

## PERSONAL VIEW

# Occupational therapy: what does this look like practised in very remote Indigenous areas?

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**F Pidgeon**

*Remote Disability Services, NT Department of Health, Darwin, Northern Territory, Australia*

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## ABSTRACT

**Context:** Occupational therapy in very remote, predominantly Indigenous, settings requires therapists to modify traditional models of practice to make practice applicable, culturally relevant and culturally safe. This article describes some of the author's observations of similarities and differences in what occupational therapy 'does' and 'is' in four different, but in many ways similar, very remote contexts. A Churchill Fellowship allowed the author to travel to visit teams in three very remote regions of Canada and the USA, allowing comparison to practice in the Top End of the Northern Territory in Australia.

**Issues:** These very remote settings are unable to support onsite therapy services resulting in fly/drive-in visits from hub towns, influencing service models and extending professional tasks and roles. In many of these remote contexts populations are predominantly Indigenous, which requires therapists to work cross-culturally. This requires occupational therapists to adapt therapy assessments and interventions to make these appropriate to the contexts.

**Lessons learned:** Therapists perceived a range of therapeutic adaptations and resources as useful in their practice and some barriers to implementing these. These included supports to practice such as cultural liaisons or interpreters; being open and respectful to differences in beliefs around health, wellbeing, desired occupational pursuits and function; using a client/family-directed approach in care planning, goal setting and development of therapeutic strategies; being selective around use of standardised assessment tools; and taking time and developing relationships with family and clients. Therapists in these areas also reported their scope of practice as being broader in remote settings, requiring skills in a greater range of areas. Therapists also reported the increased use of technology to supplement and support remote practice.

**Key words:** cross-cultural, Indigenous, occupational therapy, scope of practice.

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## Context

Practising as an occupational therapist in very remote communities is a unique experience. A 2013 Churchill Fellowship allowed the author to visit therapists working in remote regions of the Canadian Arctic (Kivalliq and Qikitani regions of Nunavut) and Navajo reservations in Arizona to compare remote practice with that of the Top End of the Northern Territory in Australia. Therapists have reported a general lack of awareness by clients, families and service providers around the role and scope of occupational therapy, similarly reported in Indigenous communities of Australia<sup>1</sup>. This can hinder service provision, but also offers the opportunity to modify practice to meet unique circumstances.

Between teams, similar themes emerged around what occupational therapy is and does in these very remote, predominantly Indigenous contexts. This article will detail some common themes and considerations of remote practice that emerged.

## Issues

Indigenous populations of the USA, Canada and Australia are well known to be at a disadvantage in measures of health, education and socio-economic status<sup>2-4</sup>. Underuse of health and disability services, believed to be due to inappropriate models of service provision, geographical isolation and limited availability, is widely recognised in the Indigenous populations of Australia<sup>2</sup> and was similarly reported by occupational therapists working in the remote teams of Canada and the USA. Therapists in these regions are typically working cross-culturally, working under a fly/drive in/out service model and frequently work in these areas for only 1–3 years.

## Lessons learned

### *Cross-cultural practice*

Occupational therapy as a profession is becoming more aware of the significance of culture, the ways in which it shapes

behaviours and beliefs, and how this influences practice<sup>5-7</sup>. All therapists visited reported that culture and language were significant influences on how they practised. Therapists were from a dominant ‘western’ culture and so were practising cross-culturally when providing services to Indigenous clients.

Therapists reported that, in many remote situations, application of best-practice models based on medical diagnosis, without consideration of client’s (and families’) goals, skills and assets, social situation, resources or environment, may actually not give the best results. Therefore practice strategies needed to be evaluated within these broader considerations.

An example of this is a therapist working in a remote Australian community who found attempts to engage elderly female clients with arthritis in a hydrotherapy group unsuccessful as older women do not typically swim in this community and were ashamed to get into the pool even if fully clothed; also, the program was dependent on the therapist as it required someone to access the pool key and to arrange transport to and from the pool. Therapists in one of the Canadian teams reported that group sessions (eg for chronic disease or cardiac rehabilitation), which work well in most mainstream areas, have not been highly successful. Hypothesised reasons for this might include people from different family groups not wanting to attend together, the lack of flexibility of group sessions to fit around broader activities happening in the week (such as funerals, tide times for fishing, movement of animals for hunting, family gatherings, poor weather) and exercise without purposeful outcomes (walking to get food, hunting, fishing) not being considered important.

The need to include the wider family in assessment and goal setting was also identified as important. Clients typically lived with extended family and the influences of this social environment were recognised to affect therapy and outcomes. Elders and significant family members were described as important in decision-making or acceptance of



therapeutic recommendations. Service models with short, infrequent visits to communities or scheduling client appointments to occur in the clinic were reported as barriers to being able to include extended family.

