Delivery of paediatric occupational therapy services to urban indigenous children: a pilot project.

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The young health practitioner checks his watch again. He's re-scheduled the Aboriginal woman's appointment twice already. She finally turns up 20 minutes late by which time the next client has arrived. The health worker feels stressed and frustrated.

This is by no means an uncommon scenario among any of the client groups education or health workers might see. However, issues of time and attendance at mainstream health services have been identified as some of the issues commonly associated with providing services to Aboriginal clients.

This paper will report on the results of a pilot project which attempted to identify the issues involved when providing occupational therapy services to Aboriginal children and their families in Brisbane. It will discuss both the issues identified and suggested guidelines for working with Australian indigenous families.

Indigenous families' access to mainstream occupational therapy services.

It has been well documented that indigenous Australians are reluctant to access non-indigenous or ‘mainstream’ health services for a number of reasons (Mobbs, 1991; Mulcaliv, 1992, Saggars, 1993). These may include poor living conditions and socioeconomic difficulties which may result in poor access to transport necessary to attend occupational therapy. There is also a suspicion of mainstream services due to the history of interference of government agencies with indigenous people as exemplified by the ‘stolen generation’ recently at the forefront of Australian politics.

Surveys in the fields of health and education have identified that many professionals are more aware of the impact of unique culture on health care and health care outcomes. There is also an increasing acknowledgment of socio-cultural and historical impacts on Aboriginal ill-health, including loss of land and grief. However, therapists are less aware of the impact of their own culture and that of their profession.

In 1997, the Brisbane Aboriginal and Islander Community Health service identified a need for the development of visiting specialist services to their clients. A pilot project was developed in collaboration with the University of Queensland Occupational Therapy Department and the Aboriginal health service to further investigate the needs of indigenous children from an Allied Health perspective.

The project involved the provision of a visiting occupational therapy service one day a week for 6 months across two school terms. Two pre-schools and two schools were serviced during that time. Children with suspected physical, developmental or learning problems were referred to the service by parents, teachers and occasionally medical personnel. The service was provided in the last term of 1997 and the first term of 1998. The aims of the project were:
• To demonstrate the ongoing need for occupational therapy services to Aboriginal children in Brisbane and
• To provide practice guidelines for occupational therapists and other health practitioners working with indigenous children in urban settings.

A qualitative methodology was chosen. To enable collection of information from a broad range of participants, the data consisted of the following:

Firstly, an evaluation of the visiting occupational therapy service. This consisted of surveys, focus groups or interviews with parents, teachers, teachers aides and liaison workers from each pre-school and school. Issues of satisfaction with the service, preferred models of consultation and perceived value from the service were discussed.

Secondly, a survey of occupational therapists working with children in mainstream settings in Brisbane over the same six months period. This included therapists working in health, education, private practice and other specialist services. Information about numbers of Aboriginal children who accessed the service and issues occupational therapists encountered when working with Aboriginal children and their families was sought. Participants were also invited to comment about their opinions of what would constitute best practice when working with these clients.

In addition, in-depth interviews were also conducted with two occupational therapists working in remote area Aboriginal and Torres Strait Islander communities in Queensland using the same question guide as that presented to Brisbane occupational therapists. This enabled for greater diversity of information as well as consulting "expert" opinion of occupational therapists known to be working with indigenous children.

Data from these different sources were verified by comparing information gained from a variety of participants in a variety of settings; a process known as triangulation. Where similar themes emerged from these different data sources, the findings were considered to be credible.

To check the themes developed from an indigenous perspective, I reported back to an independent indigenous academic who had extensive experience in the area of education. He was then able to comment on issues encompassed by these themes and offer opinions on the relative strength of themes.

Obviously, the information gathered is too large to be presented in this setting. I will therefore summarise the major issues identified by occupational therapists in both Brisbane and North Queensland. I will then discuss strategies and practice guidelines developed from all data sources.

Issues in occupational therapy service provision

Socio-economic environment
Therapists identified a number of issues related to the socio-economic status of many Aboriginal clients. These included difficulty accessing transport, poor nutrition, the loss of meaningful occupation and resulting social problems such as alcoholism and dependency on welfare. These factors not only impacted on access to their services
but potentially impacted on children's development.

