Practical strategies for working with indigenous people living in Queensland, Australia

ELIZABETH WATTS University of Queensland, Australia
GLENYS CARLSON University of Queensland, Australia

ABSTRACT: *Internationally, occupational therapists have recognized the need to provide culturally appropriate services for indigenous people. This study explored experiences, perspectives and practical strategies of occupational therapists working with Aboriginal and Torres Strait Islander people living in rural and remote areas of Queensland, Australia. Semi-structured interviews were conducted with eight occupational therapists who had at least 12 months' experience providing services to Aboriginal and Torres Strait Islander people in health, rehabilitation or education services. Key themes identified in the data focused on strategies for facilitating effective communication with individuals and families, and collaborating with other service providers. The role of Aboriginal Liaison Officers or Indigenous Health Workers was emphasized by participating therapists. Participants identified resources that they perceived as useful in their practice, such as cross-cultural training and access to indigenous health workers. Other resources suggested for further development included information about learning styles of indigenous people and information about cultural variations between specific Aboriginal and Torres Strait Islander communities. The small number of participants limits generalizability of the findings. However, therapists can decide on the relevance of strategies to their own workplaces. Suggestions for further research focused on improving occupational therapy services for indigenous people in Australia. These include an investigation of therapy goals with indigenous people, and interviews with indigenous Australians and indigenous health workers about their experiences and perceptions of occupational therapy.*

Key words: culture, indigenous people, occupational therapy.

Introduction

By almost every measure, including education, employment, housing, socio-economic status and health, indigenous people in Australia experience

disadvantage compared with the non-indigenous population. For example, 10.6% of indigenous Australians obtain a post-school educational qualification, compared with 31.2% of non-indigenous Australians (Australian Institute of Health and Welfare, 2001: 149). The personal income of persons aged 15 years or over is less than $300 a week for 65% of indigenous Australians compared with 51% for non-indigenous Australians (Australian Institute of Health and Welfare, 2001: 153). Data indicate that 'cancer caused 40% more deaths among indigenous people in Western Australia, South Australia, Queensland and the Northern Territory combined, than would have been expected, if the disease occurred at the same rates as found in the total population' (Australian Institute of Health and Welfare, 2001: 94).

Underuse of health and disability services by indigenous people (Australian Institute of Health and Welfare, 2001) has been widely recognized and is largely attributed to the cultural inappropriateness of service provision (Gething, 1995; Gulash et al., 2000; Nelson and Allison, 2000). Geographical isolation and limited availability of health and disability services further contribute to the disadvantage experienced by the 64% of Aboriginal people living in rural and remote areas of Australia (Millsteed, 1997; Australian Institute of Health and Welfare, 2001).

Ethically, occupational therapists have an obligation to effectively meet the cultural needs of all their clients (Jungersen, 1992; Australian Association of Occupational Therapists, 1996). In order to ensure culturally appropriate practice, occupational therapists need to be sensitive to and have knowledge of differences in culture and cultural issues (Fitzgerald et al., 1997). For the purpose of this study the term indigenous people has been used to collectively describe Aboriginal and Torres Strait Islander communities.

Literature reviews conducted by Wieringa and McColl (1987), Huttlinger et al. (1992) and Jungersen (1992) in relation to occupational therapy services and indigenous people in Canada, the United States of America and New Zealand respectively, emphasized the importance of effective communication, establishing rapport and collaboration with indigenous communities to improve client outcomes.

There was a general consensus in the occupational therapy literature that standardized assessments (for example, structured interviews, perceptual-motor assessment) can include items that are culturally inappropriate for indigenous people in a range of countries (Wieringa and McColl, 1987; Haig, 1993; Nelson and Allison, 2000). In their review of the international psychiatric literature, Gulash et al. (2000) identified four culturally appropriate assessment strategies for indigenous people: the Key Informant (asking key people from the person's community, such as elders, about the person's health), the Culturally Informed (asking the person questions about their illness and about the culture that they identify with), the Cultural Translator (having an indigenous health worker present to translate the meaning of the person's symptoms between cultures) and the Needs Assessment methods (not asking

about the person's health, but asking about the kind of help they think they need). Of these, the Cultural Translator method seems to be most transferable to occupational therapy.

