The Australian Journal of
INDIGENOUS EDUCATION

This article was originally published in printed form. The journal began in 1973 and was titled *The Aboriginal Child at School*. In 1996 the journal was transformed to an internationally peer-reviewed publication and renamed *The Australian Journal of Indigenous Education*.

In 2022 *The Australian Journal of Indigenous Education* transitioned to fully Open Access and this article is available for use under the license conditions below.

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a VISITING OCCUPATIONAL THERAPY SERVICE to INDIGENOUS CHILDREN in SCHOOL: RESULTS of a PILOT PROJECT

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Abstract

The need for additional support for Indigenous children at school is well documented. Occupational therapists are well positioned to form part of this support. However, many occupational therapists report that Indigenous families do not access their services and when they do, the occupational therapist feels uncertain about how best to meet their needs. This article documents a pilot project which delivered occupational therapy services within several schools and preschools in Brisbane which had significant numbers of Indigenous students. The project was evaluated using a qualitative methodology and included focus groups and interviews with teachers and parents. The results indicated that in general the service provided valuable support to students, teachers and parents. In particular, providing the service within the school context was seen as critical to its success. Suggestions for improvements in future support services are also provided.

Introduction

This article is about a visiting occupational therapy service which was trialled in several Brisbane preschools and schools in order to support their current educational goals. We include information about factors that affected children's learning at school and the impact of the occupational therapy service in supporting children, parents and teachers. Our discussion begins with some questions relevant to understanding the provision of occupational therapy to Indigenous students.

Why is occupational therapy relevant to Indigenous children at school?

Occupational therapists work with children who have a variety of physical, developmental and learning disabilities. They are concerned with the ability of children to perform the "occupations" appropriate to their age and lifestyle (Erhardt & Merrill, 1998). Australian occupational therapists see children as having four main occupations. These are play, school, self-care, and leisure and hobbies (Ranka & Chapparo, 1997). School children need to be able to master a number of tasks in order to successfully participate in their role as a student. For example, children going to school need to be able to master tasks such as playing constructively, cutting with scissors, engaging in sports activities and learning handwriting. When handwriting, children need to be able to sit with a stable posture, hold the pencil so they can control its movement, learn how to form letters and apply the right amount of pressure so their hands do not get tired. When playing sports, children need to be able to throw and catch a ball, hop, jump and skip, balance and plan new movements (e.g., when learning to swim). Occupational therapists can help children who are having difficulties in these areas by identifying where the problem is and then providing ways to help the children learn the skills they need. They also look at strategies to compensate for ongoing difficulties such as slow or messy handwriting, poor attention, poor organisation and difficulties with posture (e.g., sitting in class) (Erhardt & Merrill, 1998). This often involves providing therapy in a school setting and educating teachers and parents about how they can follow up on these ideas.

Why don't Indigenous families use mainstream occupational therapy services?

While occupational therapy services are available to all people, discussions with several occupational therapists in Brisbane indicated that very few Indigenous children are referred to or attend mainstream occupational therapy services. There are several possible reasons for this lack of representation. The focus on day-to-day survival for many Indigenous Australians may overshadow all other concerns, making attendance at occupational therapy a low priority (Coombs et al., 1983; Nelson & Allison, 2000). Many Indigenous families place greater emphasis on social relationships than may be seen among non-Indigenous Australians. Thus, Indigenous people may not attend an appointment for themselves because they place priority on assisting a family member (Gray et al., 1991; Shannon, 1994). There is also a question of whether or not Aboriginal people understand what services occupational therapists provide or how such services fit with what they think is important for their children. Many non-Indigenous, or mainstream, health and welfare services have been criticised for a lack of flexibility in service delivery to Indigenous people, resulting in poor access to these services (Wolstenholme, 1996). These services have been criticised for using rigid appointment scheduling and locations which are difficult to access with public transportation. The history of negative attitudes toward Indigenous people, as well as government policies of separation of children from families, has left a legacy of suspicion and, at times, anxiety for some Indigenous people when accessing mainstream health services (Saggers, 1993). In addition, many Indigenous people are reluctant to access mainstream health services due to perceived or experienced racism. In order to try to improve the access of Indigenous children to occupational therapy services, a pilot project was developed in collaboration between the University of Queensland Division of Occupational Therapy and the Brisbane Aboriginal and Islander Community Health Service. This article explains the development of this service and the results of the evaluation from parents, teachers and health service staff.

How was the visiting occupational therapy service set up?