Different understandings of health, causes of disease or disability, and treatment models between people and cultures were described by therapists. Often these understandings were not compatible with 'western' medical models of health. Therapists all indicated client's perspectives needed to be recognised to allow effective treatments. In one remote Australian community the pitted scarring across the legs and torso of a child following meningococcal infection was explained by the family as occurring because of the child's 'crocodile dreaming' and family were initially reluctant to engage with therapists concerned about the scars developing or adhering. After the therapist asked about their understandings and acknowledged the families' beliefs about the scars they were more willing to engage.

Another common theme was a general distrust of white health providers among many in these populations, resulting in reluctance to engage or attend appointments. This was perceived to be due to the history of colonialism and forced removals such as the Residential School System<sup>8</sup> (similar to those experienced by Australia's Stolen Generation) or previous interactions with the health system not being culturally appropriate or respectful of clients' beliefs and values.

Strategies to overcome this included taking time to develop relationships and trust, which can be assisted by being open to assisting and participating with clients in day-to-day activities such as driving clients to the store for shopping, clinic or to see family; listening and being open to hearing about family and culture; and being present as a support person in appointments. Completing therapy in an environment that is familiar and safe for the client (such as the home) and having the flexibility to come back or change location and plans was also identified as useful in developing rapport. Barriers to applying these strategies included time constraints, perceptions of worthwhile use of therapy time (at both

therapist and service levels), pre-arranged visit schedules and appointment times, infrequency of contact with clients, and social and home situation not being conducive to therapy visits.

## *Practice supports*

Cultural safety refers to a client's experience when a healthcare provider communicates in a respectful, inclusive manner, empowers the client in decision making and builds a healthcare relationship to ensure maximum effectiveness of treatment<sup>9</sup>. All teams identified this as an ongoing learning process, towards developing models of practice that are culturally safe and effective.

Gulash et al's<sup>10</sup> review of culturally appropriate psychiatric assessment for Indigenous Australians identified four strategies: using a key informant (asking relevant community members or elders about the client's health), being culturally informed (asking the person about their beliefs about their illness and the culture they identify with), using a cultural translator (having Indigenous health workers present to translate and provide insight into different cultural meanings) and using a needs assessment approach (asking clients about their perceived needs for therapy rather than about what is medically wrong).

Components of these strategies are apparent in the regions visited. All three teams that were visited employ Indigenous workers in permanent positions where they are able to be utilised as interpreters, cultural mentors and cultural translators, to provide important social and family backgrounds for clients and to provide invaluable community information and knowledge. Currently, Top End communities employ health workers within the clinic to support multiple programs and visiting services; this limits availability to when therapists are in communities and there are no competing demands.

Therapists in Nunavut participate in cultural activities such as hunting and fishing, have access to language training, and have close working relationships with Indigenous health



workers to develop knowledge of the culture and how this will influence world views, particularly in regards to health and disability.

Many therapists described client's limited awareness of their medical diagnosis or how these issues impact on day-to-day function. In some instances therapists had difficulty accessing health records to obtain medical history. This (in an unplanned way) facilitated a needs assessment approach whereby therapeutic goals were identified based on the clients' reported functional issues or areas they wished to improve, fitting well with a more holistic and social model of health which may be more culturally appropriate.

## *Occupation*

Differences in meaningful and desired activities, what occupation means to different people in different contexts, and how this affects goal development and intervention was a consideration for remote therapists. The environmental and cultural influence on what is necessary or normal for clients to be able to achieve is an important consideration for practice.

Examples of goals or desired activities being incongruent with the therapists' perceived areas of primary concern included an elderly Inuit at high risk of falls wanting to be able to get down on the floor (even if it required help) to skin seal and prepare *muktuk* (blubber and skin) because it is always done in that way, a family in Arizona whose primary goal was for the child to sit happily in the car for extended periods because even a trip to the grocery store or clinic was a 1 hour round trip, and an Australian Aboriginal man's goal to be able to roll his own cigarette. These raised the importance of being aware of different values and world views to those of occupational therapists (often focused on independence and health promotion), and the need to allow clients to develop meaningful and culturally relevant goals.

Many therapists reported that working collaboratively with family and clients to complete assessments, set goals and develop therapy plans according to the client's primary

functional concerns or valued occupations was more effective than being the 'expert' who 'treats' and 'prescribes'.

Being able to identify meaningful occupations and goals and to rate the importance of these provides clients with an ownership of the process and also indicates that therapists value client and family input. A grandmother whose primary goal was for her granddaughter to be able to write her name and complete classroom writing activities is one example where therapists would have identified very different priorities: the school-aged girl was still wetting the bed at night and unable to shower and toilet herself without assistance. Her grandmother is a school teacher so there may have been an element of 'shame' over her poor school skills. To address this, the therapist worked closely with the grandmother and provided strategies and interventions that addressed each of their primary goals.