Through research, review or professional experience, occupational therapists throughout Australia consistently identified similar key strategies for enhancing culturally appropriate practice (Preston, 1990; Glynn, 1993; Haig, 1993; Wolstenholme, 1996; Elliot-Schmidt and Strong, 1997; Fitzgerald et al., 1997; Nelson and Allison, 2000). These key strategies are: cultural awareness training during undergraduate education and for practising service providers; collaboration with and employment of indigenous people in health and disability services; involvement of significant family members in therapy sessions; collaborative goal setting with the client/family; indigenous community education about health and disability services; and flexibility in practice. These strategies were also recommended by Bostock (1991), an Aboriginal advocate for indigenous people with disabilities.

Nelson and Allison (2000) conducted semi-structured interviews with five Aboriginal parents employed in education or health services in southeast Queensland. Nelson and Allison (2000) recommended that occupational therapy intervention should respect individuality and acknowledge aspects of Aboriginal culture, which may impact on clients. They suggested that these clients need an environment where they feel safe and the option of another Aboriginal person with whom they can liaise. Nelson and Allison (2000) also recognized that children from Aboriginal families are often accustomed to group approaches to learning and may prefer not to be singled out for occupational therapy intervention.

Although many of these strategies seem to be generalizable across indigenous populations internationally, they lack specificity and details of situational applicability that allow therapists to distinguish these culturally appropriate strategies (for example, collaborative goal setting) from general occupational therapy practice. Most Australian literature has focused on occupational therapy and Aboriginal people, with little mention of Torres Strait Islander people, and is restricted to rural/remote areas of the Northern Territory, New South Wales and urban southeast Queensland. Some authors, including Nelson and Allison (2000) and Preston (1990), strongly emphasized the influence of regional diversity among Australia's indigenous people and subsequent local differences in beliefs, values and experiences. The purpose of this study was to describe the specific strategies that occupational therapists perceived as facilitating the cultural appropriateness of their practice for indigenous people living in rural and remote areas of Queensland. The specific research questions were:

1. What practice models or principles do occupational therapists apply when working with indigenous people?

2. What strategies have occupational therapists found effective when providing services to indigenous clients?
3. Why did occupational therapists perceive these strategies to be effective?
4. What supports and resources do occupational therapists identify as useful in their practice?

Method

Participants

Eight occupational therapists, with at least 12 months' experience with a client group which included Aboriginal and/or Torres Strait Islander people living in rural or remote areas of South West, Central West or North Queensland, participated in this study. Using purposive and opportunistic sampling (Patton, 2002), potential participants were accessed from the Australian Occupational Therapy Association's regional member listing. A snowball sampling approach was then undertaken, which involved asking participants to identify other potential participants (Patton, 2002). Participants had experience working with indigenous people in a range of age groups across the lifespan, for periods ranging from 12 months to 15 years; all had worked within government services including health, rehabilitation and education and all were female. Where participants had worked with indigenous people in other states/territories they were asked to recount only their experiences in rural and remote Queensland.

Data collection

Due to the limited published research in occupational therapy with indigenous people in Queensland, the nature of the research was exploratory and descriptive. Qualitative methods allow detailed description of the participant's experiences and perceptions (Creswell, 1998; Patton, 2002). For these reasons a research design based on elements of phenomenology was selected involving semi-structured interviews. The use of semi-structured interviews enables a flexible approach to exploring relevant issues and probing additional details when appropriate (Minichiello, 1995). The interview questions addressed issues arising from the literature and were developed in consultation with a colleague who has research experience in the area. Copies of the interview schedule are available from the authors. Participants were initially contacted by telephone. If they were interested in participating they were mailed a project information sheet, a consent form, a copy of the interview questions and a page requesting demographic information. Interviews were arranged for a date and time convenient to the participant. Initially, three participants were interviewed face to face and were also asked to provide feedback on the interview questions (for example, comprehensiveness, additional questions

that should be included). No modifications were suggested. Because of distance and travel issues, a further five participants were interviewed by telephone. Interviews were 30–90 minutes long and were tape-recorded and transcribed verbatim. During the interview, each participant was asked to 'describe a therapeutic situation involving a person from an indigenous family, in which you believe therapy resulted in positive outcomes'. Similar to Tannous et al. (1999), this approach was used to elicit narrative data that includes features of good practice.

Data analysis

The transcripts were analysed using inductive thematic analysis methods (Rice and Ezzy, 1999; Patton, 2002). Themes were not predetermined. During a process of repeated reading of the transcripts, themes in the data were coded and named according to terms used by participants or from within existing literature. The coded transcripts were then entered into the qualitative data management software program NVivo (Qualitative Solutions and Research, 1999). Data stored under each thematic code were then summarized. Similarities and differences between participants' experiences were identified and compared with existing literature. Participant statements were selected to represent these findings.