During discussions with several key staff at the Aboriginal and Islander Community Health Service (AICHS), the pilot project was favourably received and it was agreed that AICHS would help to coordinate it. A registered nurse on the medical team assisted in the initial establishment of the service and acted as a liaison person between the occupational therapist and the rest of the medical and other teams at the health service. Staff at the health service identified a number of schools and preschools where it was felt the occupational therapy service would be beneficial. The liaison staff member approached the staff at these preschools and schools. Of seven schools and preschools approached, two preschools and two primary schools identified that they would be interested in the occupational therapy service.

An initial meeting took place in each of these schools with the principal or teachers, the health service liaison person and the occupational therapist. At this meeting, the occupational therapist was introduced and the occupational therapy service was explained. The occupational therapist discussed different types of services which could be provided. Options included the assessment of children's needs, the provision of programs for teachers to implement and the provision of some "hands-on" therapy to meet the needs identified. Schools could opt for any combination of these services according to their needs and within the time constraints of the occupational therapist.

How was the occupational therapy service run?

A referral form was developed for all the schools in order to help school staff identify who would be appropriate for referral to occupational therapy. A parent permission form was included on the referral form. In addition, a parent information sheet and a consent form were provided to parents and teachers which they could return if they were interested in being involved in the evaluation of the service. In the two primary schools, an in-service to teachers was provided to inform them about how occupational therapy can help children and the types of difficulties they might see in the classroom which would indicate a need for occupational therapy assessment.

Over the course of the pilot project, children were withdrawn from class and assessed by the occupational therapist. Assessment tools included a range of standardised assessments and therapist observations of children performing activities such as handwriting. The primary school children were assessed in a range of areas, including processing of sensory information, gross and fine motor skills, visual perceptual skills, concentration and skills such as handwriting and cutting. At the two preschools, a general developmental screening was completed on selected children. Where screening identified the need for an assessment by another professional (e.g., a speech pathologist), this information was passed on to parents and teachers for them to act upon.

After each assessment, it was possible to provide "on the spot" feedback to the child's teacher when the child returned to class. In some instances, the parent of a child was also present during the assessment and this enabled immediate verbal feedback to the parent as well. While parent involvement was welcomed by the occupational therapist, it was not always practical for parents to come to the school or preschool. To address this problem, a report would be forwarded to the school, with the request that the school pass on a copy of the report to the parents. In addition to the report, parents and

Table 1. Functional issues identified in school aged children (n=22).

Area assessed	Number of children identified as having difficulty in this area
Postural stability	18
Coordination	2
Fine-motor skills	9
Handwriting	20
Memory	9
Visual perception	4
Visual-motor integration	6
Sensory processing	8
Attention	11
Motor planning	1
Bilateral integration	12
Suspected language difficulty	8

Table 2. Functional issues identified in preschool and kindergarten children (n=23).

Area assessed	Number of children identified as having difficulty in this area
Adaptive/cognitive skills	13
Fine-motor skills	11
Gross-motor skills	4
Visual-motor skills - 2 dimensional	16
Visual-motor skills - 3 dimensional	4
Personal/social skills	7
Suspected speech/ language difficulties	13

teachers were also provided with a written list of ideas and strategies they could use with each child to work on the areas of need identified.

The service was provided over two school terms, during which 45 children were seen by the occupational therapist. Two children seen in one of the preschools were not Indigenous, making a total of 43 Indigenous children seen. Tables 1 and 2 provide an outline of the children seen and the areas of difficulty identified.

How was the occupational therapy service evaluated?

Following the end of the six month pilot project, a comprehensive evaluation took place. This consisted of focus groups or interviews in each preschool and school where the service had been provided. Participants included teachers, teacher aides, principals, parents, family liaison workers and health workers, from both Indigenous and non-Indigenous backgrounds. A total of five focus groups and two interviews were conducted. Issues of satisfaction with the service, preferred models of consultation and perceived value from the service were discussed.

Results

The focus groups and interviews were conducted by the occupational therapist who provided the service. This may have positively biased the findings as participants may have been reluctant to be critical of the service when face-to-face with the provider of that service. However, there is much literature to emphasise the importance of an established relationship with a researcher when interviewing Indigenous people (Donovan & Spark, 1997). It was felt that, in order to have the trust of the participants, it was necessary that the interviews be conducted by a person with whom a relationship was established. The interviewer also needed to have background knowledge of both the research methodology and occupational therapy practice, limiting the number of appropriate people further. Ultimately, it was felt that any disadvantages as a result of the therapist conducting the focus groups and interviews were outweighed by the advantages. The results further confirmed this, as participants readily provided both positive and negative comments when questioned about the service. The results are reported below with direct quotes to illustrate findings. Personal names have been changed in order to maintain anonymity.