**Socio-cultural environment**
Therapists identified that their Aboriginal clients often had different values from their own including the concept of time. For example, Aboriginal people may not attend an appointment on time due to other family obligations, or a different understanding of time which is more related to general morning or afternoon periods of time rather than rigid appointment times. Differences in family situations including the role of extended families and the impact of foster care were also seen as issues in providing therapy.

**Factors intrinsic to the child and family**
Some therapists acknowledged the issue of ‘shame’ for Aboriginal families, for example, the shame of being singled out and having to see a non-indigenous person in a non-indigenous environment. There was also a general awareness that many Aboriginal families did not know what an occupational therapist was or what she could offer (although this is not particularly different from the rest of the population!).

**Relationship factors**
It was generally acknowledged by both therapists and the Aboriginal people interviewed, that the development of an effective relationship was crucial to the success of intervention. Some of the factors that impacted on this were differences in communication style. Also significant are the consistency of the therapist over time and the difficulty in contacting a child's parents especially when a therapist works in school-based services.

There were also several issues identified which impacted on service provision.

**Service provision issues**

**Logistics**
Therapists identified issues related to attendance, follow-up and care of equipment as impacting on therapy and its actual rate of success. Some therapists reported they had previously had a policy of prioritising Aboriginal clients. However with little attendance on the part of these clients, they had come to feel it was difficult to do this in light of heavily demanded services and long waiting lists. Others noted that in any case there was generally a lack of referrals of Aboriginal children to their services.

**Service delivery design and issues**
Some therapists acknowledged that there was an inappropriate service delivery design for Aboriginal clients in their service. Others felt that resource and financial limitations hindered their ability to provide a more flexible model of service delivery. Many therapists also acknowledged they felt limited by the current assessment tools available to them due to an absence of consideration of indigenous culture in the design of these tools.

**Factors intrinsic to the therapist**
Whilst therapists readily identified that their indigenous clients held different values from their own, none of the therapists in Brisbane who responded to the survey acknowledged the impact of their own values on the therapeutic relationship.
However, therapists did identify that their level of experience and knowledge about Aboriginal culture did impact on therapy, with one therapist reporting, she "learnt a lot by accident". Some therapists also expressed feelings of doubt about knowing whether they were being effective or whether their service was valued or appreciated by the clients.

**Consultation/Liaison**
It was identified by several therapists that there was a need for greater communication with and between those services working with Aboriginal children in order to avoid over-servicing. It was also felt that it was important for a therapist or service to be accepted by indigenous communities.

**PRACTICE GUIDELINES**

The strategies that will be outlined have been pulled together from the therapist responses as well as those of the indigenous people interviewed. Whilst the data collected was largely related to occupational therapy services I think you will see that like the issues presented, there is a lot of potential for translation to other settings and professions.

**Socio-economic strategies**
A. Be aware of socio-economic difficulties.
Many respondents identified that it was important to be aware of potential socio-economic difficulties.

Suggestions such as providing transport were endorsed by therapists, parents and teachers.

**Socio-cultural strategies**
• Many respondents felt it was important to recognise and accept differences in values of indigenous clients.

*If the white occupational therapist can understand and respect their ways and their culture. It mightn’t be right to you but it is to them. That kind of thing. And have an understanding of Aboriginal culture.*

• Knowledge about the family make-up and background was also important.

*Know what’s going on in their lives. If something drastic’s happened at home they're not gonna come to you and want to jump through hoops for you.*

• To make the therapy environment more culturally appropriate, several respondents suggested the use of indigenous resources such as puzzles of indigenous people as well as indigenous posters around the room.

**Relationship strategies**
• Provide continuity of therapist and service
Several Aboriginal people interviewed identified the importance of continuity of therapist and service in order to develop and maintain an effective relationship.
Yeah you gotta build that relationship first otherwise nobody will perform for you now, especially our children. And you gotta know that 6 months down the track you’re still going to be there you know, otherwise they’ll just do what they gotta do with you and then that’s it, you know?

- Be aware of differences in communication styles
  It was also important to consider differences in verbal and non-verbal communication styles and to be aware of body language. Therapists should use simple strategies such as addressing the client and their family by name, speak with clear, simple language and provide lots of encouragement and explanations. One therapist also suggested using a modified form of written communication called COMPIC which uses picture symbols with words for those Aboriginal clients who had literacy difficulties.