Research rigour

Research rigour was enhanced through both participant and colleague checks (Rice and Ezzy, 1999). Participants were sent the transcript of their interviews soon afterwards for confirmation of accuracy. The researchers independently read transcripts and identified key themes. These were then discussed to enable clarification and organization of related themes into a coding tree. Transcripts were then re-coded using the coding tree as a framework, and the colleague reviewed this coding. This process was repeated until the researchers reached consensus over each independently coded transcript. The same procedure was adopted for reaching consensus about node summaries. After analysis of all interviews, a summary of key themes was also sent to participants, who were asked for feedback on its comprehensiveness. Some minor modifications were made accordingly.

Results and discussion

The findings are presented as specific strategies used by participants in relation to themes that emerged from the data. Participating therapists identified practice models, strategies and resources, which they perceived as culturally appropriate and effective in improving outcomes for indigenous Australian clients without specifying differences in strategies between Aboriginal people

and Torres Strait Islander people. Generally strategies focused on communicating and collaborating with clients, families and service providers; with an emphasis on the role of indigenous health workers or Aboriginal liaison officers in this process (see Table 1 for a summary of the strategies). Although many of these strategies are central to occupational therapy practice with any client, participating therapists emphasized or adapted these strategies, acknowledging specific cultural reasons. Because of the complex nature of any human interaction, aspects of strategies may be present in more than one theme.

Practice models and principles

Participating therapists referred to a number of models or principles on which they based their practice with both indigenous and non-indigenous clients. The Occupational Performance Model and client-centred practice (for example, Law, 1998) were identified most often by participants. In addition the 'top-down' process, which involves defining client goals before assessing the client's performance, and case management or a 'strengths-based' approach were acknowledged in relation to specific workplaces. One therapist spoke of needing to adjust her application of a practice model for use with indigenous clients:

> I generally use ... the Canadian Model of Occupational Performance and I know that this has big limitations for them because they don't structure their life the same, with the same weighting I guess, as we do, but I still keep to that model in a sense by asking them about those areas. But I probably put more emphasis on relationships, family relationships and the spiritual side of things. (Participant 6)

Obtaining information – communication strategies

When seeking information from indigenous people, therapists often omitted an initial interview, preferring a casual discussion with the client rather than asking direct questions. For example:

> To not be threatening, to not ask too many direct questions, to be more casual, to talk about different things, talk about what's happening in town ... not wanting to know everything and not wanting to have lots of information from the people straight away ... (Participant 7)

This approach is consistent with Preston's (1990) suggestion to begin with general conversation before the intended discussion. In addition, Eades (1988) said that Aboriginal people (in South East Queensland) may prefer not to use direct questions about important personal details or to elicit a full account of an event. Some participating therapists spoke of accepting pauses: 'Bigger pauses, giving them a lot longer to respond ... I'll just wait, because most of the time they're not ready to answer your question yet, not that they didn't hear or

understand' (Participant 2). Eades (1988) suggested that the use of 'positive, non-awkward' silence may occur in Aboriginal people's communication.

Some therapists described indirect strategies for obtaining information such as observation, or asking the person to demonstrate a task or activity:

> I use a lot of observation ... I tend not to use things like narrow assessments, I focus much more on nursing reports and family report and obviously the client report ... I use a lot of demonstration, how would you do this or can you show me how you are having trouble with that? Lots of observation rather than 'sit down and look at these pictures' assessments. (Participant 6)

Eades (1988) stated that the use of observation, indirect questioning and 'gathering evidence over time' are accepted practices and central to indigenous people's information seeking.

Providing information – communication strategies

Participating therapists modified their voice to improve the effectiveness of their communication – for example, 'I try and speak a little softer' (Participant 2) and 'Your tone of voice is really important' (Participant 4). Another strategy adopted was an informal style of speech, similar to that of indigenous health workers and indigenous clients themselves. In addition, therapists avoided jargon and clarified the client's understanding, again avoiding questions: 'I do a lot of checking that they understand, and try not to make that patronising either, I don't [ask] "did you understand that?"' (Participant 5). Although effective communication has been regarded as important by many authors (Huttlinger et al., 1992; Jungersen, 1992; Wolstenholme, 1996; Elliot-Schmidt and Strong, 1997), there have been few published details of specific strategies to enhance intercultural communication.