A word of caution

As previously outlined, occupational therapists see children who have a range of suspected learning and developmental difficulties. However, participants acknowledged that for some Indigenous children, their "special learning needs" were identified within a system that did not cater for differences in their learning approach or did not consider their cultural background. One participant commented on the problems associated with the "labelling of difference being a deficit":

> and so the kids here, in terms of their experience in mainstream schools, are labelled as having learning difficulties and having special needs when in actual fact they probably just have the same needs as every child does. Because certain needs aren't being met, there's that automatic label placed on the child. And the children here, if their experience in the mainstream had been one that had been appropriate, then most likely, a lot of them wouldn't have the learning problems that they do have.

What did teachers and parents think?

About assessments

Participants identified that, where children had particular learning needs, it was important to identify and address these early. Parents and teachers felt that the assessment report was able to identify areas that could then be addressed by the school or home. One participant noted that, "it's good that you catch the problems with them when they're little. The earlier the better". However, for some children, the assessment process reinforced a sense of shame at being singled out of the class to see a non-Indigenous therapist.

Parents generally reported that they found the written information in the assessment report easy to understand and useful for helping them to help their children. Some parents acknowledged that they were initially shocked by the report's findings. Differences between parents' perceptions of the child's skills and the skills indicated in assessment results were seen as being due to the child's performance with an unfamiliar person. One parent commented: "He draws all the time, so for him not to draw a circle or anything I was shocked. Maybe 'cause he didn't want to. I don't know, but he draws all the time at home".

Participants identified that it was important for parents to understand what an occupational therapist is and to have the report in simple language. A number of strategies were suggested to improve the dissemination of information to parents after the assessment. These included the use of an Indigenous liaison person to explain reports and the use of workshops for parents to discuss the child's results. One participant felt that:

> It wouldn't hurt to have a liaison person at the ready. If there is medical jargon or whatever, [they could explain] what it actually means. You need someone who can culturally relate that so if there's a bit of fear of not knowing what [doctors are saying].

Teachers identified that the report provided them with useful information about individual children which they could then use to help cater for that child's needs in the classroom. Sometimes this provided confirmation about what they had suspected in a more general way, and helped them adjust their expectations of the child. Other teachers appreciated the support of the therapist and the time it saved, as illustrated by the following comments:

> [There were situations] where you had an idea there was a problem with a child in a specific area. But what you did was confirm that and you gave more detail about it and then went on and gave strategies to assist. So it was, I think, the comprehensiveness of that which was great.

> Conventional wisdom always seems to be that when they're avoiding a task ... they're just in a mood or they don't want to do it or they couldn't be bothered today. But being able to find out specific reasons behind things is so helpful.

> You don't feel this isolation of a teacher on their own coping with that.

About occupational therapy intervention

The children at some centres received weekly "hands-on" therapy from the therapist. In addition, all centres received program and activity ideas which were provided to teachers with a copy to pass on to the parents. Participants identified that it was important for a child's broader development to develop his/her physical skills. Some participants noted that children seemed to prefer outdoor activities more than tasks working on their fine-motor or handwriting skills:

> I suppose if they're not physically skilled then they can't perform as well socially as a well-developed physical child could.

> Kendall enjoyed the play side more than the theory side of it. He didn't like sitting down and doing the writing 'cause he found that difficult.

The use of groups in therapy was seen as an effective strategy for reducing the shame felt by some students in seeing an occupational therapist. As one participant noted, "I know a lot of the time with the smaller kids, they like to do it in small groups. They get too shy if they come out by themselves".

Some parents reported that the activity ideas provided them with the knowledge of how to help develop their child's skills in particular areas:

> Well, with what you've written here [indicates some activity ideas provided with the report] like with the cutting and the playdough, I went out and I got a lot of stuff for Eli and I'm teaching him to cut around objects.

Some teachers, however, expressed concern that parents would not follow up at home, perhaps because there was little direct contact between the therapist and the parents:

> 'Cause as it is I have sent a couple of the programs home and I haven't had any feedback from them and when I asked the parents how they're going ... they really haven't started anything yet. So maybe if it was all explained to them a little bit better too.

Teachers readily identified that activity ideas which could be incorporated into the class activities were

useful. For other teachers it helped to affirm what they already had in place:

> Well I thought the pre-writing skills were very appropriate for the level of readiness we were working on. And the children were keen to carry out those activities even if the whole class did them. I found it very useful 'cause that was part of the curriculum and it just needed extra work on it and it benefited the whole class by doing that extra work.
>
> Bronwyn's doing the motor program with the year ones you know, it sort of validated that.