- The use of an Aboriginal liaison person was also seen as particularly important when working with indigenous clients in a non-indigenous setting.

As part of the relationship building process, it was also seen as important to educate and inform parents about occupational therapy.

**Intervention strategies**

**Logistics**

Several strategies were suggested to help with some of the logistical issues mentioned earlier. These included phoning before an appointment, having a ‘drop-in”’time for appointments rather than rigid time slots and seeing the child in the morning as it was felt they would work better then. It was also seen as important to recognise and accept some of the factors intrinsic to Aboriginal children and their families such as their different concepts of time.

*I think you just gotta be patient. Like Murri’s are Murri's you know. Like, if they go to an appointment, they go. If they don't then they don't, you know (laughs). There shouldn’t be expectations, put it that way.*

**Therapy Strategies**

Therapists and indigenous people identified a number of strategies which could be effective in therapy. These included:

- Consider ways to incorporate culture
- Some therapists identified strategies such as designing a wheelchair in the colours of the Aboriginal flag as a way to cater for cultural difference.
- The use of photographic or visual home programs
- Using simple home programs with equipment readily available to clients
- Working in groups of children. This was identified as an effective way of catering for the strong emphasis placed on social relationships and the desire to reduce the sense of ‘shame’ when a person is single out.
- Modelling play and other therapy strategies for both parents and teachers to ensure follow-up of recommendations. One therapist had also begun to work with mothers of young babies at-risk to try and prevent developmental problems down the track and develop relationships with parents early.
For assessment, therapists suggested using observations to complement standardised assessments which may not be very culturally appropriate.

**Service delivery models**
There were several strategies identified to improve service delivery.

- There was overwhelming support from all data sources for community based services particularly those based in schools.
- Other strategies included: The provision of outreach services to Aboriginal based services.
- Using a team approach and including parents and other care-givers as part of that team.
- Resourcing staff already working with Aboriginal children.

An extension of this strategy is to encourage Aboriginal people to complete higher degrees in the area of occupational therapy.

**Factors intrinsic to the therapist**
There were several qualities that were considered by most participants to be important for therapists to possess when working with Aboriginal clients.

- Perhaps the most crucial of these is flexibility.
- It was also seen as important to be patient, friendly, easy-going and to have a non-judgmental, accepting attitude.
- A deep respect for people, encouragement and a willingness to listen rather than tell.
- Whilst therapists acknowledged a need for greater knowledge of Aboriginal culture, many Aboriginal people interviewed felt that if you had a little knowledge but possessed these personal qualities then the knowledge would follow more or less automatically.

*Because if you’ve got a person with the right attitude, who's non-judgemental, who's open, willing to accept difference, then they will learn those cultural things as they go along. So when you ask, is there anything specific that occupational therapists (should do)... or is there anything specific this other group of health professionals (should do)? It's very hard to say that all you need is a nice person, you know, someone who sort of doesn't make snap decisions or judgements about children or others but it's hard to say that.*

**Professional knowledge**
Therapists identified a range of areas they felt they needed more knowledge in. These included:
- the history and background of Aboriginal people
- how different Aboriginal communities and their politics worked.
- knowledge about differences in communication styles.
• knowledge about indigenous child-rearing practices and parental values
• community knowledge about local support services.
• Therapists suggested this knowledge could be gained at both an under-graduate and post-graduate level and that information should be provided by 'experts' in the field.
• Some also suggested the notion of a support person who acted in an advisory role for therapists to call and seek advice, perhaps at a state level.

A recent initiative in the department of Occupational Therapy at the University of Queensland has been a visiting service to an Aboriginal school with occupational therapy students working with small groups of grade one children to develop their school readiness skills. It is hoped that this will not only help to provide some knowledge, but more importantly, begin to develop some of the personal qualities identified above.

Working with indigenous Australians will be sure to challenge the values and models of service delivery upon which occupational therapy and perhaps many other health professions are founded. However, if we are to successfully contribute to an improvement in the health status and quality of life for Australian indigenous people we need to acknowledge the need for change to mainstream services and service delivery models despite apparent inconvenience. We also need to seriously attempt to address issues of education for both non-indigenous health workers in any field and the recruitment of indigenous people to these areas. Equally as important, I feel is the need to provide experiences which will assist in developing qualities such as flexibility, patience, and truly non judgemental attitudes.

We need to sit together.
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