



**Journal of Clinical Practice in
Speech-Language Pathology**

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**Communication
and connection:
Valuing
Aboriginal and
Torres Strait
Islander
perspectives**

In this issue:

Promoting culturally safe and responsive practice

Research informing clinical practice

Assessment yarning and culturally appropriate assessment practices

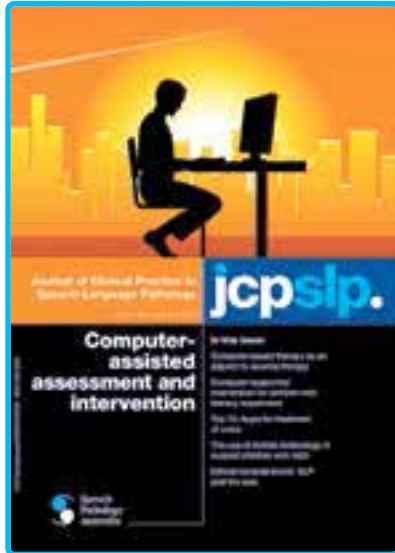
Listening to the perspectives of Aboriginal and Torres Strait Islander peoples about Speech-Language Pathology services

Developing student clinics in Indigenous contexts

Linguistic and cross-cultural considerations in Speech-Language Pathology practice



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From the editor

Leigha Dark

It is with great pleasure and excitement that I commence my role as editor of the *Journal of Clinical Practice in Speech-Language Pathology* with this issue entitled “Communication and connection: Valuing Aboriginal and Torres Strait Islander perspectives”. I am delighted to begin my journey with *JCPSLP* with this important and empowering issue and to have the opportunity to learn from the perspectives of so many different contributors.



An important part of this editorial is acknowledging the work of Dr David Trembath as outgoing editor. Over the past two and a half years David has fulfilled the role of *JCPSLP* editor with exceptional leadership, sensitivity, and understanding of the needs of the speech pathology profession and the members of Speech Pathology Australia. I would like to thank David for the way in which he has shaped the journal over this time, advocated for change and stayed in tune with topical issues facing the profession. I would also like to extend my appreciation for David’s assistance in ensuring my smooth handover and transition into the role. I wish him all the very best in future endeavours.

In the November 2016 issue, David reflected on what he felt the *JCPSLP* publication offers the speech pathology community: “The *JCPSLP* is a place where clinicians, researchers, and other members of the community come together to share knowledge, critical and clinical insights, and novel ideas to move our field forward.” While working with the authors and editorial team on preparing this current issue, these words resonated strongly with me.

Coming together towards the common goal of sharing knowledge, insights and ideas requires an open and reflexive process of communication. It happens in the spirit of fostering connections, and is achieved only with a genuine commitment to hearing and valuing a range of different perspectives. The perspectives shared in this issue of *JCPSLP* illuminate experiences, ideas and reflections that challenge and encourage us, as Speech-Language Pathologists, to develop new knowledge, skills and attitudes towards working in culturally safe and responsive ways, in partnership with Australia’s First Peoples. It is hoped that this issue of *JCPSLP* contributes positively to the conversations happening within and beyond the profession, and promotes the importance of listening to, and learning from Aboriginal and Torres Strait Islander peoples.

I would like to thank Bronwyn Davidson and Chris Brebner for taking on the roles of Guest Editors for this issue. Bronwyn and Chris have widely collaborated with Aboriginal and Torres Strait Islander speech pathologists, clinicians and academics to collate an issue of depth and insight into Indigenous ways of knowing, being and doing. There are seven articles included in this issue, along with “Ethical conversations”, “Webwords”, “Resource review”, and “Around the journals”. All align with the theme of communicating, connecting and valuing different perspectives, in particular the perspectives of Aboriginal and Torres Strait Islander peoples. I thank all who have contributed their knowledge, experiences and wisdom to this issue and hope that the contents encourages reflection on practice, inspires conversations within and beyond workplaces and advocates for the provision of speech pathology services that support the needs and values of all Australians.

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From the guest editors

Bronwyn Davidson and Chris Brebner



Good health care outcomes for Aboriginal and Torres Strait Islander peoples require health professionals to be both clinically and culturally capable (Commonwealth of Australia, 2016)



Bronwyn Davidson and Chris Brebner

It is timely that the *Journal of Clinical Practice in Speech-Language Pathology (JCPSLP)* provides this forum to report on, and in particular, yarn about a strengths-based approach to clinical practice and research that engages with Aboriginal and Torres Strait Islander people. At a time when our professional association, Speech Pathology Australia, is taking active steps to address inequities in services for Aboriginal and Torres Strait Islander individuals, families and communities, it is exciting to publish this edition that includes papers and columns addressing contemporary issues.

This edition of the *JCPSLP* represents a collaborative partnership. The editorial team has worked with Aboriginal and Torres Strait Islander speech pathologists, clinicians and academics in the preparation of this issue. In addition to all who assisted with reviewing articles we would like to sincerely thank our colleagues in Indigenous Allied Health Australia (IAHA), Tara Lewis, Jordana Stanford, Keona Wilson and Anna Leditschke, and also Shawana Andrews, Indigenous health lecturer at the University of Melbourne, for their involvement, advice and wisdom as we have planned for and prepared this edition of *JCPSLP*. Each article has undergone double-blind review by two independent reviewers. In each case at least one of the two reviewers has been an Indigenous academic or clinician. We are grateful to all reviewers who have given of their time and expertise in providing feedback to the authors of these papers.

As stated in the IAHA 2015 publication, *Cultural Responsiveness in Action: An IAHA Framework*, working in a culturally responsive way is about strengths-based, action-oriented approaches to achieving cultural safety and improved health outcomes through partnerships with Indigenous individuals, families and communities. The papers in this edition provide the opportunity for us all to reflect on and also to act on ways in which we can become more culturally responsive and committed to achieving health and educational equality for Aboriginal and Torres Strait Islander children, adults and communities.

In this issue of *JCPSLP* we present a diverse range of papers that highlight different aspects of improving speech pathology services for Aboriginal and Torres Strait Islander Australians.

Robyn Sandri and Judy Gould use a framework of cultural safety to highlight strategies and understandings to assist non-Indigenous speech pathologists to work effectively and ethically with Aboriginal and Torres Strait Islander Australians. Karen Brewer's article focuses on practical considerations for speech pathologists working with Maori families with communication disorders in New Zealand. Tara Lewis and colleagues outline how yarning can be used as a culturally appropriate form of assessment of young Aboriginal and Torres Strait Islander children's language and communication. Laura Graham and Nicole Byrne discuss the factors that support Aboriginal families to access and engage with speech pathology services, with a focus on ways in which services can become more culturally safe and appropriate. Beth Armstrong and colleagues' paper discusses characteristics of Aboriginal English important for speech pathologists to consider when working with Aboriginal people who have aphasia. Gwendalyn Webb and Cori Williams present the findings of their research exploring the perceptions of educators and parents/carers about Aboriginal children's communication and literacy. And last but not least, Anne Hill and colleagues present their experiences of developing student clinics in Indigenous contexts.

As Guest Editors of this edition of *JCPSLP*, it has been our intent to advocate for both communication and connection as we, in speech pathology practice, seek to better understand, value and respect Indigenous ways of knowing, being and doing. We hope you, the readers of this journal, will join us on this journey.

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Our journey towards 2030

Building a diverse, culturally responsive Association

Gaenor Dixon

The Speech Pathology 2030 – Making Futures Happen project identified eight key aspirations that reflect a shared vision of the future of the profession. These eight key aspirations outline a diverse and dynamic profession that will enable every person and community to determine and access the services that they need; services that promote and support skilled, confident families and carers, communication accessible communities, and professional collaborations.

In 2017, our profession does not reflect the make-up of our diverse and vibrant society. The percentage of Aboriginal and Torres Strait Islander speech pathologists is less than the percentage of Aboriginal and Torres Strait Islander people in our community. We need to examine the impacts that this has on both the profession and on our services. What barriers are preventing Aboriginal and Torres Strait Islander people from joining the profession? What can we do to address this?

For First Australians who have speech, language and communication needs our services are not always accessible or inclusive. Culturally responsive and safe practices that are co-designed by our clients through choice and knowledge is an aspiration of the 2030 plan. Culturally responsive services will also, by their nature, ensure that the needs of families and carers are considered – that speech pathologists will take the time to understand each family and their goals, their strengths, their needs and their way of doing things.

In moving towards these goals Speech Pathology Australia is implementing several initiatives. The Association is forming an Aboriginal and Torres Strait Islander Advisory Committee, which will provide advice to the Board and the Association on its strategy and activities.

One of the first tasks for the committee will be to provide advice on an organisational reconciliation action plan. This plan will outline the systemic barriers to participation in speech pathology by Aboriginal and Torres Strait Islander speech pathologists and clients, and undertake activities to redress those barriers.

Speech Pathology Australia is working with a coalition of staff from speech pathology university programs to explore ways in which Aboriginal and Torres Strait Islander perspectives can be embedded within university curricula. As part of this process, the Association has reviewed the Competency Based Occupational Standards (CBOS) to ensure that the standards reflect the profession's commitment to the delivery of culturally responsive and secure services for Aboriginal and Torres Strait Islander clients and communities. When a more in-depth review of the document is undertaken over the next few years, the Advisory Committee will provide further advice on the CBOS.

At the time of writing, Speech Pathology Australia is also actively investigating the provision of cultural responsiveness training to support our members (and others) in reflecting on their practices and how those practices may enable or create barriers to access and participation in speech pathology services by First Australians.

Our 2030 vision is ambitious, but one that is *attainable* if we work together with open minds, seek to understand, be prepared to question our practices – even where it may be uncomfortable – and to make changes. Our profession cannot afford to stand still; communication is a basic human right for all Australians.



Gaenor Dixon

Gaenor Dixon is the current President of Speech Pathology Australia and has held office since 2015.





What is spoken, and what is heard

Bridging the services gap via culturally safe practice

Robyn Sandri and Judith Gould

KEYWORDS

ABORIGINAL

PLAYGROUPS

PRIVILEGE

STOLEN GENERATIONS

URBAN

THIS ARTICLE HAS BEEN PEER-REVIEWED

Most Aboriginal Australians now live in urban centres, and many Aboriginal children and families are not recognisable to mainstream service providers as they are fair skinned. This article tells what lived Aboriginal reality, or world, is like for one Aboriginal educator living and working within an urban Aboriginal space. The authors, one an Indigenous educator and academic and the other a non-Indigenous speech pathologist who has been fortunate to have received guidance from many Aboriginal mentors including the first author, will discuss how respecting and understanding the offered lived experiences of Aboriginal peoples, when viewed from within a cultural safety framework, provides non-Indigenous speech-language pathologists with all they need in order to work ethically and effectively within the Indigenous space. So many professionals come into Aboriginal settings to make a difference. Understanding the lived experiences of Aboriginal peoples may enable this to difference to happen a little better.



Robyn Sandri (top) and Judith Gould

Robyn's story

Ten years ago, I established a number of Indigenous playgroups in mainstream schools in Queensland (Sandri, 2015). The playgroups were focused upon developing pre-literacy skills and acted as a transition to formal school agencies. I have worked in rural and remote locations, but on this occasion, as with most of my career, I worked in an urban mainstream setting. For those of us who do, our Country is urban concrete. Although I have Indigenous heritage, I had never worked in Indigenous settings or with Indigenous people prior to establishing the playgroups. In fact, I had lived overseas for most of my adult life, working and studying in England and America. I knew of my Aboriginal heritage, but it was rarely discussed or noticed by others for I was a fair-skinned Aboriginal woman. In other words, I look white and we fair-skinned Aboriginal people are legion in a time of dual cultural marriages.

When I began my research for my Indigenous PhD, I decided to use the setting of one of the playgroups I had established. I was no longer the facilitator, so with the permission of the playgroup families, I immersed myself in it for three years to undertake my collaborative research journey. I did not immediately become one of the mob. The young mothers I had worked with, had, for the most part, children in primary school, and very few of the families knew me. I appeared as a stranger to them. I was an educated, teacher-like authority person. I looked just like a white authority figure in their midst. I was treated with wariness for a long time, until they saw I was there to help the kids without judging or devaluing them. In my role, I came to see what is so discussed in the literature, but not often really understood by mainstream researchers and service providers. It was a revealing experience to me.

I came to see that Australia has many worlds. Working in this context, I could clearly see that there is a mainstream, white, Eurocentric Australia and there is another place. This other place, the families called "Aboriginal world". In the urban context, it was not a different traditional cultural space, but a colonised space shaped by daily lived experiences. I found the families' narratives of their own school experiences full of experiences of exclusion, racism, discrimination and fear. Much of this manifests into anxiety and mental health issues (Maiin, 2003). Aboriginal world is not a lesser space to its inhabitants; it has a very different tone and sensibility to mainstream world. It has its own culture, its own history, its own language, ways of knowing, fears and most of all the participants know it is a place oppressed by the elite world of white authorities and experts. Aboriginal Australians live in this colonised space on a daily basis.