About the occupational therapist

Participants identified that it was important for therapists to understand the family and cultural background of the children they see for therapy. One participant felt that it was essential to "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". Participants emphasised the importance of establishing a relationship with the child over time in order to gain a more reliable picture of the child's abilities. They also identified the need for a consistent person and service in order to develop ongoing trust:

> They [the children] seem to be more focussed on relationships than they are on … [other things] they're more likely to do something because a relationship exists between them and the tutor than they are because someone says that they should do it.
>
> I think with any kids, just be patient. 'Cos I think it don't matter if you're non-Indigenous or Indigenous, get to know them. Don't just treat them as another patient or another thing … Build a rapport with them so that in turn they'll respect you. You know, take the time for them.
>
> Yeah you gotta build that relationship first otherwise nobody will perform for you now, especially our children. And you gotta know that six 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?

Teachers identified that it was important for the therapist to fit in socially. One teacher gave the following feedback: "I think you fitted in well too with people here. You got along well with everyone and that's important too you know". One of the criticisms of the service from teachers was that there was not enough contact with the parents: "I mean I guess we could have got them to come down to the assessment as well and that way it's all you know linked together. That would be something I'd like, I'd focus on for the next time".

About school-based occupational therapy

Much discussion was generated about the most appropriate location for the occupational therapy service. Most participants identified that the school was an appropriate place because it eliminated the need for transport and relieved the burden for attendance from the parents. It was also suggested that having the service based in the school reduced the sense of shame parents felt in accessing mainstream services: "It's probably perceived as more normal because it's here and you're not having to go to the hospital or go to the clinic or whatever". Participants also felt having a school-based service reduced the amount of time a child had to be away from their normal classroom routine:

> I reckon all occupational therapists should be in schools because the children, they only have like the half an hour to an hour session, they're not losing on a whole school day and their routine [is] not interrupted. 'Cos our kids, you've gotta have routine with our children you know.

The Aboriginal and Islander Community Health Service was also identified as an appropriate location for the service:

> Well, you're aware of [the] community health service. It's just an automatic thing. They just feel comfortable in coming here and feel they know us all here. And they deal with the same people over and over, like staff wise. I think going into a mainstream [service] … well it's not community minded. Maybe not the same person all the time they see there.

About timing

Participants acknowledged the difficulty of waiting for services in the mainstream system and identified that they would have liked the service to be available longer:

> It's just the time was too short. But we were really pleased with it … You gave us some great insights but there wasn't enough time to fully develop those.
>
> Have more children seen. Because after those few children that we did send to you, it was like gee I wish we'd done so and so and so and so and so and so because we'd just find that there are some things

that are lacking in them and you'd think "I wonder if there is a real problem there"

In terms of the time of day the service was provided, some participants identified that it was important to see the children in the morning. One teacher commented about their experience with one child:

> I found with Kendall, you had to work in the morning with him 'cause in the afternoons he was tired and didn't want to do anything. And I think you find that with a lot of children. That's where you get more of your full work done with them in the morning's sessions with them than in the afternoon. 'Cause come the afternoon they're all tired and they don't want to do nothing.

Pointers for future occupational therapy services

From the data collected, it appears there are several implications for service providers when working with Indigenous children and their families. Participants were extremely supportive of a *school-based service* for the following reasons:

- it was convenient for teachers, parents and children;
- it could potentially reduce the amount of shame felt by parents and children;
- it was an important adjunct to the teachers' daily work in the classroom by identifying a child's difficulties and providing activities to be incorporated into class; and,
- it reduced the amount of time and effort spent accessing a mainstream service.

While other locations such as the Aboriginal and Islander Community Health Service or, in some cases, the child's home were also seen as appropriate locations, the school was the preferred option.

Other important implications for service delivery included:

- consistency of the occupational therapist over time;
- an ongoing service which could follow children throughout their schooling;
- working as a team with health service staff, teachers, parents, the child and liaison workers;
- the need for other support services such as speech therapy and social work; and,
- the need for more culturally appropriate assessment tools.

This study has demonstrated the improved access to occupational therapy services for Indigenous children when the services were based in an Indigenous health or educational setting. It seems from this information that there is strong support for an ongoing occupational therapy service across several Indigenous preschools and schools in Brisbane. While therapists in mainstream services can modify their attitudes and practice to cater more appropriately for Indigenous children, the issue still seems to be that Indigenous people do not access these services for a variety of reasons, including the parent's suspicion of mainstream services, difficulties with transport and lengthy waiting lists. If there was to be a school-based service, there would need to be an occupational therapist who was committed to working in that setting over time in order to establish trusting relationships with teachers, parents and the children.

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