workshops facilitated nationally. Demand has ensured that further workshops, covering identified topics, have already been planned for 2006 and notification of these will be in the next newsletter. Your local Support Groups will also be asked to contribute.

Before the end of the year, all candidates in training will receive a list of Diversional Therapy Support Workshops for your area for 2006. This will also include Human Services Workshops. We also have eleven assessors who are registered to assess a majority of the Support of the Older Person units and the Dementia unit. You will be given contact details of these assessors as well.

Conclusion
From 2005 until now in 2009, the discussions and challenges have continued around ensuring that a meaningful qualification for diversional therapists is retained. The trainees presently undertaking study to gain this qualification should understand that the qualification exists in its current form only because of the commitment and dedication of diversional therapists who are truly and totally committed to this profession.
Occupational therapy

Occupational Therapy Code of Ethics

The Occupational Therapy Code of Ethics presents standards of conduct expected of all occupational therapists registered to practise in New Zealand. This Code is reproduced as it appears on the occupational therapy website.

Relationship with Recipients of Occupational Therapy Services

1 Occupational therapists shall respect the autonomy of consumers receiving their service, acknowledging the consumers’ roles in family/whanau and society, and sharing power and decision making wherever practically possible. Occupational therapists shall:

1.1 have the needs of the consumer as the focus of their practice.

1.2 work with consumers to determine goals and priorities, involving family/whanau/significant others if this is the consumer’s choice. Situations in which consumer choice is overridden, e.g., for reasons of safety, should be clearly documented, including a transparent reasoning process.

1.3 work in ways that are compatible with consumers’ culture to assist them to achieve desired outcomes.

2 Occupational therapists shall ensure that people receiving their services feel safe, accepted, and are not threatened by actions or attitudes of the therapist. Occupational therapists shall:

2.1 accept referrals for which they have the professional skills and resources to meet the consumers’ need. The reason for non-acceptance of any referral will be explained.

2.2 not enter into or continue with any relationships (personal or professional) with consumers or their carers that will, or have the potential to, exploit or harm the consumer and/or their family/whanau.

2.3 respect the consumer’s right of refusal for services, involvement in research, or educational activities.

2.4 protect the confidential nature of consumer information gained through professional contact, within the limits prescribed by the Privacy Act 1993, and in accordance with local policies and procedures.
Occupational therapy

3 Occupational therapists shall demonstrate that the dignity, privacy, safety, health and concerns of people receiving their services are important and respected. Occupational therapists shall:

3.1 acknowledge the holistic nature of each individual and practise with due care and respect for diverse consumer culture, needs, values and beliefs.

3.2 ensure consumers are able to make informed choices and give informed consent in writing, except where any enactment, the Code of Health and Disability Services Consumers’ Rights, or common law provides otherwise, before commencement of any occupational therapy intervention/service, or consumer participation in studies or research. In situations where consumers have diminished competence, the occupational therapist shall be guided by the Code of Health and Disability Services Consumers’ Rights. In relevant situations, the occupational therapist shall seek consent from the family/whanau prior to the commencement of occupational therapy interventions or participation in studies or research.

3.3 base intervention on the best available information, both current and historical.

3.4 accurately record/report consumer information and interventions to facilitate the care, treatment and support of consumers, relevant to the context.

3.5 ensure all care is taken to maintain confidentiality of records, including electronic communication.

3.6 protect consumers by ensuring that duties assigned or delegated to other occupational therapy personnel are commensurate with their qualifications and experience.

3.7 ensure formal supervision is provided for other occupational therapy personnel (including registered occupational therapists, occupational therapy assistants/instructors and students) for whom she or he is responsible.

3.8 receive effective professional supervision relevant to the work setting.
Occupational therapy

4 Occupational therapists shall prioritise the allocation of available resources to achieve the best possible outcome for consumers. Occupational therapists shall:
4.1 use a coherent, robust, and transparent rationale to prioritise the allocation of service and resources.
4.2 advise key personnel (e.g., managers, other service providers, consumers, and their family/whanau) when resources are insufficient to allow for safe and adequate service provision.
4.3 document unmet needs, and actions taken to address these.