I am an Aboriginal woman, but have very little tradition or language with which to identify. All that is left of my language is a list of nouns and some recordings in the State Library of Queensland. I was not brought up traditionally, as my tribal lands, people and knowings were gone. Nonetheless, I was brought up as a colonised Indigenous woman with a colonised history. My grandmother was a stolen child, taken on a shopping outing in St George, despite her family being exempt from removal as station workers. When she turned 21 she was granted a Certificate of Exemption, which meant she could live as a white woman provided she adhered to the conditions specified in her certificate. She was not allowed to drink alcohol, nor mix with any Aboriginal people – even her own family – and finally, she was not allowed to speak her own language.

Should she violate her conditions, she could be imprisoned or returned to the mission.

When my grandmother had her own children, she told and taught them nothing of their Aboriginal history. She would have known her native language, but she never spoke it to us. She lived in hiding, in fear of white authorities all her life. Her children were raised to “pass”. That is, to live and act white. They were dark-skinned children taught to say they were olive-skinned Greeks. It was a life of subterfuge and fear. This continued into my own family life. Aboriginality was implied, understood, but never spoken of or admitted too. What our family feared, like all Aboriginal families, was our children being taken. We too constructed a Greek existence with my mother working in a Greek café, and making Greek pastries. Life as an Aboriginal Australian was a life without rights, so it was better to deny our cultural heritage and be just like everyone else. It was a life underpinned by fear and trauma.

When I came into the playgroup, I expected to be in the surrounds of people who knew their culture. It was not so. The most pervasive aspect of colonisation I discovered was how few of the families even knew their own families, as so many had been taken from their parents and raised in white foster homes and institutions. Sadly, most had experienced abuse of all kinds in these homes. Even those placed in “good” homes felt discrimination and racism as they attempted to fit into these mainstream lives. They had no place to belong, and they did not know what it meant to be Aboriginal. They did not know their tribes, their Country, their grandparents, their language, their stories or lore. I discovered this was not a cultural tribal people, but a fragmented group of people who identified their Aboriginality as a collective of disadvantaged and devalued people.

The playgroup, which was situated on a mainstream school campus, became a culturally safe place for the families. It was staffed by Aboriginal workers, and the families gathered weekly. It was a place where they shared their collective story. They felt a sense of release to be themselves and not fear judgement or devaluing as people. I began to see life for the Aboriginal families from the inside. Sometimes a family would not come for a few weeks. When I asked after them, I was told they “took off” because child protection was after their kids. I would hear stories of intrusion into family lives. One elder told me, “They take our kids so easily”.

As the playgroups developed into successful Murri (Aboriginal people from Queensland) groups, they were often visited by researchers, service providers, and even child protection workers requesting permission to bring along Aboriginal children in out-of-home care. In this context, the mainstream people were the “others”. The tone of the group changed when “outsiders” were present. It was typically a group full of laughter, chat, and playing with the children. The mums joined in all the activities including the painting and collages and took their art home with them “for the fridge”. This sense of light-heartedness disappeared when researchers came in. The mothers would tend to group to the back of the room, stay silent and watchful. They would often leave early for things they had “forgotten” to do. Many would not come. It was not unusual for a researcher to come, and no families would arrive. Outsiders read this as non-compliance, of a lack of Indigenous family interest in their children’s education. In time, it was decided no researchers or visitors would be permitted to visit, unless with the express permission of the families.

What I learned was that, despite how well the children transitioned into school, the burden of historical colonisation weighed heavily upon our families. I also learned that it was an ongoing practice, based on families feeling disrespected and “less than” by many well-educated researchers. The families were intimidated by the power and authority that mainstream workers demonstrated in the playgroup. This was simply the invisible cloak of white privilege that mainstream European Australians wear comfortably. Yet, it is very disturbing to Aboriginal people. Another significant finding was that as Aboriginal people seek to be invisible in society, they seek to be invisible to researchers, teachers and workers. In this situation it manifest as telling me stories of challenges which they cast as their own fault. One mother initially told me how good school was and that her difficulties were to do with her being a slow learner. A year or two later, she told me just how difficult school was because of racism and discrimination. She felt forced to escape school when her parents would not allow her to leave. She ran away, used drugs and alcohol until she fell pregnant and returned home and to an alternative school program. Yet, these lived realities were most likely invisible to the mainstream inhabitants of the school space. She went on to successfully undertake a degree in web design at university. There was nothing slow about her learning.

Working within frameworks of democratic human rights and culturally safe ways was a way to bring expert knowledge and skills into the playgroup. This is where the bridge between our Aboriginal and white Australian worlds exists. I wanted to share this story, as an example of collaborative practice between informed families and professionals, as the way forward. Understanding who you are, as viewed by the Aboriginal *other* does matter. Perhaps it makes the privilege you wear more understandable.

I hope I have given you a glimpse of a view from the *other* side. If nothing else, what you hear is often what Aboriginal people offer you so you will not judge them. They are seeking a place in their children’s education where they matter, and they belong.

Cultural safety as a way forward

The concepts of cultural awareness, cultural sensitivity and cultural appropriateness as they relate to providing professional support for and with Australia’s First Peoples have long been promoted as underpinning effective speech-language pathology (SLP) professional practice (Gould 2009, 1999; Pearce & Williams, 2013; Speech Pathology Australia, 2007). Cultural safety extends beyond these concepts. Cultural safety, as a concept, was devised by the nursing profession in Aotearoa/New Zealand in the 1990s. The Nursing Council of New Zealand’s (2011) definition of culture and cultural safety is:

The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual. (p.7)

Aboriginal peoples intuitively talk about and possess a deep intrinsic understanding of what cultural safety means to them in a practical and real sense. In order to make the cultural safety concept known and accessible for non-Indigenous health professionals also, Taylor and Guerin (2010) have summarised the five core components of culturally safe practice as follows:

- reflective practice
- regardful care
- decolonisation
- minimising power differentials
- effective communication.

Using excerpts from Robyn's story as examples, the authors examine how SLPs can engage with these five core principles in their work with Australia's First Peoples.

Reflective practice

The mothers would tend to group to the back of the room, stay silent and watchful. They would often leave early for things they had "forgotten" to do. Outsiders read this as non-compliance, of a lack of Indigenous family interest in their children's education.

When a breakdown in communication or a professional relationship occurs, critical reflection provides the way to achieve repair and to ensure future success. Reflective practice, when done superficially, involves examining or deconstructing a specific situation in terms of one's own culture, values and beliefs; such thinking constituting a reflexive application of unacknowledged thoughts, judgements and assumptions. Effective reflective practice instead requires professionals to be mindful of their own self (Durey, 2010). When working with Australia's First Peoples, this involves non-Indigenous SLPs identifying and understanding what they bring to each professional situation as members of the dominant colonial culture within Australia. It involves remembering that privilege is typically hidden to those who possess it; being able to critically reflect on how the SLP interprets or sees a situation requires an active analysis of and stepping back from our own values, attitudes and beliefs. It involves understanding that there is much non-Indigenous SLPs do not know or cannot see impacting the lives and behaviour of Aboriginal and Torres Strait Islander peoples. It involves embodying the old adage "we do not know what we do not know".

Regardful care

One mother initially told me how good school was, and that her difficulties were to do with her being a slow learner. A year or two later, she told me just how difficult school was because of racism and discrimination. These lived realities were most likely invisible to the mainstream inhabitants of the school space.

Every person has a story. Regardful care involves looking beneath the surface. It involves looking for what makes each individual person, their words, their actions, their needs unique. Regardful care involves understanding that "no one size fits all". Each Australian First Peoples' community is unique. Identifying as an Aboriginal and/or Torres Strait Islander person and as a member of an Australian First Peoples' community is an extremely important and deeply personal, yet individual construct.

Health professionals are typically aware of the need to provide services and support which embrace equity, providing what individuals need to achieve success, rather than promoting equality, providing equal services to all

regardless of specific characteristics or need (Braveman & Gruskin, 2003). Regardful care epitomises the need for equity.

Decolonisation

I came to see that Australia has many worlds. But working in this context, I could clearly see that there is a mainstream, white, Eurocentric Australia and there is another place. This other place, the families called "Aboriginal world".

To contextualise this quote from Robyn's story, the work of Mita (1989, as cited in Tuhiwai Smith, 1999) offers insight: "We have a history of people putting Māori under a microscope in the same way a scientist looks at an insect. The ones doing the looking are giving themselves the power to define" (p. 58).

Australia's First Peoples share this history. This shared history cannot be considered a historical event, in a distant period in time called "colonisation" which has no reverberation in modern day Australia. Rather, as for Indigenous peoples worldwide who have been colonised by a western power, colonisation remains a pervasive and persistent, if often unconscious, core driver as service providers and policy-makers go about their day-to-day work of "creating a better Australia" for its First Peoples. We have only to think of the inadequate cultural training provided to non-Indigenous professionals within undergraduate tertiary programs and workplace environments (Downing et al., 2011); the lack of interpreters for Aboriginal and Torres Strait Islander languages spoken within Australia (Commonwealth of Australia, 2012); the lack of funding for bilingual language teaching within remote Aboriginal community schools (Commonwealth of Australia, 2012); or the repeated failing of our health system to adequately care for the health of Aboriginal and Torres Strait Islander Australians (AIHW, 2016; AMA, 2007) to observe colonisation as an active and unyielding process within Australia.

The key to implementing effective decolonisation practices is switching, as highlighted by Mita (1989, in Tuhiwai Smith, 1999), is questioning who exactly has the power to define First Peoples' culture, language, identity and futures. Who gets to define a First Peoples' very sense of self and the paths they wish their lives to take? Australia's First Peoples work tirelessly and strongly in order to achieve this reversal of focus. Non-Indigenous SLPs can learn from this strong guidance and transference of knowledge that can be gained only through lived experience. In the same way that colonisation constitutes a conscious and active process, so too does decolonisation; a process that needs to follow a very conscious and explicit path.

Decolonisation is about redressing the current harmful imbalance of power that exists at both a systemic/ structural/political and individual professional level within Australia. Decolonisation recognises the current living landscapes that exist within Australia. Decolonisation involves exposing and eradicating those detrimental practices, beliefs and value systems which have existed since these lands were invaded, claimed and subsequently colonised by the British. Decolonisation is about reframing choice, power and control. Decolonisation is about eliminating practices and perspectives imposed by those who have been conditioned by society to believe in the myth of white elitism which is harmful to First Peoples' lives as they exist now and into the future.

Minimising power differentials

The families were intimidated by the power and authority that mainstream workers demonstrated in the playgroup.

SLPs are typically familiar with minimising power differentials arising from the professional/client relationship as this principle underpins much of our work within primary health care and family-centred practice. When a non-Indigenous SLP first meets an Aboriginal and/or Torres Strait Islander person, there already exists a predetermined relationship accompanied by a deep history based on the process of colonisation within Australia (Westerman, 2004).

It is extremely important for non-Indigenous SLPs to listen to what Australia's First Peoples tell us about how the imbalance of power arising from colonisation directly and strongly impacts them and their health and well-being. Transference of power can be a very difficult process for non-Indigenous professionals to undertake. In addition, SLPs may genuinely feel they are achieving this important aspect of implementing culturally safe practice when those Aboriginal peoples with whom they are working may continue to be feeling "overseen" or evaluated or judged. Engaging in ongoing reflective practice, learning from Aboriginal colleagues, is the best way for SLPs to truly learn how protective of their professional or white colonial power they really may be in practice.

SLPs can learn to trust in a more culturally safe process which, in the way we do for all peoples, honours the truth that people know their own situation the best and they know their own culture the best. What can be perceived as a service-delivery barrier by a non-Indigenous SLP can often be resolved through prioritising and embodying the respect required to have faith in Aboriginal knowledges and understandings of their own families and communities.

Effective communication

I did not immediately become one of the mob. I appeared as a stranger to them. I was treated with wariness for a long time, until they saw I was there to help the kids without judging or devaluing them.

"You [white people] say things two ways; one thing with your mouth, and another with your eyes" (Gould, 2015, p. 8). SLPs are very familiar with the power communication plays in everyday life. Taking meaning and understandings directly from stories presented to SLPs to assist our learning ensures that this learning is not lost through the layers of analysis, analysis that may be being conducted cross-culturally, that typically accompanies literature discussing Aboriginal perspectives and knowledges (Sandri, In press; 2013). Learning what is otherwise hidden within the myth of white elitism is often only discovered through conversing directly with Aboriginal and/or Torres Strait Islander peoples themselves.

Robyn's story illustrates how effective communication can break down barriers, build relationships and facilitate reconciliation and personal healing. Aboriginal and Torres Strait Islander peoples must decide how their lives are to be discussed, when and by whom.