Some therapists were able to enhance their communication of information using non-verbal media such as written resources that were specifically for indigenous people. For example: '... a brochure ... if a person is returning home from hospital say following a stroke ... It was developed in the Northern Territory I think, and the explanation is very culturally appropriate, written in appropriate language ... Aboriginal cultural language' (Participant 5).

In addition, the use of diagrams, drawings, pictures or photographs was emphasized. For example, one therapist used 'a program handout, a visual, and it has line drawings ... and I also took Polaroid pictures of that child' (Participant 4). Demonstration was another non-verbal communication strategy, for example: 'I might actually say "You do it with me" or "We're going to do this, I'll demonstrate it first and then you do it" ... so they get to physically practise it and they actually get to see it rather than just explaining it or leaving them a picture of it' (Participant 5).

Similarly, Nelson and Allison (2000) suggested the use of alternative media such as pictures, particularly in paediatric occupational therapy. One therapist

also used slide shows and 'virtual reality' models of babies to provide health information about the effects of alcohol or smoking during pregnancy to indigenous women's groups. Therapists recognized the importance of providing information to not only the client but also the family and the community: 'You also look after the family care too ... I'm trying to look with those mothers at the prevention of abuse ... by encouraging really safe practices at home' (Participant 4).

Similarly, Gething (1995) and Haig (1993) recognized the need for education for Aboriginal communities about health, disability issues and services, recommending that occupational therapists take a proactive role in this area.

Focusing beyond the individual – practical strategies

Applying a holistic approach, in relation to individual situations, therapists collaborated with family members, health professionals or workers from other agencies. They also acknowledged environmental factors that may impact on the individual.

Involving the family

Participating therapists acknowledged the nature and significance of family relationships in indigenous cultures, for example, 'and they usually live with their grandmother, with cousins' (Participant 2) and 'In the client's eyes I think the family tends to be fairly important to the Aboriginal person' (Participant 5). In response to this, therapists encouraged immediate and extended family members of the client to attend therapy sessions.

> That holistic approach is really important, the big family approach, you just don't work with the one person ... I always ask if the mother would like to have her mother, or grandmother or anybody else sitting with her, a sister, come in. That is much less threatening for that person. I was recently working with a very young mother who was coming in for the second time and she brought two sisters with her this time. We did the whole session, the four of us together, and had fun doing it, and that was a really important strategy. (Participant 4)

The client, family and occasionally other professionals (for example, indigenous health workers and physiotherapists) were also involved in collaborative goal setting: 'And I make an effort to get all parties that they want involved ... in the assessment and forming some sort of goals ...' (Participant 6). Collaborating with the client and family members to set relevant goals was also emphasized by Huttlinger et al (1992), Jungersen (1992), Nelson and Allison (2000) and Wolstenholme (1996). This is consistent with general practice principles espoused in client-centred practice (Law, 1998; Sumsion, 1999).

Participating therapists reported that group assessment and intervention strategies were successful. Nelson and Allison (2000) reached a similar conclusion.

> I tend not to single Aboriginal kids out for assessments, I usually take two kids at once. I just find that they appear to be a bit less daunted. (Participant 1)

> Initially I asked this family would they like to join the baby group we were having ... that will work very well if you've got a very young mother of 13 or 14 years ... You need to just talk to her as part of a group ... (Participant 4)

Therapists reported considering environmental influences on the client before providing home programmes: 'I think very carefully about whether to give a home program .... They might have eight or nine kids, so we try and do as much at school as we can' (Participant 1).

Addressing disempowerment

Therapists recognized that indigenous people often feel disempowered in government systems and services:

> They don't necessarily have a lot of other contact with government organizations ... they don't always feel in a position of power to be able to negotiate or deal with them ... (Participant 1)

> So you start having people who are wary of you in the first place, so if you keep them in an environment where they are feeling on the back foot it makes it ten times harder to do anything ... (Participant 2)

Saggers (1993) explained that European colonization has eroded the cultures of the indigenous Australian, and has resulted in alienation, discrimination, marginalization and ill-health among these people.

Therapists described several strategies for addressing this disempowerment, focusing on how certain environments either facilitate or impede client empowerment in relation to therapy services. Environments in which clients seemed more comfortable included outdoor environments like the beach, park and hospital grounds, and also the client's school or home.