Relationship with Society and Potential Consumers

1 Occupational therapists shall accurately represent their skills and competencies. Occupational therapists shall:
1.1 accurately represent their skills and areas of competence to potential consumers (including employers), whether those services are to be provided directly or indirectly. An area of competence will be supported by demonstrable training, knowledge, experience and skill.
1.2 only provide services and use techniques in which they are qualified and competent.

2 Occupational therapists shall ensure their fee structure is fair and reasonable. Occupational therapists shall:
2.1 charge fees which are a fair reflection of services delivered both to individual consumers and organisations with whom they have contracts for service.
Relationship with Colleagues and the Profession

1 Occupational therapists shall practise within the boundaries of their experience, training, and competence. Occupational therapists shall:
1.1 accurately represent their experience, training, and competence to colleagues
1.2 identify when consumer needs fall outside their scope of competence, and take appropriate action e.g. consult with other persons/access other resources when additional knowledge and expertise are required, refer consumers to other team members or to other services available.

2 Occupational therapists shall support the maintenance of occupational therapy standards of practice. Occupational therapists shall:
2.1 be responsible for actively maintaining and developing their personal professional competence.

2.2 practise according to documented standards relevant to their work area.
2.3 recognise when personal psycho-emotional and/or physical health may compromise their service to consumers, and take appropriate remedial action.

3 Occupational therapists shall not bring the profession or other health practitioners into disrepute. Occupational therapists shall:
3.1 uphold and foster the values, integrity, and ethics of the profession.
3.2 identify and report any breach of this Code of Ethics to the Occupational Therapy Board for investigation.
3.3 take due care, and act with integrity not to undermine or defame another health practitioner’s professional reputation.
3.4 disclose any affiliation that may pose a conflict of interest or interfere with good practice. In a situation where a conflict of interest is identified, the occupational therapist will ensure the conflict is satisfactorily addressed.
3.5 refrain from using, or participating in the use of, any form of communication that contains false, fraudulent, deceptive or unfair statements or claims.

3.6 if offered tokens such as favours, gifts or hospitality from consumers, their families or commercial organisations, always respond in a manner commensurate with contextual guidelines and accepted practice, the intent of the donor, and best therapeutic outcome.

4 Occupational therapists shall acknowledge and respect other colleagues. Occupational therapists shall:

4.1 acknowledge and support other colleagues whose culture, values and beliefs may be different from their own.

4.2 respect the needs, practices, special competencies and responsibilities of their own and other professions, institutions and statutory and voluntary agencies that constitute their working environment.
Competencies for Registration as an Occupational Therapist

The following Competencies are reproduced with the same wording – but in a different format – as they appear on the occupational therapy website.

COMPETENCY – Implementation of Occupational Therapy

OUTCOME: the entry level practitioner will:
Facilitate & enable occupations for people through engaging their needs, preferences & capacities in the context of their environment to optimise ability & functional independence.

PERFORMANCE CRITERIA

1.1 Establish the need for, & the role & function of, occupational therapy in partnership with the client/tangata whaiora.

1.2 Negotiate mutually agreed, prioritised goals.

1.3 Acknowledge client/tangata whaiora values, beliefs, attitudes & practices.

1.4 Use current theory, evidence, & sound clinical reasoning to inform best occupational therapy practice.

1.5 Identify contra-indications & consequences of intervention.

1.6 Demonstrate understanding of perspectives of occupation as a core modality.

1.7 Use meaningful occupations to achieve, maintain, or enhance performance components, skills, habits, & roles of the client.

1.8 Identify opportunities to use the client’s/tangata whaiora actual occupation & environment to enhance occupational therapy interventions.