Prioritising for the future

Non-Indigenous SLPs can learn about culturally safe practice. What is really needed, however, is the involvement within the Australian workforce of SLPs who do not need to

be taught this thing called culturally safe practice. Australia needs more SLPs for whom working within culturally safe ways with Aboriginal and Torres Strait Islander peoples is simply an extension of who they are every day, in the same way that white Australian SLPs currently work day in day out without too much conscious thought needing to be given to cultural differences and sensitivities. Once again, it is the Aboriginal and Torres Strait Islander peoples themselves who are determining ways of ensuring this occurs. Dr Faye McMillan (2016), Indigenous Allied Health Australia (IAHA) chairperson, stated in response to the historic apology by the Australian Psychology Society to Aboriginal and Torres Strait Islander Australians (APS, 2016) that "IAHA encourages other allied health professions to take the lead of psychology, and to engage in some critical reflection around the impact of their interventions on the health and wellbeing of Aboriginal and Torres Strait Islander peoples" to ensure "a future where Aboriginal and Torres Strait Islander people control what is important to them rather than having this controlled by others."

Prioritising First Peoples' voices through working within culturally safe ways can go a long way towards ensuring that this vision comes to fruition.

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Clinical insights from research with New Zealand Māori

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There are many challenges facing Māori families who require speech-language pathology services and the speech-language pathologists who work with them. This article offers practical suggestions for clinical practice, gained from undertaking qualitative kaupapa Māori research (research undertaken within a Māori world-view) with Māori families with communication disorders in New Zealand. The focus of the article is not on the findings of the research but on the research practices that could also be applied in clinical practice. These include the centrality of relationships, being decolonising and transformative, and listening to clients' stories. While they will not resolve all inequities in service provision for Māori, when applied to clinical practice these promise to be a step in the right direction.

There is no need to begin with a litany of the disparities in health and education for Māori (the indigenous peoples of New Zealand), the difficulties facing Māori whānau (families) who require speech-language pathology services, or the challenges for the speech-language pathologists (SLPs) who work with them. Any clinician who has worked with a Māori, or Aboriginal, or Torres Strait Islander family without having sufficient cultural or linguistic knowledge, appropriate therapy resources, or sufficient support will be familiar with these issues.

Some clinicians are already investing a large amount of good will and hard work into working with Māori clients, whānau, and colleagues. This is recognised by the Māori whānau who have reported positive therapy experiences, greatly helped by positive relationships with their SLP (McLellan, McCann, Worrall, & Harwood, 2014). However, many problems remain. While there are success stories, there are also stories of whānau who had terrible experiences of speech-language pathology (Faithfull, 2015; McLellan et al., 2014). From the clinician's perspective, SLPs have demonstrated that they want to provide a culturally safe, accessible, and relevant service for Māori clients but face many barriers to providing such a service. These include being acutely aware of their lack of

knowledge when working with Māori, difficulty connecting with Māori clients, whānau, and colleagues, and limited time and resources for tailored service provision (Brewer, McCann, Worrall, & Harwood, 2015).

In light of this, this article offers some practical suggestions for clinical practice, gained from undertaking qualitative kaupapa Māori research (defined below) with whānau with communication disorders in New Zealand. The focus of this article is not on the findings of the research, rather on the kaupapa Māori research practices that could also be applied in clinical practice – in particular, the centrality of relationships, being decolonising and transformative, and listening to clients' stories.

Kaupapa Māori theory and research

Kaupapa Māori could be translated as "Māori ideology". The concept is not easily grasped and does not lend itself well to definition or short summary. Pihama (2015) states: "Kaupapa Māori theory is shaped by the knowledge and experiences of Māori. It is a theoretical framework that has grown from both mātauranga Māori [Māori knowledge] and from within Māori movements for change" (p. 8). Kaupapa Māori research applies kaupapa Māori theory. It began in the education sector in the 1980s. The genesis of kaupapa Māori research is linked to the development of kura kaupapa Māori (Smith, 2011). Kura kaupapa Māori are Māori primary schools that not only have te reo Māori (the Māori language) as the sole language of instruction but employ Māori philosophy and pedagogy. Kaupapa Māori research has been undertaken in a variety of health areas including traumatic brain injury (Elder, 2013), stroke (Harwood, 2012), and aphasia (Brewer, Harwood, McCann, Crengle, & Worrall, 2014). It is now well established as the most appropriate research approach for issues related to Māori health (Health Research Council of New Zealand, 2010; Pūtaiora Writing Group, 2010).

Relationships

For indigenous and other marginalized communities, research ethics is at a very basic level about establishing, maintaining, and nurturing reciprocal and respectful relationships, not just among people as individuals but also with people as collectives, as members of communities, and with humans who live in and with other entities in the environment. (Smith, 2005, p. 97)

KEYWORDS

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As explained in the above quote, relationships are an essential ethical requirement in kaupapa Māori research. Relationship building takes place before the research starts and relationships are maintained long after the project finishes (Pihama, 2011). Similarly, good relationships are essential in education and health service provision for Māori (Bishop & Berryman, 2006; McLellan et al., 2014; Ministry of Education, 2013). Relationships are not only between the SLP, patient, and extended family, but also between the collectives and communities that individuals are part of, and Māori colleagues in the SLP's workplace. There is possibly a greater impetus to persist with relationship building in research than in clinical practice. It is often necessary to build relationships with gatekeepers in order to undertake research, be it to gain a signature on an ethics application or to recruit participants. These relationships are no less important in clinical practice, although they may be on a different scale, with different timeframes and less funding.

Relationships require time and dedication. There is a Māori expression "he kanohi kitea" or "the seen face". It means that it is important to be present in person, helping out with humble tasks, and making your requests to the right people in the right ways. This helps a person to build credibility within Māori communities (Bishop, 1992). Relationships with key people don't just happen. They require persistence, humility, and lots of time spent kanohi ki te kanohi (face to face). There are financial costs in time and travel. At times it can feel like the effort and expense is wasted, but in the long run the benefits outweigh the costs.

How to build relationships

This section offers some suggestions for building relationships with Māori colleagues and communities. These relationships provide the foundation for relating to clients and families.

Who can I collaborate with in my workplace (or beyond) to provide a better service for Māori clients and family?

The situation will vary greatly from area to area. Most SLPs working in education in New Zealand are employed by Ministry of Education Special Education. Their offices have kaitakawaenga who are employed to provide cultural support and liaison. For public health care funding, New Zealand is divided into 20 districts. The Ministry of Health funds disability support services and some health services nationally but the majority of health services (including speech-language pathology services) are provided or funded by 20 district health boards (DHBs). DHBs have staff in positions equivalent to kaitakawaenga but their roles vary from place to place. Some DHBs emphasise the relationship between the Māori health professional and the allied health professional and the two working together with the patient and whānau. Other DHBs do not have sufficient staffing for that level of Māori health involvement and emphasise upskilling allied health professionals so they are able to proceed alone. With the latter it would be worthwhile cultivating a relationship so that, even if the SLP carries out day-to-day clinical work independently, there is someone from whom to seek advice as needed.

What do we talk about?

Interactions with Māori colleagues may be less direct or business-like than interactions with other allied health professionals. Do not expect to arrive with a list of questions and leave with a list of answers. Start by listening

to what is important to your colleague. Consider discussing:

- your respective roles, approaches, specialisations
- understanding of rehabilitation/education
- aims for the therapy process
- how you can work together for the patient and family.

Approach as a learner rather than an expert. Think "they could show me how to work with Māori whānau" rather than "I could show them how to work with people with communication disorders". Be prepared to hear a perspective totally different from your own and potentially change therapy goals and priorities based on the content of the discussion.

When there is no one with whom to build a relationship

If there is apparently no one with whom to build a relationship, try looking more widely. The receptionist, doctor or technician might be a member of the local Māori community and have their finger on the pulse of what is happening for Māori in your workplace. While staff in such positions are under no obligation to provide support for working with Māori whānau, they might be happy to facilitate introductions with the right people.

In some places there genuinely is no one with whom to build a relationship. This is often the case for SLPs working for smaller organisations or in private practice. For service providers who work with a significant number of Māori clients, cultural support is essential. It may be necessary to plan long term and allocate funds to employ a cultural support person. An alternative for businesses and organisations that see Māori clients only occasionally is to seek support from outside of the organisation. Places to look include Māori health providers, Whānau Ora services, universities, Māori research groups, Māori medical and allied health groups (e.g., Te ORA or Ngā Pou Mana), night classes (e.g., Te Wānanga o Aotearoa), online professional development (e.g., mauriora.co.nz), and professional associations (e.g., New Zealand Speech-language Therapists' Association).

Decolonising and transformative

An important aspect of kaupapa Māori research is that it is decolonising and transformative (Pihama, 2011). Colonisation, past and present, disrupts Māori knowledge, beliefs, language and world views (Pihama, 2011) as well as producing health inequities that affect Māori communities (Reid & Robson, 2007). Decolonisation involves recognising where this modern-day colonisation is occurring, and "interrupting" it using traditional knowledge and thought brought forward into the contemporary context (Pihama, 2011, p. 51). Transformative means that the research has to make a positive change for Māori (Pihama, 2011). These two concepts have a direct application to clinical practice. It is likely that SLPs have no intention of perpetuating colonisation, and "client-centred practice" aims to make a positive or transformative change for clients. However, before we become too self-congratulatory as a profession, there are a few things to consider.

The resources and language used in therapy can perpetuate colonisation and result in therapy that is not transformative. Informing the design of a kaupapa Māori speech-language therapy package (currently in progress), Tawhai, a Māori stroke survivor, explained his experiences of speech pathology: "They've got American books. Scientist or whatever you call them, like you [SLPs], they're using American books and they're trying to fix my brain

Glossary	
he kanohi kitea	the seen face
kaitakawaenga	mediator, arbitrator
kanohi ki te kanohi	face to face
kaupapa Māori	Māori ideology
kura kaupapa Māori	Māori immersion primary school
Māori	the indigenous peoples of New Zealand
marae	traditional meeting place
mātauranga Māori	Māori knowledge
Ngā Pou Mana	Māori Allied Health Professionals of Aotearoa
Pākehā	non-Māori, usually used to refer to New Zealand Europeans
Te ORA	Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association
te reo Māori, te reo	the Māori language
Te Wānanga o Aotearoa	a Māori university
whānau	(extended) family
Whānau Ora	Healthy family. The New Zealand government's current approach to education, health and social service delivery

with American words". There are very few New Zealand-specific therapy assessments and resources, no Māori-specific resources for adults, and many challenges involved in making them (Brewer, McCann, & Harwood, 2016). We are largely reliant on imports from the US and Britain. Therapists tend to use these with acknowledgement of their limitations, but possibly without sufficient thought to the impact they might have on the client.

Tawhai's experience did not stop with the use of "American books". He described a system that was colonising and, sadly, he placed some of the blame on himself, saying "I s'pose I was asking them the wrong questions of them I s'pose, I don't know. Because it wasn't helping, it was a Pākehā [non-Māori] system and it wasn't working on me, it wasn't working".

Similarly, regardless of whether an SLP speaks te reo Māori, their attitude towards the language can be colonising or decolonising and result in therapy that is transformative or not. McLellan et al., (2014) reported the experiences of a woman with aphasia whose SLP, who did not speak te reo Māori, did not recognise when she was correctly using te reo Māori to answer questions. This contributed to a poor therapeutic relationship and the woman resisting therapy. Parents and teachers in a kōhanga reo (Māori immersion preschool) reported an SLP assessing a child only in English when his first, and strongest, language was te reo Māori. They contrasted this with the experiences of

another child whose SLP, who did not speak te reo herself, incorporated te reo Māori in therapy and the child had a beneficial therapy experience (Faithfull, 2015).

So how does an SLP deliver therapy that is decolonising and transformative when they do not speak te reo Māori and there are few New Zealand-specific resources? As for any client whose language the SLP does not speak, the use of appropriate interpreters is paramount. It is important to consider that it may not just be words that need to be interpreted but Māori concepts (McLellan et al., 2014). One way of making sure that resources are suitable is to use age-appropriate resources from the client's own whānau and community, for example, local newspapers, magazines, books, photos, stories, games, or toys. Because they come from the community they will be relevant to the community. At times it will be necessary to undertake formal assessment, although the value of this is questionable if the assessment was not designed for, or normed on, a Māori, or even New Zealand, population. In these circumstances it would be wise to discuss the assessment with Māori colleagues in advance and seek their advice about any items that might cause confusion or offence. Then decide whether these items can be removed from the assessment or need to remain. The SLP can then thoroughly prepare the client and whānau for what to expect from the assessment and debrief with them after it has been completed.