## *Assessment*

There is a general consensus in the literature that standardised assessment tools can include items inappropriate to Indigenous populations<sup>7</sup>. Many tools contain tasks, language or materials that may be unfamiliar to these populations and thus the results are not reflective of the client's true abilities<sup>6</sup>.

None of the services visited have access to tools standardised to their populations and the occupational therapists reported that they frequently adapted assessments or methods to give a more realistic review of a client's functional capacity in their required daily activities.

Reported strategies included using clinical observation of occupational performance over a standardised assessment, adjusting tasks within assessments to make them more relevant to the client (eg cooking in the client's own environment, cooking something they routinely prepare), clarifying with caregivers that a child has had exposure to a task prior to evaluating performance in a developmental assessment, and cross-referencing information obtained with family, carer, client, school or other involved providers to ensure it was accurately interpreted.



Functional assessment and clinical observations of a typical activity in the client's usual environment is a strategy used by therapists in all regions.

It was identified that it is important to use family or local health workers' knowledge to clarify how tasks are typically completed, and for therapists to use this information to evaluate performance rather than their own understandings and routines, as these may not be the same. Examples of situations where evaluation based on normal performance in a western setting could be misleading include the common addition in remote Aboriginal communities of cold water to the cup when making tea (tea is often drunk lukewarm or cold), or the common use of whatever utensil is closest to put spreads on bread (eg a spoon or cutting knife might be used) as utensils are usually a scarce commodity.

### *Visiting services*

All these teams, and the author's own team, provide services to very remote locations with small populations spread across large regions. These small communities or farming regions are unable to support therapists in each town (small population size, lack of housing, isolation). All are serviced out of hub towns by fly/drive-in therapy services. This travel can be expensive (in Nunavut, flights to one community costs \$800–\$1500 one way) or time consuming (Arizona therapists drive up to 3 hours each way to see a client).

This influences practice models towards assessment and program development, with reliance on family, clients or school support staff to implement recommendations and carry out programs, as this cannot be carried out by visiting therapists. Research demonstrates the need for consistent and frequent practice, best incorporated into daily life activities, to maximise therapeutic effect.

The Qikitani team has trained and employed local community allied health assistants to assist with therapeutic tasks. This was reported to be very effective; however, there has been some difficulty in staff retention on a longer term basis and the intensive 12-month training program used does not allow

for training of new staff as needed. This team also supplement community visits with video-conferencing appointments to screen and review clients; however, this does require on-the-ground support to facilitate link-ups.

In Arizona the early intervention teams use a 'coaching' framework, with the therapist's role being to develop the family's skills and capacity to implement those activities identified to improve functional performance.

### *Extended scope of practice*

Another consistent theme was the need for therapists working in remote contexts to be skilled generalists, able to work across a broad scope of practice depending on what the next referral brings.

Access to specialist visiting teams (both medical and in specialist fields of occupational therapy) are limited in remote areas. Frequently a single occupational therapist visits each community, and must work with all clients across various practice areas. This raised the issue of access to adequate professional development to develop proficiency across these multiple practice areas given travel is prohibitively expensive and online training options were described as limited. Video-conferencing was identified as a potential (not currently used) opportunity to link with specialist services in larger centres to access support.

There has also been much discussion in literature around extended scope of practice and tasks occupational therapists may do that are not typically associated with this profession<sup>11-14</sup>. In these very remote areas, therapists reported completing tasks that are not core to the profession when the relevant discipline was not visiting in the near future. Examples included an occupational therapist issuing and training a client in the use of a mobility aid, completing informal screens of language and speech proficiency to determine if a referral for a speech pathologist was required, completing the gross motor components in developmental assessments or supervising a home exercise program.



Physiotherapists reported that on occasions they would complete home assessments and make recommendations, or complete the fine motor component of developmental assessments.

Interestingly, some tasks held as core to a specific profession in Australia are commonly completed by another profession in a different country; for example, swallow assessments and modification of diets are in many areas of Canada completed by the occupational therapy department, and physiotherapists are very rarely involved in wheelchair and seating assessments in Canada or the USA.

Therapists also reported their scope of practice frequently included case coordination or case management to ensure clients had access to the required services or medical services required, providing health promotion messages, providing general health education around conditions or medical needs, and being a trainer and educator for clients, carers and therapy assistants.

## Conclusions

While challenging, remote occupational therapy offers many opportunities to therapists wishing to develop a broad skill range and practice outside of the traditional roles and tasks completed by this profession. This article presents a few ways in which therapists modify practice, within constraints of service delivery models, to make occupational therapy relevant and applicable in remote areas. Further work is needed to develop and routinely incorporate strategies into practice to make services truly client focused and culturally meaningful.

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