1.9 Identify the effect of environmental factors on the client’s/tangata whaiora function & dysfunction.

1.10 Demonstrate understanding & uses of the occupational therapy process.

1.11 Select, analyse, structure, synthesise, adapt & grade activities/occupations to achieve client/tangata whaiora goals.
1.12 Demonstrate competent use of a range of appropriate assessment techniques as a base for intervention.

1.13 Safely use relevant, approved techniques & technology.

1.14 Use a systematic problem solving approach.

1.15 Identify need to change or modify occupation or environment.

1.16 Adapt & prescribe occupations, techniques & equipment relevant to client/tangata whaiora need.

1.17 Assist/enable the client/tangata whaiora to access appropriate resources.

1.18 Promote health practices, attitudes, & environments which contribute to occupational well being.

1.19 Evaluate outcomes & client/tangata whaiora satisfaction & modify interventions accordingly.

1.20 Seek feedback from clients/tangata whaiora to evaluate safe and effective practice.

1.21 Identify the appropriate end point of intervention.
Occupational therapy

COMPETENCY – Safe, Ethical, Legal Practice

OUTCOME: the entry level practitioner will:

Act, & justify actions, in compliance with ethical, legal, professional & safety requirements.

PERFORMANCE CRITERIA

2.1 Comply with the Health Practitioners Competence Assurance Act 2003.

2.2 Comply with the Code of Ethics for Occupational Therapists in NZ (2004).

2.3 Comply with all other relevant legislation, regulations, codes (eg Health & Disability Code of Rights, & Privacy Code), service standards, & professional guidelines.

2.4 Attend to safety of client/tangata whaiora, self, & others.

2.5 Respect privacy & maintain confidentiality.

2.6 Recognise when privacy & confidentiality cannot be upheld and act appropriately.

2.7 Recognise when there is a conflict of interest & refer client/tangata whaiora on to an appropriate service or support.

2.8 Provide occupational therapy services that recognise principles of social justice.

2.9 Provide occupational therapy services that enable & empower clients/tangata whaiora & enhance their participation.

2.10 Professionally present, record & report information.

2.11 Comply with basic health & safety procedures (eg First Aid, CPR) relevant to setting.
2.12 Use ethical reasoning to make and justify decisions on ethical issues in practice.

2.13 Seek appropriate guidance to resolve ethically challenging issues.

2.14 Conduct ethically sound & safe therapeutic relationships.

2.15 Participate in a continuous quality improvement approach to contribute to the safety of practice.

2.16 Demonstrate awareness of the scope & limitations of occupational therapy & own knowledge & skills.
OUTCOME: the entry level practitioner will:
Provide a service that takes into account the socio cultural values of the client/tangata whaiora, family/whanau & significant others.

PERFORMANCE CRITERIA

3.1 Demonstrate understanding of the complexity of culture.
3.2 Recognise the multiple realities & identities people bring to the practice context eg, gender, ethnicity, religious belief, sexual orientation, ability, life stage.
3.3 Demonstrate understanding of power dynamics in therapeutic contexts & foster opportunities for clients/tangata whaiora to maximise self advocacy skills.
3.4 Demonstrate awareness of the cultures of occupational therapy & their potential impact on the person.
3.5 Identify personal significant cultural values, beliefs, attitudes, & prejudices & understand their potential impact.
3.6 Recognise own level of cultural safety, consult & refer on where indicated.
3.7 Identify & safely respond to client / tangata whaiora values, beliefs, attitudes & practices.
3.8 Recognise & respect the uniqueness of the individual in the context of their community.
3.9 In consultation with the client/tangata whaiora, identify & work in partnership with resources of family/whanau, community, & significant others.
3.10 Ensure intervention is guided by reflective practice.
3.11 Action Treaty of Waitangi partnership responsibilities, liaising & developing relationships with local iwi & Maori health, welfare & education workers.
3.12 Respond appropriately in situations where cultural difference may be an issue.
Occupational therapy

COMPETENCY – Communication

OUTCOME: the entry level practitioner will:
Use a range of communication skills to establish & maintain effectual therapeutic & working relationships.