Decolonising therapy is also about creating the right atmosphere for therapeutic engagement. Parents and teachers interviewed by Faithfull (2015) reported a situation where the SLP was repeatedly invited to come to the kōhanga reo, the setting in which the child would have been most comfortable, but the SLP continued to push for home visits, to the detriment of the therapeutic relationship. While it can be difficult to create the right atmosphere in a hospital or clinic setting, the environment has an impact on the transformative potential for the therapy (McLellan et al., 2014). SLPs, managers, and funders need to consider where the client is most comfortable ahead of where policy dictates that therapy can take place. Even if the therapy location is inflexible, there are small ways in which people can be made to feel more at home, such as the artwork that is on the walls, the cleanliness of the environment and the provision of water, tea, and coffee.

The decolonisation and transformation emphasised in kaupapa Māori research is not only for the good of the individual but the good of the whole community. While speech-language pathology strives to be client-centred, we must also consider not just being transformative for individuals and whānau but for communities. What do overall patterns of Māori health and education tell us? Who is missing out on therapy? Who has been discharged because they "DNA'd" too many times? Who has shifted house so many times that we have lost track of them? We cannot say that our service is decolonising and transformative if it does well for the families we see for therapy but fails to deliver for others.

Qualitative researchers listen to people's stories

The final research element to guide clinical practice is not from kaupapa Māori research per se, but from qualitative research. Qualitative research often investigates people's experiences of a health condition or a health/education provider. Following the example of qualitative research, clinicians will be equipped to provide a better service for

whānau if they allow for more listening and reciprocity. This will give clients the opportunity to share their experiences and hopes for therapy. While such listening may be time consuming, it provides for a better outcome in the end. Mrs Iraani Paikea, a stroke survivor, explained this:

Listen to the background of that person. They'll just speak it out anyway from their mouth. And you just listen to what they are saying. And then you'll be able to relate back to them... It makes them open up their mouths and give you more, more information that you require from that person.

The benefit of listening to clients is illustrated in the following anecdote, from my PhD research (McLellan, 2013). Several years ago I interviewed Latimer, a Māori man with aphasia who lived on his marae (traditional meeting place) in a rural area. Latimer had no family nearby, but a good relationship with his SLP, so he asked if the SLP could be his support person for the interview. After the interview the SLP commented that during the interview I had stayed quiet much longer than she normally does in a therapy session. She observed that Latimer resumed talking after a pause, telling stories that would not have been told if I had spoken too soon. Four years later I was back in the area, meeting the same SLP. She mentioned the time we had interviewed Latimer, remembering that I had shared some of my background with him, and he had formed a relationship with me quickly and told me things that he had never told her. This was salient enough for her to remember four years later.

The SLP in this example is not Māori but she grew up in the area, is very well connected in the community, and goes far beyond the call of duty for her clients. Unsurprisingly, she is also exceptionally good at relationship-building. Yet she still felt that she learned from my practice, as a visitor to the area. Why was this the case? It is possible that Latimer warmed to me so quickly because I am Māori. That is something that can't be changed. It is also possible that it was to do with how I approached him. I shared of myself and found commonalities on which we could connect (Lacey, Huria, Beckert, Gilles, & Pitama, 2011). I took with me a book including family photos, maps, and photos of places that are important to me. This enabled us to share something without the need for words. Finally, because I was bound by conventions of qualitative research, I listened to Latimer without interruption and allowed long periods of silence. Those are all practices that anyone can adopt to enhance clinical practice.

Conclusion

Kaupapa Māori and qualitative researchers have a lot to learn from clinical practice but they also have a lot to offer. This article has focused on three research practices that can inform clinical practice – the centrality of relationships, being decolonising and transformative, and listening to people's stories. While they will not resolve all inequities in service provision for Māori, when applied to clinical practice these, and other kaupapa Māori practices, promise to be a step in the right direction.

Note

¹ In keeping with kaupapa Māori research, and approved by the University of Auckland Human Participants Ethics Committee, participants quoted in this article are referred to using the name by which they asked to be identified. In most cases this is their real name.

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Yarning

Assessing proppa ways

Tara Lewis, Anne E. Hill, Chelsea Bond, and Alison Nelson

KEYWORDS
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YARNING

THIS ARTICLE HAS BEEN PEER-REVIEWED



Tara Lewis (top) and Anne E. Hill

Current speech-language pathology (SLP) assessment methodology and tools privilege western values and world-views of communication and often lead to misdiagnosis of Aboriginal children’s speech and language abilities. Understanding, recognising and valuing the importance Aboriginal people place on communication may support speech-language pathologists in conducting culturally responsive assessments and in providing client support. This paper highlights the importance of changing traditional SLP assessment methodologies to incorporate Aboriginal ways of communicating through a new methodology called *assessment yarning*. The absence of culturally responsive assessment methodologies such as yarning not only increases the risk of mis-/over-diagnosis of speech/language impairment but also reproduces certain racial hierarchical arrangements whereby Aboriginal language/communication styles are framed as inherently deficient and inferior. Of most importance is the need to ensure that knowledge of communication difference translates to proper assessment and care for Aboriginal children and their families.

In Australia, many speech-language pathologists (SLPs) regard normed and criterion referenced assessment tools and methodology as the gold standard for collecting data pertaining to a child’s overall speech and language abilities. These are utilised in part to differentiate between typically developing children and those with language delay or impairment (Haynes & Pindzola, 2008). Assessment of speech and language skills focuses on “typical” acquisition of a range of constructs such as the use of a broad inventory of speech sounds, understanding and use of a range of grammatical constructions including pronouns, verbs, and complex sentences, and receptive and expressive vocabulary (Hegde & Pomaville, 2008). These assessment tools and methodologies will yield an

adequate set of data to inform diagnosis and intervention for children who speak Standard Australian English.

Traditionally, the processes followed in speech and language assessments adhere to a standard methodology of assessment. Assessments follow western values and world-views of communication (Pearce & Williams, 2013), are usually conducted in Standard Australian English, and are one on one with the speech pathologist and child. In addition, the child is asked numerous direct questions to ascertain their communication abilities (Hegde & Pomaville, 2008) in an environment that is removed from their natural context (Ball, 2009). For an Aboriginal child, this standard assessment methodology may be foreign and may not cater for their cultural experiences and world-view.

Limitations to current SLP practice

In light of these concerns, there has been recent research revealing difficulty in using standardised assessment tools and methodology with Aboriginal children (Gould, 2008a, 2008b; Malcolm, 2011; Pearce & Williams, 2013). The assessment tools utilised are normed on the monolingual mainstream population and speakers of English as a second language or speakers of English dialects are often excluded from the sample cohort (Pearce & Williams, 2013). The assessment tools are inherently western in nature in that they portray the experiences of Australian, American, and English cultures and languages (Pearce & Williams, 2010). Rarely are factors such as the cultural, linguistic, historical, sociopolitical, and educational contexts of Aboriginal people represented within the assessment tools. For example, the Renfrew Action Picture Test (Renfrew, 2003) is administered in a way that promotes a western world-view of storytelling, and seeks Standard English word usage and sentence structure from the child. The child is expected to sit down, look at the pictures and explain what is happening through responding to direct questions. For an Aboriginal child, a question/answer format does not constitute storytelling; storytelling relies on a shared relationship and understanding and incorporates Aboriginal lore and learnings. In order to explain what is happening in a picture or story, as Malcolm (2000) states, a child must have a cultural script or schema that can support their explanations.

Not only is there evidence to suggest current assessment tools may be problematic for use with Aboriginal children, there is emerging evidence demonstrating the potential bias in the way assessments are conducted with Aboriginal children (Gould, 2008a; Malcolm, 2011; Pearce & Williams,

2013). The use of these standardised assessments and western methodologies often leads to misinterpretation of the Aboriginal child's speech and language abilities and also to misdiagnosis of speech and/or language impairment (Gould, 2008a; Pearce & Williams, 2013). It was reported by de Pleviz (2006) that the number of Aboriginal children diagnosed with intellectual impairment or behavioural disorders significantly exceeds the proportion of non-Aboriginal children. Pearce and Williams (2013) believe this stems in part from misdiagnosis arising from the inherent cultural and linguistic bias in assessment methodologies that favour white Australian cultural experiences. Therefore, there is a need to consider not just if the assessment tool can be adapted but whether an entirely different methodological approach is required to ensure that assessment recognises the important differences in Aboriginal communication styles.

There has been some literature that has detailed differences in communication styles for Aboriginal people (Collard, Fatnowna, Oxenham, Roberts, & Rodriguez, 2000; Eades, 2013; Malcolm, 1994). Some research has highlighted how Aboriginal children may approach assessment tasks differently to non-Aboriginal children (Malcolm, 2011; Malcolm et al., 1999; Moses & Yallop, 2008; Moses & Wigglesworth, 2008; Reeders, 2008; Thwaite, 2007). For example, Gould (2008a; 2008b) made reference to Aboriginal children approaching assessment tasks that are meaningful and purposeful as well as contextual. While current speech pathology assessment tools provide meaning and purpose for speech pathologists and other referring agencies, they often offer little meaning and purpose for Aboriginal children. Much of the documented research pertaining to modifying assessment tasks relates to social language use, such as providing the child with expectations about the tasks, the speech pathologist relinquishing power and seeing the child as an equal in communication (Pearce & Williams, 2013), use of indirect questions and comments (Reeders, 2008), and adopting a conversational approach to questioning (Thwaite, 2007). Applying a conversational approach goes some way toward respecting and valuing Aboriginal ways of communicating in the assessment methodology. Many Aboriginal people refer to this conversational style as yarning which recognises the importance of culture, connection and relatedness to Aboriginal people (Geia, Hayes, & Usher, 2013).

Where SLPs have attempted to modify practice to consider Aboriginal cultural factors, it has usually been in documenting expressive language use to take account of Aboriginal English (Gould, 2008a, 2008b; Miller, Webster, Knight, & Comino, 2014; Pearce & Williams, 2013; Pearce, Williams, & Steed, 2015). The child's use of Aboriginal English is often highlighted through language sampling and/or expressive language subtests from standardised assessments and discussed in terms of grammatical, phonological and semantic differences to Standard Australian English (Miller et al., 2014; Pearce & Williams, 2013). Receptive language is rarely reported on and the approach taken continues to follow traditional SLP assessment methodologies. Understandably, as speech-language pathologists grapple with what constitutes a culturally responsive approach to assessments, there has been debate in the literature regarding the use of standardised assessments such as the Clinical Evaluation of Language Fundamentals, 4th edition, Australian Standardized Edition (Semel, Wiig, & Secord, 2006).

While some researchers have used the CELF-4Aus with Aboriginal children and modified only the assessment tools (e.g., including a language sample) but not the assessment methodology (Miller et al., 2014), others have argued for a more comprehensive modification, including reformatting the test scores to indicate and give credit to the use of Aboriginal English (Pearce & Williams, 2013). The Pearce and Williams (2013) study revealed that the use of standardised assessments should be avoided when assessing the skills and abilities of Aboriginal children. Instead, the authors suggest that it is important to develop assessments and translate new assessment methodologies that value the importance and difference in Aboriginal communication styles (Gould, 2008a; Pearce & Williams, 2013). As Gould (2008a) argues, "no matter what the assessment task may look like on the surface, if the administration of the test or assessment follows non-Aboriginal ways of communicating, it will be problematic" (p. 646).

This paper will extend Gould's call for change in assessment methodology to explore yarning as "an Indigenous cultural form of conversation" (Bessarab & Ng'andu, 2010). Specifically, the paper will explore yarning as a mode of communication among Aboriginal people, and consider its applicability as a culturally responsive methodology for assessing the communication strengths of Aboriginal children. It draws largely on the experiential practice knowledge of the first author (TL), an Aboriginal speech pathologist.

The first author TL is an Aboriginal woman; Iman on her father's side and Yarowair on her paternal grandmother's side. Yarning has been a critical way of knowing (learning through yarns), being (enacting her identity through yarning) and doing (as a process for engaging in the social world) throughout her life and within her own community context. It is through yarns and yarning with her Elders, family and community that her sense of belonging, connection, place and identity has been constructed. She is a mother of three children and gains so much strength from her gundoos (children) to ensure they are afforded the same opportunities as other Australian children and are privileged with the same yarns she was privileged with as a child. It is through her Iman world-view that she conducts herself as a SLP and her experiential knowledge as an Aboriginal SLP that guides her journey and practice of establishing connections and relationships with clients, families and communities through yarning. It's the disjuncture of her Aboriginal world-view and her profession as an SLP that leads her to the conversation of what's proper and proppa communication for her people. Without proppa yarns with the people she is working with, genuine connection, place and relatedness cannot be established and maintained.

What is yarning?