> And also I do a lot of home visits, but I, myself, find it's nicer to get some water or some coffee and sit in the park ... I tend to do that more for indigenous clients than other people. (Participant 3)

> She [a child] hated being inside ... so we ended up treating her outside in the gardens in the front area, under some trees, in some shade, on a blanket, with her family, outside, and she loved it ... (Participant 7)

The use of culturally appropriate environments was similarly emphasized by

Jungersen (1992), Nelson and Allison (2000) and Wieringa and McColl (1987).

There was variation in individual responses to therapists being in the client's home environment. For example, 'she was much more communicative on her home ground, she was obviously much more relaxed, she was willing to joke and share more intimate moments that would keep our goals on track' (Participant 8). This is contrasted with: 'while the family was happy to talk to us in the hospital and for it to be dealt with at school, they were very reluctant to let anybody actually into the house' (Participant 5). When home visits were necessary (for example, for assessment of home modifications) therapists reported the need to be flexible in their approach toward setting appointment times: 'So I might arrange to go and see him ... and then he would get way-laid or whatever ... so I'd just go round later in the day or go round the next day, that's just the way that I work, I'm sort of mobile' (Participant 3).

Hospital environments seemed to impede client empowerment, as therapists reported that clients made negative statements about this environment like 'Hospitals are where people go to die' (Participant 2).

Choice of environment was linked to building rapport with clients: 'By just moving the location ... she became more receptive' (Participant 8). In addition to this, therapists emphasized the importance of facilitating the development of rapport by allowing more time to establish a relationship ('Some of the young women are very shy initially, until they get to know you and that could happen over 3–4 visits until they feel comfortable' (Participant 4)); and providing a 'common link' ('So I tend to say "I was talking to so and so the other day" ... so that they understand that other community members have been through the process and I remember them. So just to give a common link' (Participant 2)). Wolstenholme (1996) also suggested taking extra time to develop relationships when working with Aboriginal people.

Therapists noted that being aware of their own body language and the body language of the client assisted in conveying the therapist's sincerity and recognizing when rapport had not been established:

> Body language is really important. I find our indigenous community pick up on non-spoken body language. If they feel negativity coming from us they will surely pick it up ... If I haven't connected with the family I know it right away because indigenous mothers will look sideways and they won't give me eye contact; they will tell me with their body language that they don't like this and they want to escape; they won't interact with me. (Participant 4)

These characteristics and strategies are similar to those outlined by Mosey (1996), who described the process of conscious use of self in occupational therapy practice, especially in relation to developing rapport.

Therapists facilitated clients' self-confidence by emphasizing their strengths and giving the client more control:

> So it was basically skill development and giving him a real sense of worth ... I find that works really well, when you focus on the person's attributes, their strength and their perseverance and their courage ... and keep on reinforcing their strengths and their skills which motivates them to keep on engaging and striving.... (Participant 3)

Applying a functional approach

Geographical remoteness and poor socio-economic circumstances arising from high rates of unemployment result in limited resources in many rural/remote communities (Saggers, 1993). Participating therapists commented on the need to be sensitive to social issues in indigenous communities that often impact on their clients, like alcohol abuse, violence and suicide. For these geographic and socio-economic reasons therapists selected activities and materials according to appropriateness and accessibility for their clients.

> Basically taking the therapy outside and not using a lot of traditional therapy toys and lovely expensive therapy balls that flash and whiz and did all sorts of things ... More like plain balls, tennis balls, just stuff that the families would have, the toys that were available from Woolworth's and from K-Mart ... and also just leaves and branches. You know doing tactile stimulation with just things from outside, like playing in the dirt with the hose and stuff that people can do at home.... (Participant 7)

As standardized assessment tools were reported by therapists to often be inappropriate for indigenous people, because of unrepresentative norms and inappropriate assessment equipment, therapists modified assessment equipment to improve both cultural and practical appropriateness – for example:

> With assessments I use appropriate tools, such as in one of our assessments for picture identification which is receptive language power, the pictures are actually inappropriate, so I've got plastic crocodiles and other pictures representing the things the children would know rather than a boot – for example none of the children wear shoes. So I'm trying to use appropriate equipment, I modified some of the assessment tools I use. (Participant 4)

> I often can't get the child to maintain eye contact very well, so it's not really appropriate. Visual tracking ... I often just scrap that question. I guess I just check whether or not they've had their vision tested.... (Participant 5).