PERFORMANCE CRITERIA

4.1 Use a range of communication skills.
4.2 Adapt style & method of communication to suit the individual client/tangata whaiora.
4.3 Assist the client/tangata whaiora to identify & communicate his/her own needs.
4.4 Identify cultural differences & their potential impact on communication.
4.5 Facilitate the teaching-learning process in a variety of occupational therapy settings.
4.6 Responsibly share knowledge.
4.7 Communicate all relevant information to colleagues & consumers in a timely manner.
4.8 Develop effective & co-operative relationships within teams (including multidisciplinary teams) & with other workers & agencies.
4.9 Assess the effectiveness of own communication.
4.10 Demonstrate effective conflict management techniques.
4.11 Present concepts & information clearly using inclusive, unambiguous, gender neutral language.
4.12 Ensure all communications are clear, concise, & accurate, where written are dated & signed, & all conform to accepted standards.
4.13 Demonstrate effective non-verbal communication.
4.14 Articulate own professional opinion & provide substantive rationale.
4.15 Obtain information from, & provide appropriate information to, community & professional organisations.
OUTCOME: the entry level practitioner will:
Manage performance & monitor personal resources to ensure performance is professional, collaborative & supportive of service & team goals & colleagues.

PERFORMANCE CRITERIA

5.1 Function autonomously & work collaboratively with others involved in service delivery to ensure best outcome for client/tangata whaiora.

5.2 Participate in regular individual or peer supervision in a manner which supports ongoing development.

5.3 Comply with current NZ Association of Occupational Therapists Standards of Practice.

5.4 Work within recognised roles, functions & parameters of occupational therapy.

5.5 Articulate, negotiate, & demonstrate the role & function of an occupational therapist within a team.

5.6 Identify the role of support staff & work collaboratively.

5.7 Recognise abilities in colleagues and support them in developing those abilities.

5.8 Provide appropriate support & guidance to staff & allocate tasks where authority has been delegated.

5.9 Manage workload, complete tasks, & meet responsibilities in a timely & goal directed manner.

5.10 Demonstrate professional behaviour & presentation appropriate to the context.

5.11 Assess the effectiveness of supervision, support, & guidance & seek changes as required.
5.12 Use feedback, supervision, support, & guidance to improve own performance.
5.13 Recognise & manage relevant personal health needs to optimise professional & personal functioning.
5.14 Demonstrate networking by forming relationships to enhance professional performance & meet client/tangata whaiora needs.
5.15 Contribute to development of team objectives & share responsibility for team outcomes.
5.16 Promote team functioning by making a positive contribution to the team & by supporting team members.
5.17 Work co-operatively & collaboratively to ensure a consistent approach to attaining common goals.
5.18 Recognise when boundaries between personal & professional roles are compromising therapeutic outcomes.
COMPETENCY – Management of Environment & Resource

OUTCOME: The entry level practitioner will:
Manage the environment to contribute positively to the client’s/tangata whaiora experience & their ability to participate, & ensure effective use of resources.

PERFORMANCE CRITERIA

6.1 Develop & maintain a safe human & non-human environment, with particular attention to management of risk.
6.2 Practise within the required standards, policies & procedures of the work area.
6.3 Demonstrate awareness of service priorities & objectives.
6.4 Adhere to local protocol regarding resource management & utilisation.
6.5 Demonstrate basic understanding of issues of equitable distribution of resources.
6.6 Comply with the local recording, reporting, & data collection systems.
6.7 Demonstrate an understanding of the principles & processes of quality improvement.
6.8 Manage change effectively.
6.9 Demonstrate an awareness of the impact of social & political trends on occupational therapy services.
6.10 Demonstrate understanding of socio-political (or governmental) & organisational decision-making & policymaking processes.
6.11 Promote occupational therapy.
Seek & use opportunities to continually develop professional
knowledge & practice.

PERFORMANCE CRITERIA

7.1 Use & contribute to resources that develop self & the occupational therapy profession.

7.2 Identify own professional abilities & attitudes, strengths, & limitations, & how these affect performance & the service provided.

