Editorial: Occupational therapy and the right to occupational participation

Prompted by the Black Lives Matter movement, which resurged in 2020 following the killing of George Floyd by a white US police officer, the World Federation of Occupational Therapists (WFOT, 2020) issued a Statement on Systemic Racism which identified the imperative and obligation for all occupational therapists to address systemic discrimination, oppression and injustices and to promote occupational rights. *Systemic racism* refers to the ways in which structures of policies and practices determine the availability of life chances and occupational choices, embed inequities in all aspects of social, political and economic life and preserve the unearned advantages of white people.

The occupational therapy profession has not been in the habit of examining clients' occupational challenges – or its own practices – as manifestations of oppression and injustice. Indeed, the profession has actively perpetuated the notion that any and all disadvantages confronted by people with impairments are inevitable consequences of their differences from valued norms; that diminished occupational and social participation are inevitable sequelae of impairments. This is not an evidence-informed assumption.

Epidemiological research has demonstrated that the unfair distribution of opportunities to participate in society is not randomly distributed, but produced by social forces and social structures (Marmot *et al.*, 2008). Socially constructed hierarchies that divide people into categories effectively maintain, reproduce and promote ideologies of superiority/inferiority and determine the availability of occupational opportunities. For occupational therapists, it is important to recognize that racism is interlinked with ableism and with cis-genderism: each reflects an ideology that upholds certain bodies as normal, desirable and appropriate; upholds as "natural" the inequitable privileges and opportunities that flow to those with white, able, cis-gendered bodies (and especially to white, male bodies); and effectively marginalizes those who do not conform to these norms. The oppressions of racism, gender binarism, ableism and disablism derive from shared ideological roots.

The term *ableism* refers to social practices that centre and privilege able-bodied forms and that preserve unfair and unearned advantages and opportunities for those "able" to conform to these forms. The term *disablism* refers to the ways in which people with impairments are disabled and disadvantaged by ableism's inequitable social structures and unjust practices (Hammell, 2020). Disability researchers have noted that "persons with impairment are actually disabled when they do not have equal access to essential services, education and health, are deprived of economic opportunities, cannot access the labor market and experience higher multidimensional poverty and lower health related quality of life compared to the rest of the population" (Trani *et al.*, 2018, p. 55).

White, able-bodied, cis-gendered people – like this author – have not earned our socially valued bodies, but we derive significant, unearned advantages and occupational opportunities from our privileged statuses. (Being *cis-gendered* means that the gender I was assigned at birth is the gender with which I have always self-identified). Systemic racism, white supremacy, ableism, disablism, sexism, patriarchy, heteronormativity, gender binarism, caste and classism are manifestations of injustices that contribute to inequitable occupational choices and opportunities and that exert a noxious impact on human health and well-being. These unfair and avoidable inequities are a consequence, not of happenstance, but of complicity. (The term *inequity* refers to differences that are avoidable, unfair and unjust, differentiating these from differences that are simply unequal).

Ableist values shape the practices of occupational therapists, such that patients are exhorted to minimise their bodily deviations from the dominant group's valued norms, strive to attain higher levels of physical function, achieve independence in self-care and become more productive.

Congruent with an ableist ideology, occupational therapy's "standardised" assessments frequently capture information solely pertaining to individuals' inabilities, thus limited occupational participation is inevitably attributed to individual deficiencies. Information derived from such decontextualised assessments is incomplete and potentially misleading. Globally, people with impairments experience disproportionate levels of poverty and inequitable access to education, employment, transportation, buildings, technology, green spaces, arts, cultural, religious, social, recreational and other community resources; injustices that render them are disabled. Moreover, disabled people of colour may restrict their social participation due to fears of systemic racism, and traditional gender roles – not impairments – may constitute the most formidable barrier to occupational participation for disabled women and girls (Trani *et al.*, 2018). Research methods, assessments and outcome measures that are not designed to identify contextual issues may erroneously attribute diminished occupational participation among people with impairments to physical – not attitudinal and structural – barriers, providing a flawed basis for occupational therapy action.

WFOT (2014) has declared that "Occupational therapy contributes to the global health of society and individuals by enabling the right to engage in meaningful, purposeful occupations, irrespective of medical diagnosis, social stigma or prejudice." It is noteworthy that our World Federation did not

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assert the profession's contribution to be the enablement of self-care, productive and leisure occupations, nor the maximization of function and independence, but rather as enablement of the *right* to occupational participation (Hammell, 2020).

Understanding the impact of injustices and inequities on the occupational rights of clients ought to prompt the occupational therapy profession to consider the ways in which our own practices contribute to oppression, pondering, for example, whether *we* ensure that clients can attain the services, access and equipment required to equalize their occupational opportunities or whether we act as resource gatekeepers and collaborators with unjust policies (Hammell, 2020).

Enablement of the *right* to occupational participation requires the occupational therapy profession to contest the ableist norms that so effectively disable people with impairments and commit to acknowledging and addressing the social determinants of occupation, participation, well-being and health.

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