Yarning is a reciprocal mode of communication used by Aboriginal people who share lived experiences of their families and communities (Geia et al., 2013). To yarn is to share about oneself through two-way sharing of stories, which informs relationships, connection and relatedness to kin (Geia et al., 2013). Yarning is an Aboriginal way of knowing, being and doing and incorporates history, culture, language and identity (Geia et al., 2013). This includes the task of imparting ancestral knowledge to younger generations and fostering a sense of identity and group belongingness (Collard et al., 2000; Eades, 2013; Malcolm,



Chelsea Bond (top), and Alison Nelson

2013). Yarning is the vehicle for maintaining cultural integrity and Aboriginal world-views (Geia et al., 2013).

Yarning is more than telling someone something and/or having a conversation. It entails talking via stories that convey rich and deep meanings that move beyond thinking to actually feeling and connecting back (Bond, Foley, & Askew, 2016). The use of Standard Australian English or inserting Aboriginal language words cannot adequately convey these meanings and connection (Butcher, 2008). As yarning recognises the centrality of Aboriginal communication and connectedness, it is important that speech pathologists effectively engage in yarning to ensure the strengths of Aboriginal children are validated and respected in a way that minimises misdiagnosis. The term *assessment yarning* may be useful in conceptualising the components of yarning and to support SLPs in using yarning as an assessment methodology.

Assessment yarning

Yarning as an assessment methodology can be thought of as the method for gathering client information. Assessment yarning is applied to collect a comprehensive and meaningful case history and is also used when collecting the necessary clinical data of the assessment tasks. It is the methodology employed that facilitates the journey of the clinician and client where stories are shared and a strong authentic relational construct is formed. Engaging in assessment yarning provides clinical insight into the centrality of the client and their family's journey. Assessment yarning enables clinicians to really "see" the client in their "humanness" within their context and to potentially disrupt any preconceived notions about the client. It is imperative the clinician discloses who they are, where they are from and who they are connected to through the methodology of yarning. This displays a sense of belongingness and connection with people and place. It also allows the client to see the clinician as someone who really cares and facilitates an emotional connection between the clinician and the client. This, then, is more than an establishment of rapport. It is through yarning that a two-way sharing of stories and learning from each other becomes paramount for the assessment methodology.

Assessment yarning allows for ongoing assessment throughout the entire journey of the child and their family and is not restricted to one or two sessions as per traditional western style assessments. The following questions may assist the clinician to ensure that assessment yarning practices are maintained.

1. Is the yarn reciprocal?
2. Is the yarn meaningful?
3. Is a deep relational connection being formed?
4. Is the aim of yarning to support learning through teaching?
5. Am I listening for the meanings and information being conveyed through yarning?

Yarning as an assessment methodology – practice frameworks

The use of assessment yarning supports clinicians in providing a culturally responsive service in that they are not only aware of their own culture and how it may affect their interactions with clients (Nelson, 2007), but are applying this knowledge and transforming their practice in a way that supports Aboriginal ways of communicating. By applying assessment yarning, clinicians become aware of how their world-view and assumptions may shape bias in an

assessment context and therefore create opportunities that recognise and respect strengths and difference rather than using assessment to define deficit. Two therapeutic and assessment frameworks that utilise a strengths based practice model will be discussed to further articulate how yarning could be used to facilitate a deeper connection with Aboriginal families that promotes and provides accurate client information.

The Making Connections Framework developed by the Institute for Urban Indigenous Health is a key practice framework that uses yarning as a methodology throughout the family's entire journey with the allied health therapists (Nelson, McLaren, Lewis, & Iwama, in press). The framework's cyclical approach outlines the importance of getting connected, being connected, staying connected and building connections with clients, their families and communities. The core component of the framework is around the centrality of the child and their family needs through an ongoing relationship. This includes understanding another's view and demonstrating an ongoing commitment and availability for support. This can be demonstrated only through proppa yarning with clients and their families. The framework acknowledges that additional effort may be required to stay connected and maintain connection with families, the clinics and the community. Connection is intentional and purposeful and is maintained through the use of yarning and sharing stories. Clients are rarely discharged from the service as a deep sense of family and connection is established and maintained through yarning.

The Gumerri Assessment, developed by the first author, is a receptive and expressive communication assessment that is designed to appreciate the communication strengths of Aboriginal children aged from 5 years to 12 years. It employs a strengths based approach by recognising the importance Aboriginal families place on culture, home language and ways of communicating. The philosophy of Gumerri is based upon cultural safety, cultural responsiveness (Indigenous Allied Health Australia, 2015) and language preservation. The assessment methodology centres upon Undoo Kurunpa, the child's spirit, and applies assessment yarning throughout the entire assessment to establish a genuine relational construct and connection with the child and their family.

The assessment questions create opportunities for yarning and it is expected that the clinician will be an active participant in those yarns. Different question formats are applied through yarning such as direct and indirect questions and the use of comments. For example, in order to follow a yarning methodology, one of the questions is: "You know, I loved going swimming when I was at school. Do you like swimming? Where can we go swimming?" Along with the child, the clinician is expected to share their lived experiences of how and where they grew up as they journey through the meaningful and purposeful assessment questions. The assessment tasks and questions are interconnected with ancestral history and relate to the world-views, knowledges and experiences that many Aboriginal children are accustomed to living and thus can only be experienced through yarning.

The Gumerri Assessment and Making Connections Framework recognise the centrality of yarning to developing ongoing relationships with Aboriginal people. Both these practice methodologies recognise the need to move beyond traditional assessment and therapeutic methodologies and replace them with yarning as a method

to gain valuable insight into the family's experiences and strengths. It is important that clinicians working with Aboriginal families are equipped with the appropriate knowledge and resources to support families in ensuring Aboriginal ways of communicating are maintained (McLeod, Verdon, & Bennetts Kneebone, 2014; Verdon & McLeod, 2015). The elicitation of the child's home language and emphasis placed on yarning are instrumental in the assessment process; otherwise, current standardised assessment practices may produce assessment results that determine Indigenous language deficit rather than Indigenous language difference (Gould, 2008a, 2008b; Pearce & Williams, 2013).

Conclusion

In most cases in Australia, the current SLP assessment methodology follows a traditional western approach that remains static even when assessing different populations. Aboriginal people place significant importance on yarning as a mode of communicating and the universal assessment methodology used by SLPs does not facilitate yarning nor cater for Aboriginal ways of knowing, being and doing. Many SLPs are also unfamiliar with Aboriginal yarning and talking through story and therefore assessments continue to be conducted in "conventional" western ways. As a consequence, Aboriginal ways of communicating are often undervalued and labelled as a deficit or impairment.

This paper has highlighted the importance of changing traditional SLP assessment methodologies to incorporate Aboriginal ways of communicating through a new methodology called *assessment yarning*. SLPs need to develop their literacies in Indigenous knowledges and Indigenous modes of communication to avoid reifying Indigenous language deficit. The absence of culturally responsive assessment methodologies such as yarning not only runs the risk of mis-/over-diagnosis of speech/language impairment but it reproduces certain racial hierarchical arrangements whereby Aboriginal language/communication styles are framed as inherently deficient and inferior. Of most importance is the need to ensure that knowledge of communication difference translates to proppa assessment and management and mitigates against the risk of misdiagnosis (Gould, 2008a; Malcolm, 2011). While it is beyond the scope of this paper, further discussions are required regarding how to support speech pathologists in accurately analysing an Aboriginal child's communication abilities once assessment yarning and the assessment process have been completed.

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Aboriginal families' experiences of attending speech-language pathology services

Laura Graham and Nicole Byrne

Speech-language pathologists may be uncertain about how to work with Aboriginal families. However, Aboriginal children are at increased risk of communication impairment, due to a range of risk factors. The aim of this pilot study was to identify factors that assisted Aboriginal families to attend and engage with paediatric speech-language pathology (SLP) services and to gain feedback from caregivers on ways to improve the cultural-appropriateness of these services. Semi-structured telephone interviews were conducted with ten caregivers of Aboriginal children attending a mainstream (i.e., not Aboriginal-specific) SLP service. The participants' responses related to three themes: the client and caregiver, the health service, and the community and Aboriginal culture. Possible solutions for improving services were provided by the caregivers, which included providing information to families about what to expect from therapy, services being flexible with appointments, and displaying Aboriginal artwork. The need for further rigorous research in the area is highlighted.

Many speech-language pathologists are reportedly uncertain of how to work with Aboriginal families (Cahir, 2011). However, it is critical to improve practice, particularly as Aboriginal children in Australia experience poorer health and well-being than non-Aboriginal children (ARACY, 2013), including a higher risk for communication impairment. Factors impacting on communication include higher rates of otitis media (Couzos, Metcalf & Murray, 2001), low literacy rates (Pink & Allbon, 2008), and increased likelihood of being in foster care (Nathanson & Tzioumi, 2007). Webb (2012) identified that modifications to traditional service delivery (e.g., allowing time to develop relationships with Aboriginal families before commencing therapy, conducting services within the Aboriginal community) are required for therapy to be effective with Aboriginal families in paediatric speech-language pathology (SLP) services. To date, no Australian

studies have investigated Aboriginal families' experiences with paediatric SLP services. There is currently a large gap in information available on how to support Aboriginal families to access paediatric SLP services and this pilot study aimed to gain an initial insight into factors that may affect attendance and engagement with SLP services. Several factors affecting attendance and engagement with other health services have already been identified in the literature, particularly, access, relationships and the presence of Aboriginal staff.

Access to health care services by Aboriginal families

It has been reported that a reduced number of Aboriginal families access mainstream (i.e., not Aboriginal-specific) childhood health care services, including early childhood services (Ou, Chen, Garrett, & Hillman, 2011), disability services (DiGiacomo et al., 2013), and occupational therapy services (Nelson & Allison, 2004). Reduced access to speech pathology services has been linked to lack of awareness of what the service provided (Nelson & Allison, 2004; DiGiacomo et al., 2013), and beliefs around the causes of communication impairment. For example, Berndt (1982) reported that traditional Aboriginal beliefs attributed hearing problems to a ghost kidnapping the child and attributed speech problems to a softening of the tongue. Access to both services and transport has been identified as an issue for Aboriginal families in both rural and urban areas (Eades et al., 2010; NACCHO, 2001). Services offered within environments not requiring travel (e.g., school-based occupational therapy service) were rated highly by parents (Nelson & Allison, 2004).

Relationships and communication

Relationships have been identified as especially important to Aboriginal people, including the relationships between Aboriginal people and health care workers. Having a positive relationship has been described as "pivotal" to successful outcomes for working with Aboriginal people (Nelson & Allison, 2007). The relationship should be built on appropriate communication (DiGiacomo et al., 2013) and can often take time to build and develop (Nelson & Allison, 2007). A SLP study with non-Aboriginal families found a good relationship was an important predictor of satisfaction with SLP services, while a poor relationship may be implicated in disengagement from services (McAllister et al., 2011).

KEYWORDS

ABORIGINAL
ATTENDANCE
ENGAGEMENT
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SPEECH-
LANGUAGE
PATHOLOGY

THIS ARTICLE
HAS BEEN
PEER
REVIEWED



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(top) and
Nicole Byrne

Communication between Aboriginal clients and non-Aboriginal clinicians is important for effective engagement with health services, including non-Aboriginal clinicians having respect for cultural differences (McBain-Rigg & Veitch, 2011) and an understanding of historical events and their impact on Aboriginal health and well-being today (Cox, 2007). It has been identified that some Aboriginal peoples' access to health services has been negatively impacted upon by their feelings of being treated differently by staff or organisations based on perceptions related to their race (DiGiacomo et al., 2013; Martin & DiRienzo, 2012). If Aboriginal families feel safe and welcomed, they will be more likely to engage with services (HNELHD, 2014).

Presence of Aboriginal staff

The presence of Aboriginal staff (Martin & DiRienzo, 2012; Wylie et al., 2013) or employment of Aboriginal people as liaison officers (DiGiacomo et al., 2013; Nelson & Allison, 2004) to assist communication between the client and non-Aboriginal clinician has been reported to facilitate Aboriginal people accessing mainstream health services. Unfortunately, Aboriginal people are underrepresented in the health workforce (Pink & Allbon, 2008). While there has been a small increase in the number of Aboriginal speech-language pathologists in recent years (Byrne, 2015), they make up only 0.2% of the SLP workforce (Health Workforce Australia, 2014). However, it is likely that additional factors also need to be addressed, and asking families may shed light on what they see as the issues influencing access to SLP services and ultimately lead to finding appropriate solutions.

Facilitating culturally appropriate mainstream services

A survey by McBain-Rigg and Veitch (2011) reported that Aboriginal peoples' perceptions of health services were negatively impacted by feelings that their specific cultural differences and needs were not taken into account. This includes understanding that family commitments, such as caring for family members or attending funerals, will often take precedence over health care appointments (Nelson & Allison, 2004; Williams, 2012). Increasing awareness of Aboriginal culture among non-Aboriginal staff, through initiatives such as cultural education to address individual racism, has been cited as a way to make health care services more culturally appropriate (Martin & DiRienzo, 2012).