Nelson and Allison (2000) suggested similar alternatives to traditional assessments.

Activities of Daily Living were used during assessment and intervention, but therapists allowed extra time for the client to become familiar with the environment and the equipment to be used.

> My therapy is very much based on what they already do, like if you're hanging out the clothes, then you're already using those muscles, and I guess activities that they are already doing, and interests that they already have, rather than setting a theraputty program.... (Participant 6)

Being non-judgmental during the assessment process was emphasized by some therapists: 'We were getting back to really basics and I tried to do this in a very non-threatening way, so it wasn't "oh, you're not doing that very well"...' (Participant 4).

Using a collaborative service approach

Participating therapists collaborated with workers in a range of government, community and private agencies, highlighting the need for effective communication, documentation and inter-agency coordination:

> So I'm very careful that we communicate properly ... we're not just an independent service as therapists working, we are really communicating with all the people [within other services] that matter.... (Participant 4)

Therapists often experienced the benefits of combined team skills in health, rehabilitation and education services:

> We managed to work with the social worker, the doctor and the Aboriginal liaison officer to get him on a disability allowance ... I don't think it was so much the traditional [occupational therapy] remediation that actually made a difference to his outcome, I think it was, yes, the team. (Participant 2)

However, several issues were identified. First, some health professionals work on a rotational basis, leading to frequent changes of team members and consequent limitations in individuals' ability to maintain relationships with clients and understand the socio-cultural environment. In addition, two therapists reported that indigenous clients occasionally felt uncomfortable in team meeting situations involving numerous non-indigenous professionals. In order to address this issue one therapist 'narrowed the number of people involved ... I spoke directly to her and then went back to the other professionals' (Participant 8).

Many therapists collaborated with other services in the geographically dispersed communities to support their follow-up intervention, for example:

> I also have groups, I don't run them at the school but I set them up and the teacher actually runs them ... I do find that works quite well and it's often necessary in the outreach towns ... In other cases I have worked with [Staff from] Aboriginal Housing. (Participant 5)

Supports and resources for therapists

The following is a compilation of people and resources that therapists accessed in their practice with people from indigenous families. Further resources suggested by therapists for future development are then outlined.

Existing supports and resources

Indigenous health workers and Aboriginal liaison officers employed within health and disability services to assist indigenous people to access such services also supported therapists through two main roles. The first was to provide a link between indigenous clients and the government services they were accessing: 'The [indigenous] health worker will often translate and be the go-between ... so really the involvement of the [indigenous] health worker was very important for following through long term' (Participant 4).

This seems to be consistent with the 'cultural translator' role described by Gulash et al. (2000). Second, therapists recognized the skills and local knowledge of indigenous health workers and Aboriginal liaison officers when seeking information:

> [Indigenous] health workers give me an enormous amount of knowledge about the communities, the families.... (Participant 4)

> I got a lot of assistance from Aboriginal health workers ... we were doing some paediatric handouts ... just knowing an appropriate way of presenting it and appropriate language and we could speak to them about things that were acceptable and things that are done and things that aren't. (Participant 7)

In many areas indigenous health workers or Aboriginal liaison officers also led cross-cultural training workshops. Therapists said these workshops assisted them to gain appropriate skills and knowledge, including an awareness of their own culture.

> The awareness training is run through the Indigenous mental health workers ... and that was probably the best sort of thing that gave me some insight into ... what the people had been through and what the issues were likely to be; a few things about different taboos and things that you shouldn't do, particularly if you are working with people who are very traditional ... One of the skills of practice that I learned was cultural competency, and we all had the opportunity to reflect on our own culture and how important it was to us. (Participant 2)

These aspects of cultural awareness seem to be consistent with Fitzgerald et al. (1997) and MacDonald's (1998) descriptions of knowledge and self-exploration as components of cultural competency.

Participating therapists commented that there was little published literature specifically about indigenous people and occupational therapy in Queensland, and said that generalizing information from other states does not account for regional diversity: 'There isn't a whole lot.... I guess the NT [Northern Territory] research – it's not always valid to us ... because the issues are different ... enormous differences in the situation, every community is very,

very different' (Participant 5). Nelson and Allison (2000) and Preston (1990) also acknowledged the diversity in beliefs, values and experiences of indigenous communities in different parts of Australia.