7.3 Use reflective practice to set goals, utilise resources, & access information to gain the skills & knowledge required in a specific setting to ensure continuing competence.

7.4 Use professional literature as a resource to keep up-to-date with occupational therapy practices and developments.

7.5 Update & review knowledge of occupational therapy theories, techniques, technology & outcomes.

7.6 Utilise opportunities for mentoring in relation to career development.

7.7 Actively participate in local performance development & review processes.

7.8 Demonstrate an understanding of research processes & the interpretation of results.

7.9 Contribute to the occupational therapy body of knowledge by sharing findings with others, both formally & informally.
Notice of Scope of Practice and Related Qualifications Prescribed by the Occupational Therapy Board 2004

Pursuant to Part 2, section 11(1) of the Health Practitioners Competence Assurance Act 2003 ("the Act"), the following notice is given. This notice sets out the scope of practice for occupational therapists as determined by the Occupational Therapy Board under the Act from the commencement of Part 2, section 11 (1) on 18 September 2004.

Title and Commencement
1. This notice may be cited as the Occupational Therapy Board (Scope of Practice) Notice 2004.
2. This notice comes into force on 18 September 2004.

General Scope of Practice:
Occupational Therapist

Occupational therapists are registered health professionals, who use processes of enabling occupation to optimise human activity and participation in all life domains across the lifespan, and thus promote the health and well-being of individuals, groups, and communities.

These life domains include: learning and applying knowledge; general tasks and demands; communication; mobility; self-care; domestic life; interpersonal interaction and relationships; major life areas; and community, social and civic life.

Enabling occupation incorporates the application of knowledge, principles, methods and procedures related to understanding, predicting, ameliorating or influencing peoples’ participation in occupations within these life domains.

Such practice is evidence-based*, undertaken in accordance with the Occupational Therapy Board’s prescribed Competencies and Code of Ethics, and within the individual therapist’s area and level of expertise.
Qualifications for the General Scope of Practice: Occupational Therapist

In order to practise within the General scope of Practise: Occupational Therapist, the person will have a minimum of a bachelors degree in occupational therapy from an accredited educational institution, or qualifications and experience assessed by the Board as equivalent.

_Dated at Wellington this 19th day of August 2004_

JEANETTE SCHLEMMER,
Registrar, Occupational Therapy Board

*Evidence based practice utilises clients’ knowledge of their occupational concerns and circumstances, insights drawn from experience and reflection, and critical appraisal of best available evidence drawn from research, experts and theory to inform practice decisions.*
**Booklist and websites**

**Booklist**

Below is a list of publications which diversional therapists may find of use when planning activities and programmes. These publications should be available from public libraries or could be purchased from book stores.


Booklist and websites

Privacy Resources


Booklist and websites

Websites

International Federation on Ageing Declaration on the Rights and Responsibilities of Older Persons:

http://www.un.org/ageing/un_principles.html or
http://www.ageconcern.org.nz/archive/infocentre/unprinciples

The Diversional Therapy Association of New South Wales:
http://www.diversionaltherapy.com.au

New Zealand Society of Diversional Therapists Inc:
http://www.diversionaltherapy.net.nz/

The New Zealand Association of Occupational Therapists:
http://www.nzaot.com/

Occupational Therapy Board of New Zealand – Kaihaumanu Tūoro o Aotearoa, policies and publications:

New Zealand Legislation (legislation can be browsed for no charge on this website):
Booklist and websites

Privacy Commissioner – Te Mana Matapono Matatapu:
http://www.privacy.org.nz/

Privacy Act Principles:

Health Information Privacy Code 1994:

On the Record – A practical guide to health information privacy:

Health Information Check-up – Know your Privacy Rights:

The Treaty of Waitangi – Te Tiriti o Waitangi. A series of useful booklets is available here:
http://www.nzhistory.net.nz/politics/treaty/treaty-faqs#WherecanIobtainprintedbookletsabouttheTreaty