This pilot study aimed to explore caregiver experiences within an urban paediatric SLP service, and to identify (a) factors that facilitate Aboriginal families accessing the services, (b) ways to increase engagement of Aboriginal families with the service, and (c) ways to make the service more culturally appropriate.

Method

Approval to conduct this research was granted by the Hunter New England Human Research Ethics Committee (reference # 13/08/21/4.04) and the Aboriginal Health and Medical Research Council Ethics Committee (reference # 954/13).

Research design

A qualitative research methodology via telephone interview was employed to allow exploration of an area in which there is limited pre-existing knowledge (Bowling, 2002). The methodology was developed in consultation with the Hunter New England Aboriginal Health Unit to ensure

cultural and ethical suitability (AH&MRC, 2013), and procedures and interview questions were reviewed by health professionals working with Aboriginal people and an Aboriginal caregiver to ensure they were culturally appropriate. All documentation for the research provided to prospective participants identified the support and collaboration with the Aboriginal Health Unit (e.g., Aboriginal Health Unit logo and artwork).

The principles of appreciative inquiry (Cooperrider & Whitney, 2005) were adopted in developing the interview questions, whereby participants were encouraged to identify positive experiences (e.g., "what's worked well?") of their engagement with the SLP service, and also to identify what would motivate them to continue to engage with the service. This contrasted with existing studies into health care access and SLP experience (not specifically focused on Aboriginal peoples) which have focused on barriers to service use. Appreciative inquiry has been found to be a culturally safe methodology with Aboriginal communities (Murphy, Kordyl, & Thorne, 2004), and health research (Fowler et al., 2012). The decision to use interviews was based on the observation by Form, Bouchier, Cvetkovski, and Stewart (2012) that they are less prone to bias when compared to other methods (e.g., written surveys) and doing so is endorsed by Aboriginal community organisations. Sharing information via interviews also aligns with the strong oral culture of Aboriginal people (Gorman & Toombs, 2009), and alleviates embarrassment surrounding potential literacy issues (SCRGSP, 2009).

Study setting

The study was conducted with the support of clients, caregivers, and staff at a paediatric speech pathology service provided in one of the seven community health centres in the Greater Newcastle area. According to the Australian Bureau of Statistics (2011), the Aboriginal population in Greater Newcastle is approximately 2.8% of the total and a review of service data at the time of the study indicated that 10.4% of clients referred to the SLP service identified as Aboriginal. The SLP service had instituted a number of initiatives directed at improving engagement with Aboriginal clients (e.g., contacting the caregiver via telephone at the first point of contact, maintaining the same clinician, encouraging support people to attend appointments, and allowing extra appointment time). Despite these initiatives, speech-language pathologists reported that attendance and engagement of Aboriginal families at the service remained lower than that of non-Aboriginal families. None of the speech-language pathologists in the service identified as Aboriginal and both of the authors had completed specific Aboriginal cultural respect training.

Participants

Twenty-four participants were invited by speech-language pathologists to participate in the study over a 6-month period, and 12 consent forms were returned to the first author, indicating a response rate of 50 per cent. The participants were caregivers of children currently attending regular speech-language pathology services, as they could indicate the factors that assisted families to attend. The inclusion criteria for the participants were that the clients (children) were Aboriginal and were currently attending therapy. The participants' demographics are presented in Table 1. Ten interviews were conducted in total, as two individuals who initially responded were unable to be contacted.

Characteristics	Participants (n = 10)
Participant's gender	9 female, 1 male
Participant's relationship to child	9 parents, 1 foster carer
Child's gender	9 female, 1 male
Child's age (school or preschool)	9 preschool, 1 school
Child's communication disorder	6 speech sound disorder 1 expressive language delay 3 speech sound disorder and language delay

Procedure

The first author arranged and conducted nine interviews, while the second author arranged and conducted one, to ensure the interviewers did not have a clinical relationship with the participants. This was necessary so as to ensure that the caregivers felt comfortable, and were able to discuss their engagement with the SLP service with a clinician who was not providing services to the child. In each case, the relevant author contacted the participant to organise a time for the phone interview to occur. Some participants were willing to complete the interview on initial contact, whereas others identified a later convenient time. The interviewer introduced herself, ensured that the caregivers had read the information about the study and answered any questions they had before commencing. The interviewer first outlined that the focus of the phone call was to get feedback about the things that had made it easy for their family to attend SLP services. Second, the interviewer identified that participants were free to talk about factors that were relevant to their experiences with SLP services and that some questions may be asked by the interviewer along the way. The participants were also informed that they were able to abandon the interview at any point and that notes would be taken which they were able to review.

The semi-structured telephone interviews (Shuy, 2002) took approximately 10 minutes and enabled participants to raise issues that were relevant to them (Bowling, 2002), while also allowing for a conversational approach which has been successful with indigenous participants internationally (Kovach, 2010). In order to avoid a structured interview format, not all questions were asked of all participants and the questions that were asked were dependent on responses by caregivers and flowed on from their comments. The interviewer made online, verbatim transcriptions of pertinent key comments and statements by the participants.

Analysis

Analysis was conducted using qualitative analytic procedures for interpretative phenomenological analysis, which involves examining how people make sense of experiences (Smith & Osborn, 2008) and has previously been used in Aboriginal health research (Shahid, Bessarab, Howat, & Thompson, 2009). First, each written transcript of key comments was read numerous times by the first author to become familiar with each transcript. Second, participants' comments were allocated to subthemes. Analysis involved constant comparison and testing of subthemes against the data by the author (Joffe & Yardley,

2004). Finally, the 16 subthemes, which emerged from grouping similar comments, were clustered into three major themes. The first author transcribed and coded all of the samples, and later the second author coded a randomly selected 40% of the participant utterances against the 16 subthemes. The rigour of coding was confirmed with an interrater reliability of 93 per cent for the 16 subthemes between the two authors.

Results

This pilot study investigated Aboriginal families' experiences of attending paediatric SLP services. The participant responses fit into three major themes of "client and caregiver", "impact of the health service" and "community and Aboriginal culture". The subthemes associated with each of the major themes are listed in Table 2. An overview of themes and possible solutions are outlined in Table 3, and are explored in the following sections.

Theme	Subtheme
Client and caregiver	Changes to child's communication observed by caregiver Awareness of service Expectations of service Commitment of caregiver Child or caregiver's experience with SLP Child's receipt of attention Caregiver skill acquisition
Impact of the health service (individual clinician and organisational factors)	Flexibility Relationship Location and physical access Outreach services (e.g., in home or preschool) Multiple services in one location
Community and Aboriginal culture	Changes to child's communication observed by others Others' perceptions of child Aboriginal staff and resources Community awareness of SLP

While participant responses spanned the three themes, the first theme (perceptions, experiences and skills of the client and caregiver) emerged strongly. Example responses from each theme and subtheme are provided, and the specific interview identifier is provided in parentheses (e.g., Interview #2 presented as (2)).

Theme 1: Perceptions, experiences and skills of the client and caregiver

Changes to child's communication observed by caregiver

Caregivers reported positive changes in their children's communication (and confidence): "We're understanding a whole lot more" (2); "Doing the speech, we make a game of it. It really builds up his confidence when he knows he can do it" (7).

Awareness of service

Participants described the ways that they found out about SLP services: "Someone suggested the lady [speech-language pathologist] that we went to" (2).

Table 3. Potential strategies to facilitate Aboriginal families' engagement with SLP services

Theme	Subtheme	Possible strategies
Client and caregiver	Awareness of service	Hold community education sessions Encourage clients to share their positive SLP experiences with family and community Hold drop-in clinics in familiar locations (e.g., Aboriginal Medical Service)
	Changes to child's communication	Inform caregivers that improvements in a child's communication can lead to improvements in behaviour, confidence, and education Encourage caregivers to seek feedback from stakeholders (e.g. preschool) about improvements in their child's communication
	Expectations of service	Hold a separate session before assessment, to gather case history from caregiver Enforce positives that caregivers are doing (e.g., bringing their child to the appointment), and things that they have picked up on (e.g., practising speech sounds at home) Inform caregivers: <ul style="list-style-type: none"> • What SLP services entail (e.g., assessment followed by therapy) • That therapy will be practical, relevant and enjoyable • About strategies they will learn for themselves to use with their children at home • About expectations and requirements of therapy, (e.g., number of sessions, homework) • That personal and health questions will be asked
Impact of the health service (individual clinician and organisational factors)	Location and physical access	Identify site that is most easily accessible for public transport
	Flexibility	Talk to caregivers about what would be a good time for them to attend (e.g., fitting in with other commitments) and arrange appointments at these times
	Relationship	Spend the first session getting to know the family Maintain same clinician throughout service provision (if not possible conduct a handover appointment where new speech-language pathologist attends session)
Community and Aboriginal culture	Aboriginal culture	Treat each caregiver as an individual Ensure Aboriginal-specific SLP resources (e.g., dolls, books) are available Consider including Aboriginal languages in therapy Aboriginal staff to support clinical staff to engage with Aboriginal families

Expectations of service

Participants spoke about their experiences with SLP services, expressing some uncertainties initially about what therapy would entail:

It was a lot different to what I expected. I was expecting it to be, not exactly boring, but not as enthusiastic as it is. (8)

They [other Aboriginal people] probably don't get to experience what speech therapy is like. So many questions are asked in the first appointment. (10)

Commitment of caregiver

One theme that emerged strongly was that of caregiver commitment and motivation. A number of participants emphasised their commitment to their children's care, and wanting the best outcomes for their children: "We both put ourselves on the backburner and do everything we can for the kids" (3); "It's going to improve his future" (2).

Child and caregiver experience with speech therapy

It was important for caregivers that their children liked the speech-language pathologist: "He's excited to go there" (2).

Child's receipt of attention

It was also important for caregivers that their children received individual attention: "The work is directed especially at her, as her own person, and L loves the individual attention she gets from [the speech-language pathologist]" (3).

Caregiver skill acquisition

Caregivers also reported the benefits of learning new skills themselves: "It's shown me how I can do different sounds with my son" (8); "We play the games at home and we both enjoy them" (3).

Theme 2: Impact of the health service (individual clinician and organisational factors)

The participants mostly spoke about their experiences with the SLP service, but also made comments relating to Aboriginal-specific health services they had attended.

Flexibility

Some participants identified that the service flexibility facilitated them to attend SLP: "It's been pretty good working around our schedule. I don't work Fridays, so we can normally get an appointment on Fridays" (1).

Being able to bring siblings to their child's SLP appointment was seen as positive by participants: "I'm able to take my baby as well and [speech-language pathologist] doesn't mind" (5).

Relationship

Positive aspects of the relationship between the speech-language pathologist and both the caregivers, and the child, were directly referenced by many: "[The speech-language pathologist] is friendly and welcoming" (3); "Seeing the same person and having continuity of care. I feel comfortable" (4).

Receiving positive feedback from the speech-language pathologist was cited as important by some participants: "It's good to hear it from a professional – that you're doing the right thing" (7).

Difficulty in knowing how to contact the speech-language pathologist was also mentioned: "If you lose a piece of paper, or move house, it can be difficult to know how to contact" (4).

Location and physical access

Participants were recruited from seven sites, so responses relating to location or transport varied depending on participant location. Some participants listed location and transport as factors impacting on attendance:

It's only 15–20 minutes away, so that's good. (5)

I don't have a car, and to catch another bus would take half an hour and have to walk 10 minutes or more.

That would make it really hard to get there. (3)

Outreach services (e.g., in home or preschool)

Attendance at an Aboriginal maternal and child health service was discussed by one participant, with benefits including home-visiting: "They come to you – this was helpful when I didn't have a car" (4).

Multiple services in one location

Some participants mentioned services that they had attended which provided multiple services, e.g., an Aboriginal Medical Service: "The whole family goes there – my child has had the same doctor there since I was pregnant with him. They provide services like speech and dental" (5).

Theme 3: Influence of the client's community and Aboriginal culture

Changes to child's communication observed by others

Caregivers reported receiving feedback from others in the community about changes they had noticed in the children's communication: "More people are understanding him" (10); "Preschool noticed the difference" (5).

Others' perceptions of child

Negative perceptions about children with communication impairment were raised: "Some people look down on you when you have children that have something wrong with them" (3).

Aboriginal staff and resources

Participants reported benefits of Aboriginal-specific services, relating to the resources, as well as the staff:

My son loves the picture there – the Aboriginal pictures – he looks at all of them. (3)

Having someone to understand culturally – no judgement. (4)

My son has had the same doctor there since I was pregnant with him. (5)

When asked how the SLP service could be made more culturally-appropriate, participants provided the following suggestions:

Having someone call rather than send a letter. (4)

Need to make people more aware of why there are no adults with speech delay. (10)

Extra free lessons. (8)

Some things that people may like are Aboriginal languages being included in therapy. (7)

Some participants did not identify any strategies for the service: "I'm really happy with going now" (2).