Resource suggestions

Therapists identified a need for information on generalized cultural differences: 'I'd also like some information on ... differences in learning styles for Aboriginal kids as opposed to other kids ...' (Participant 1). In addition, they requested specific information on particular rural/remote communities, family groups and cultural practices: 'I'd like to have the background on each community and [family] groups from each community, how they came to be there, or the history. I think it is important to know that background information' (Participant 4).

Furthermore, therapists reported a need to develop appropriate information pamphlets defining the role of occupational therapy, including referral information, to assist indigenous clients.

Therapists identified a need for an assistive equipment trial service for indigenous clients living in rural and remote areas. Access to electronic equipment was also suggested (for example, a digital camera, video conferencing facilities and other communication equipment): 'I think a good digital camera that took more than eight pictures ... that would probably be a really good idea too' (Participant 4).

Therapists suggested that adaptation and/or standardization of assessment tools for indigenous people is necessary to improve the accuracy and relevance of assessment results and to reflect lifestyle and priority differences between cultures.

Conclusions

The key themes identified in this study focused on strategies for facilitating effective communication with individuals and families, and collaborating with other service providers, emphasizing the involvement of Aboriginal liaison officers or indigenous health workers. The findings of this study (summarized in Table 1) are largely consistent with the strategies identified in the existing literature as culturally appropriate for indigenous populations internationally and throughout Australia. However, unique to this study is the identification of specific details used to develop such strategies and some cultural rationales for their use. For example, recognizing the importance of family support and directly involving mothers, grandmothers and sisters in therapy sessions. Furthermore, therapists' suggestions for future resource development are reported. These include information about specific Aboriginal and Torres Strait Islander communities, appropriately worded pamphlets explaining

occupational therapy, culturally appropriate assessment tools and assistive equipment trial services.

The small number of participants in this study limits the scope of the data collected and their potential generalizability. However, the findings are presented in detail to enable readers to determine their relevance to their own experience and practice. This study only explored the perceptions and experiences of occupational therapists working with indigenous people. Further research in this area could involve interviewing indigenous clients, Aboriginal

TABLE 1: Participants' suggestions for How to Make Occupational Therapy Practice More Culturally Appropriate

- Use casual discussion rather than direct questioning
- Accept longer pauses or silences in conversation
- Use informal communication, similar to Aboriginal liaison officers and indigenous health workers or indigenous clients
- Speak softly
- Clarify client understanding, avoiding questions
- Provide written resources (e.g., drawings, diagrams, pictures or photographs)
- Use observation and demonstration
- Provide health promotion information to indigenous community groups
- Encourage immediate and extended family members to attend therapy sessions
- Use collaborative goal setting with clients, family and other professionals
- Use group assessment and intervention approaches, particularly with indigenous children
- Be aware of physical and social environmental influences on indigenous clients when planning home programmes
- Use environment to facilitate client empowerment (e.g., outdoor venues, school or client's home)
- Allow time to develop relationships and build rapport with indigenous clients/families
- Be aware of therapist and client body language
- Facilitate indigenous client's self confidence by emphasizing strengths and giving them more control
- Select activities and materials according to appropriateness and accessibility for individual client
- Modify assessment equipment to be culturally/practically appropriate
- Use activities of daily living in assessment and intervention
- Collaborate with government, community and private agencies, especially in geographically dispersed communities
- Use a multidisciplinary team approach in health, rehabilitation and education services
- Limit the number of service providers attending meetings with indigenous clients
- Recognize Aboriginal liaison officers' and indigenous health workers' role in assisting rapport building and communication between therapists and indigenous clients
- Recognize Aboriginal liaison officers' and indigenous health workers' skills and knowledge of local community issues and cultural norms
- Attend cultural awareness training to increase awareness of own and other cultures
- Be aware of regional diversity among indigenous communities

liaison officers or indigenous health workers about their perceptions and experiences of occupational therapy services. A study of therapy goals with indigenous people could be undertaken. In addition, participant observations of occupational therapists working with indigenous clients may identify other strategies that contribute to culturally appropriate intervention and improve outcomes for specific Aboriginal and Torres Strait Islander communities. However, the strategies collated in this study may help occupational therapists to improve the cultural appropriateness of their practice, and in turn perhaps enhance the health and quality of life of indigenous people who access occupational therapy services.

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Address correspondence to Glenys Carlson, Lecturer, Department of Occupational Therapy, The University of Queensland, Brisbane, Queensland 4072, Australia. Email: g.carlson@mailbox.uq.edu.au