The different backgrounds and experiences of Aboriginal families were succinctly expressed by one participant: *Everyone's so different* (7).

Community awareness of SLP

Some participants noted that other people in the Aboriginal community were not aware of SLP services, or the significance of communication impairments, and suggested greater community education: "Try and get out there [into schools and community] and provide more information to families" (6).

Discussion

The themes that were identified by the caregivers in this study are consistent with those identified in other studies investigating Aboriginal clients' experiences with Aboriginal or mainstream health services, and clients' (not specifically Aboriginal clients) experiences with SLP services, including the skills and knowledge of the caregiver (Department of Social Services, 2013; O'Callaghan et al., 2005), the impact of the service provider (NACCHO, 2001) and the relationship with the community (McBain-Rigg & Veitch, 2011). The caregiver perceptions of the SLP service were consistent with those identified by non-Aboriginal families attending similar SLP services elsewhere, such as relationship with the speech-language pathologist, flexibility, awareness, and access to transport (McAllister et al., 2011; O'Callaghan et al., 2005). This overlap in themes indicates that many issues are common for both Aboriginal and non-Aboriginal families attending SLP, but some issues (e.g., positive reinforcement, explanations of wider impact) may be more salient or be relevant (e.g., Aboriginal staff and resources) only to Aboriginal families.

Factors that facilitate Aboriginal families to access services

Participants in the present study were already engaged in SLP services, however, some participants did highlight that other Aboriginal people may not be aware of the need for SLP services, and this is consistent with previous research regarding SLP services (O'Callaghan et al., 2005). Caregivers need to be aware of the SLP service and its benefits in order to access and engage with the service. SLP services need to reinforce the benefits of attending therapy in relation to skills required for broader life and community aspects (e.g., social, vocational, and well-being benefits) through community education. However, if barriers still exist (e.g., knowledge, transport, location, other commitments, illness), then families may continue to have difficulties accessing and engaging with services. Participants identified that flexibility with the site where services were provided was important in regards to easy access to public transport. This could be further facilitated by SLP services routinely providing caregivers with information on transport options (e.g., public transport, community transport).

Ways to increase Aboriginal families' engagement with services

Participants overwhelmingly cited improvements in their children's communication and their own skills as being facilitative to their engagement with the SLP service. Improvements in the children's communication skills encouraged attendance, with caregivers willing to accept

help and advice from professionals in a mainstream setting. The emphasis on attaining the best possible outcomes for their child was consistent with the findings from a large-scale Aboriginal study (Department of Social Services, 2013). Their willingness to accept this help and advice was supported by participants' strong commitment to their child's care and future. Parents' ability and willingness to engage in therapy may be an indicator of awareness of the long-term implications of untreated communication impairment (McAllister et al., 2011). In this research, caregivers identified that the development of their own skills had enabled them to conduct work with their child at home.

It was also important to participants that other people in their lives (e.g., preschool teachers, community members) noticed improvements in their children and their own skills. Priest, Mackean, Davis, Waters, and Briggs (2012) found that sharing positive messages about Aboriginal children's health and well-being was important to Aboriginal families. Speech-language pathologists should therefore provide caregivers and other stakeholders with both positive and specific reinforcement to highlight how Aboriginal families are positively engaging with the SLP service (e.g., attending therapy, participating in the session, completing homework) and how their children are improving as a result of the intervention and their commitment. This positive reinforcement may help to override the feelings of disempowerment felt by Aboriginal people when encountering the often-reported negative health (Priest et al., 2012).

Responses from the current study confirmed that relationships are a crucial part of any therapy with Aboriginal people (Eckerman et al., 2010; Nelson & Allison, 2004), and highlighted the importance of both trust and consistency. Participants frequently reported positive aspects of the relationship with the speech-language pathologist, consistent with other studies (Eckerman et al., 2010). Webb (2012) identified that time should be taken to develop and maintain relationships with Aboriginal families. For the current service this includes the family attending sessions to become familiar with the service, prior to commencing the SLP assessment.

Participants provided recommendations for ways for the SLP service to improve engagement with other Aboriginal families (including Aboriginal artwork, phone calls rather than letters). Sharing of information of what has worked in one service may assist other services to successfully implement relevant strategies in their own practice, i.e., knowledge transfer (Graham et al., 2006). Such strategies can occur at the individual speech-language pathologist level (e.g., developing the relationship) or at SLP service level (e.g., include photos of Aboriginal families on service brochure), while other strategies may require higher level organisational support (e.g., service provided at the Aboriginal Medical Service).

Ways to make the service more culturally appropriate

Aboriginal cultural factors were identified as significant by some participants in the current study and they noted, for example, the importance of displaying Aboriginal artwork. SLP services should also consider having available Aboriginal-specific therapy resources (e.g., dolls, puzzles, books) as well as utilising assessment tools identified as relevant for Aboriginal children. In line with recommendations from Aboriginal families and organisations (e.g., NACCHO, 2001; Priest et al., 2012), it could be seen as best practice for Aboriginal families to be

treated by Aboriginal speech-language pathologists. However, with the low number of Aboriginal speech-language pathologists (Health Workforce Australia, 2014), this would not be feasible. Potential ways to address the current shortage of Aboriginal speech-language pathologists may be to include use of an Aboriginal liaison person, and cultural respect training of non-Aboriginal speech-language pathologists, to facilitate more culturally appropriate services (Martin & DiRienzo, 2012).

Consistent with the literature (NACCHO, 2001; Priest et al., 2012), the current participants identified Aboriginal-specific services that they had engaged with, but they did not identify a preference for an Aboriginal SLP service. It is unclear whether this relates to the lack of access to Aboriginal speech-language pathologists, and further investigation is warranted. The lack of Aboriginal speech-language pathologists has not been addressed to date (Byrne, 2015) and consideration needs to be given to whether increasing Aboriginal SLP staff would positively impact on access and engagement of Aboriginal people with SLP services.

The service and health staff commitment to the completion of cultural respect training (Martin & DiRienzo, 2012) will facilitate increasing staff understanding of the historical and ongoing factors that impact on the engagement and attendance of Aboriginal people in mainstream health services. Additional strategies to increase cultural appropriateness of the service include incorporating photos of Aboriginal families in SLP service brochures and increasing liaison with Aboriginal organisations to provide clinical staff with information and education on engaging with local Aboriginal families.

Limitations and future directions

The participants were unaware of the Aboriginality of the interviewers and thus a preference to engage with known Aboriginal health staff may have impacted on some caregivers' participation. Future research may benefit from consideration of an Aboriginal person being involved as interviewer. The use of phone interviews may have limited the depth of information provided by caregivers (Bowling, 2002). Future research could consider using face-to-face interviews.

Participants were recruited for the study if their child was listed as Aboriginal in their medical record. Aboriginal people do not always identify as Aboriginal when asked by mainstream services (HNELHD, 2014) and thus potential participants may have been excluded from the study.

Further research in this area would benefit from a larger sample, from a wider geographical area and from consideration of the capacity to conduct face-to-face interviews or a focus group, for more in-depth exploration. Triangulation of the data set, including surveying of speech-language pathologists, Aboriginal community members who have not engaged with the SLP service, other professionals (e.g., teachers, general practitioners), and families accessing Aboriginal-specific SLP services would also provide other valuable perspectives.

Clinical implications

This pilot study identified 16 factors that were facilitative of Aboriginal families attending the SLP services. These factors related to the caregiver, the health service, and the Aboriginal community and culture. It is recommended that speech-language pathologists identify opportunities to engage with the local Aboriginal community to ensure

Aboriginal families and key stakeholders are aware of local SLP services, including reasons for referral to SLP, referral mechanisms, and expectations of the services. Speech-language pathologists can assist families to engage in services by allowing time to build the relationship, maintaining a consistent clinician, and being flexible with scheduling appointments and venues. Health service providers are recommended to identify ways to ensure the service is culturally appropriate, including provision of Aboriginal-specific resources (e.g., toys, artwork), the availability of Aboriginal liaison officers and providing non-Aboriginal staff with cultural respect training. Many facilitative aspects referenced by participants were not specific to SLP, such as relationships, flexibility, and culture. Clinical implications and solutions from the current study may also have applicability for other allied health and community services working with Aboriginal families.

Note

In accordance with NSW Health policy, the term "Aboriginal" is used throughout this document to include Aboriginal and Torres Strait Islander peoples. No disrespect is intended towards Torres Strait Islander staff, patients or communities.

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Assessment and treatment of aphasia in Aboriginal Australians

Linguistic considerations and broader implications for cross-cultural practice.

Elizabeth Armstrong, Graham McKay, and Deborah Hersh

This paper discusses the notion of language difference related to aphasia assessment and treatment in the context of differences between Standard Australian English and Aboriginal English. While cross-cultural and cross-linguistic differences and their effects on clinical approaches have been an important focus of discussion in the field of aphasiology due to the increasing diversity of clinical populations, literature related to language variation within the one language is sparse. This paper discusses Aboriginal English, a dialect of English that differs from Standard Australian English, in relation to conceptual-cultural frameworks, and social-pragmatic patterns of language use in Aboriginal Australians, along with their potential impact on clinical practice. Aspects such as grammatical and lexical features of Aboriginal English, event and story schemas, and pragmatic features serve to highlight differences between Aboriginal English and Standard Australian English. Reference to the variety of Aboriginal languages will also be made, along with discussion of interpreting issues. Variations described in the paper are highlighted in terms of their significance for potential misdiagnosis of pathological patterns of language use and the careful consideration required to accurately assess communicative competence in non-dominant languages and dialects.

Inter-cultural assessment and treatment presents numerous challenges to speech-language pathologists around the world. Clinicians must face issues such as dealing with languages other than their own, assessing what is “normal” and “pathological” against a background of cross-cultural pragmatic differences, and attempts to assess and treat with (and sometimes without) the assistance of interpreters or culturally/linguistically appropriate tools. Though discussion of explicit cross-cultural and cross-linguistic issues can be found in the

literature, little has been written about the challenges faced when the aphasia clinician encounters different varieties of their own language – for the purposes of this paper – English. For many years now, different varieties of English have been acknowledged as valid variants of English rather than sub-standard versions of English. It is becoming increasingly common to hear reference to British English, American English, Australian English, Singaporean English, with systematic phonological, grammatical and semantic variations acknowledged as characterising particular types. However, while the dominant form of English is often discussed, for example, in the media of a country, relatively little is heard of the non-dominant (non-standard) varieties. This paper explores this issue in the Australian context, contrasting Standard Australian English (SAE) with another variety within Australia, Aboriginal English (AE), and examines implications for the assessment and treatment of Aboriginal Australians with aphasia.

Eades (2004) defines Aboriginal English as “the name given to dialects of English spoken by Aboriginal people throughout Australia, which differ from Standard Australian English (SAE) in grammar, phonology, lexicon, semantics and pragmatics” (p.491). Variation ranges from the “heaviest” (i.e., most different from SAE) in remote areas to relatively “light” in urban/metropolitan areas. While according to the 2011 Australian census, “English” is the only language used by 83% of Indigenous people across Australia (ABS, 2011), this finding could be misinterpreted because of the failure to distinguish between Aboriginal English and Standard Australian English.

Issues related to language difference are significant for clinical aphasiology practice in Australia, given the high incidence of stroke and other forms of brain damage in Aboriginal Australians (and hence the potential for aphasia) (Katzenellenbogen et al., 2010; Jamieson, Harrison, & Berry, 2008). The age at onset of stroke for Aboriginal Australians is significantly younger than their non-Aboriginal counterparts (Katzenellenbogen et al., 2010; Katzenellenbogen et al., 2016), and Aboriginal stroke patients are also more likely to be dependent at discharge compared to non-Aboriginal patients (Kilkenny, Harris, Ritchie, Price, & Cadhilac, 2012). Higher incidence of stroke exists in the context of higher risk factors and co-morbidities in Aboriginal Australians, i.e., hypertension, diabetes, cardiovascular disease (Australian Institute of Health and Welfare, 2016). This situation exists in the context of a relative lack of knowledge about this group, with only a few published studies to date exploring

KEYWORDS

ABORIGINAL

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the experiences of Aboriginal people with acquired communication disorders (Armstrong, Hersh, Hayward, Fraser, & Brown, 2012; Armstrong, Hersh, Hayward, & Fraser, 2014; Armstrong, Hersh, Katzenellenbogen et al., 2015) or the attitudes of health professionals working with Aboriginal and Torres Strait Islander clients with acquired communication disorders (Hersh, Armstrong, & Bourke, 2015; Hersh, Armstrong, Panak, & Coombes, 2015; Cochrane, Brown, Siyambilapatiya, & Plant, 2015).

In the same way that speech pathologists need to be aware of potential effects of aphasia on languages other than English in order to be able to assess and treat disorders, it is equally important that they have knowledge of different forms of English and related cultures of different English speakers so as to be able to place these speakers in the context of their own linguistic and cultural backgrounds. While the features discussed in this paper are specific to Australian Aboriginal English, the principle of addressing language variation is applicable to cross-cultural assessment and treatment in speech-language pathology in general. It is particularly applicable to other indigenous peoples internationally – a context in which again little is written regarding aphasia. To the authors' knowledge, five papers are currently available related to the Māori experience of aphasia (Brewer, Harwood, McCann, Crengle, & Worrall, 2014; Brewer, McCann, Worrall, & Harwood, 2015; McLellan, McCann, & Worrall, 2011; McLellan, McCann, Worrall, & Harwood, 2014a; McLellan, McCann, Worrall, & Harwood, 2014b), and one in the US context (Huttlinger & Tanner, 1994). However, these papers focus on broad cultural issues rather than specific linguistic ones.

While broad social and cultural issues are crucial parts of the context regarding services for Aboriginal clients (see Penn & Armstrong, in press, for overview), this paper will focus on specific linguistic and conceptual-cultural issues reflecting differences. A pilot study undertaken (Armstrong, Hersh, Hayward, & Fraser, 2014), and a larger Western Australian state-wide study currently underway (Armstrong, Hersh, Katzenellenbogen et al., 2015) address the broader issues such as construction of disability in Aboriginal Australians, and attitudes to aphasia and the aphasia experience, as well as services offered.

This paper does not provide a detailed description of the phonological and lexicogrammatical aspects of AE features (for a more detailed view of phonological and lexicogrammatical aspects, see Blair and Collins, 2001; Butcher, 2008; Walsh and Yallop, 1993). Neither does this paper refer explicitly to broader dialectal issues – for a discussion of broader cultural and identity implications of AE as a dialect, and its relationship to Standard Australian English, the reader is referred to Malcolm (2013). Rather, this paper highlights some of the differences between SAE and AE that are important to consider in aphasia assessments. In particular, the paper challenges the use of “normative” or “perceptual” judgements of symptoms without a clear understanding of what is “typical” in AE contexts.

Features of AE

Phonological features

Some knowledge of phonological differences between SAE and AE is important for the speech pathologist managing people with aphasia because of obvious implications for the identification of phonemic paraphasias or apraxic errors. Firstly, there are key vowel differences between AE and SAE. For example, short and long vowel pairs may not be differentiated in Aboriginal English (e.g., /i/ versus /ɪ/, e.g., *creek* pronounced as /krɪk/); and most diphthongs are

monophthongised (Malcolm & Grote, 2007, p. 154). Unstressed vowels at the beginning of words are often omitted as in words such as *along* (Malcolm, 2001). Fricatives of SAE often correspond to stops in AE and the voiced–voiceless distinction in consonants may not be made as consistently in AE. For example “finish” may be pronounced as /pɪnɪʃ/, *they* as /deɪ/ and *bed* as /bɛt/ (Malcolm & Grote, 2007, p. 154). However, awareness of phonological including phonotactic differences is also important, as phonological features are involved in the realisation of numerous grammatical aspects of language. For example, there is a strong tendency for consonant clusters to be simplified and, among other things, this can be a contributing factor to the non-use of inflectional suffixes such as plural –s on nouns and singular present tense –s on verbs. Hence, phonological issues can have an impact on grammatical analyses as well.

Speech pathologists need to be aware of the nature of such contrasts before being able to make judgement calls on the presence or absence of phonemic, lexical or grammatical errors. Absence of such appreciation could certainly lead to false identification of “errors” or pathology.

Lexical features

In terms of lexical skills – a key focus of language assessment in aphasia – numerous semantic differences exist that would impact on assessment and treatment practices. While the words of AE are superficially very similar in spoken form to words of SAE, this masks extensive differences in meaning and use. Malcolm and Grote (2007) note a number of examples of semantic extension (e.g., *learn* = *teach* and *learn*; *grannies* = *grandchildren* or *grandparents*; *raw* = *uncooked* and *unripe*); semantic narrowing (e.g., *language* = *Aboriginal language*; *clever* = *with spiritual powers*); and semantic shift (e.g., *kill* = *hit* or *kill*; *too much* = *very much*; *stop* = *remain at a place for some time*; *cheeky* = *dangerous*). Use of words can be much wider than in SAE as in the use of ‘long’ in both horizontal and vertical dimensions (= both *long* and *tall*) (Malcolm & Grote, 2007, pp. 158–159).

A common area of mismatch between SAE and AE in this respect arises in kinship terminology. Take, for instance, the terms *father*, *mother*, *uncle*, *aunt(ie)*. In Standard Australian English *father* and *mother* are terms that typically refer to unique individuals in relation to each person. In the Aboriginal English of Arnhem Land, following the pattern of the local Aboriginal languages, *father* includes not only one's own father but also all of one's father's brothers. Similarly *mother* includes all of mother's sisters. These terms are even more inclusive than in SAE because these relationships are classificatory rather than biological, so they include many people who are not biologically related to the individual. As a result of this expansion in the range of people covered by the terms *father* and *mother*, the terms *uncle* and *aunt* are much more restricted in their range of referents in AE and Aboriginal languages. Similar patterns apply in other parts of Australia too, with some exceptions. In Aboriginal English in southern Australia, however, the terms *uncle* and *auntie* are used to refer to and to address a wider and different range of people/elders than is applicable in Standard Australian English or in Arnhem Land Aboriginal English.

Another example involves the term *afternoon* as used in central Arnhem Land Aboriginal English. A simple undertaking such as *I'll come and see you this afternoon* would leave a SAE speaker thinking that the speaker would turn up sometime after 12 noon. An AE speaker of that area

would not expect to see the speaker before 4.30 or 5 p.m. or so. In this AE, the word *afternoon* signifies “late in the afternoon when the sun is no longer high overhead and the day has got cooler”. (This aligns directly with the way the day is classified in local Aboriginal languages. The period roughly 10 a.m. to 4.30 p.m., (when the sun is high in the sky and the day is hot), is called, in Aboriginal English of that area, *dinner*, this being also the term for the midday meal.

There are obvious implications of these lexical differences in terms of standardised testing and analysis of word usage during discourse. While different usage could again result in attributing semantic “errors” – semantic paraphasias for example – apparent “misunderstandings” by Aboriginal speakers could be seen as being representative of an aphasic comprehension deficit rather than accurate comprehension in their own semantic framework.

Grammatical features

In terms of morphology, overall there is reduced functional morphology and fewer function words in AE compared with SAE. Malcolm and Grote (2007) summarise the morphological features of Aboriginal English as follows:

Many morphological features which are obligatory in Standard English are optional, if present at all, in Aboriginal English. This may be seen in part as a carry-over of the processes of simplification from earlier contact varieties from which the dialect has evolved, but also the result of deliberate communicative strategies, as the users of this dialect tend to avoid explicitness and to expect a significant interpretive role on the part of the listener, taking due account of context. (p. 155)

For instance, an important feature of AE is lexical substitution, where a pro form such as *thing/ting/sing* takes the place of a noun – when it is assumed that the meaning can be found in the surrounding physical context, rather than in the text. Explicitness is not a feature of AE. This will be referred to later in terms of pragmatics and discourse as well.

Among the morphological features not used or optionally used in Aboriginal English are plural marking on nouns (e.g., *tell me how many stroke you had*), possessive marking on nouns, past tense and third person singular present tense marking on verbs (e.g., *she come down and pick me up; he work at the hospital*) and the verb to be as an auxiliary or copula (e.g., *you speaking to people; she only down in my house*). In some cases distinctive alternative morphemes or constructions may be used in AE, such as the preverbs *bin* for past tense (e.g., *we bin see*) and *gonna* or *gotta* for future tense (e.g., *we gonna start*) or the use of juxtaposition to mark possession (e.g., *my mum mum = my mum’s mum; one little boy trouser = one little boy’s trousers*) (Malcolm & Grote, 2007, pp. 155–157; Malcolm & Koscielicki, 1997, p. 68).

While such specific grammatical markers are not typically a focus of clinical aphasia assessments, they are relevant to studies investigating cross-linguistic differences in manifestations of Broca’s aphasia, and again, are important to note as they may be erroneously considered to be grammatical “errors” indicating pathology for diagnostic purposes rather than normal usage. In particular, the difference in verb usage is relevant to judgements of grammaticality in aphasic discourse where the verb has become a focus of both assessment and treatment in recent years (Webster & Whitworth, 2012). Again, while different patterns of verb usage are acknowledged in cross-linguistic studies, such patterns of difference within a

language such as English may be deemed pathological by the unaware clinician.

Of particular interest is the fact that the pronoun systems of SAE and AE are different. Pronoun usage has been fairly extensively researched in aphasia in terms of discourse cohesion with pronouns being said to be both “overused” in many forms of fluent aphasia due to speakers’ word-finding difficulties associated with explicit referents, and confused at times with *he* often being substituted for *she* and vice versa (Glosser & Deser, 1990; Nicholas, Obler, Albert, & Helm-Estabrooks, 1985; Williams, Li, Della Volpe, & Ritterman, 1994). In AE, case and gender distinctions are not necessarily maintained in the third person singular (e.g., *him* used as subject pronoun instead of SAE *she*). Also related to reference and cohesion, determiners are often not used in noun phrases (e.g., *man came home*). In addition, non-specific lexical referents such as *something* or *someone* as referred to above, have also been noted as pathological in fluent aphasic discourse when used extensively, substituting for more explicit referents. Such terms are common in AE and this is thought to be due to the implicit nature of Aboriginal discourse stemming from shared experience among many speakers at a local level. Unless these differences were known to the assessor, the resulting patterns would again be marked as “errors” of reference. Further research would have to explore whether or not the referencing system is affected in AE and how this might manifest itself.

Event and story schemas (macrostructure)

As narrative analysis is arguably the most commonly used discourse analysis in aphasiology (Olness & Engelbretson, 2011), and as elicitation of narrative as the individual’s personal story and way of working through identity issues is being increasingly encouraged in clinical practice (Hinckley, 2007; Shadden, Hagstrom, & Koski, 2008), it is important to note that Aboriginal stories can reflect schemas which are not necessarily shared with non-Aboriginal listeners (McGregor, 1987; Malcolm & Rochecouste, 2000). Stories told using these schemas (genres) do not necessarily sound like “real” stories to non-Aboriginal listeners because they lack elements considered to be key in western narratives such as complication and resolution. For Aboriginal listeners and storytellers this is not something they notice since their story schemas/genres are different.

In the early 1970s, prior to the formal identification of such schemas, co-author Graham McKay was collecting stories in the Rembarrnga language of Arnhem Land from a Rembarrnga speaking man (BN). This narrator mentioned in conversation that he and his extended family had recently been travelling on foot in the bush and that one night their camp had been invaded by a buffalo. In anticipation of a “good” story – because that sounded like a great complication – Graham asked him to tell the story for the tape recorder. He began his story (in Rembarrnga) “*We left from...*” and he continued along the lines of “*we went to x, we ate a, we slept, we got up, we went to y, we ate b, we slept, we got up, we went to z, we met so and so there...*” etc. The story continued in this vein (classic Travel schema) covering about a fortnight’s travels before coming to an end back at their starting point. The buffalo in the camp episode never appeared. When this was pointed out to him after conclusion of the story BN graciously told a very short story that contained only the buffalo in the camp episode – an exciting Complication that had had no place in his Travel schema story. The Narrative genre was not so culturally relevant to him as a Rembarrnga speaker.

Clear examples of schemas can be found in the work of Malcolm and Rochecouste (2000) in which the authors analysed data collected from children in the Yamitji region of Western Australia (Geraldton is the regional centre). Malcolm and Rochecouste identified eight story schemas that emerged from casual group conversations – Travel, Hunting, Gathering, Observing, Encountering the unknown (“scary things”), Isolation from the group, Problem-solving, and Borrowed schemas (including fairy tales, news contributions and jokes). These schemas varied from SAE schemas in aspects such as detail, explicitness and sequencing – all of which are central to current speech-language pathology assessments of “normalcy” of discourse. Hence again it is crucial these aspects are understood in order for assessments to be meaningful.

In addition to actual schema structure organisation, several discourse *strategies* have also been identified that contribute to the coherence of the discourse (Malcolm & Rochecouste, 2000). Three examples of these are: surveying, topical development by association, and collaborative narration. According to Malcolm and Rochecouste,

surveying is an inclusive way of describing a scene or a succession of actions so that nothing is highlighted above the rest. Thus, undeveloped detail may be included simply because it is there, rather than because it progresses a particular narrative trajectory. (p. 270)

If we consider that seemingly irrelevant details are often labelled “tangential” in clinical assessment contexts, this strategy is of interest. Similarly, the strategy of “topical development by association” – where the speaker develops the narratives through association of topics rather than chronological sequencing – may fit into this category of “tangential”. This occurs both within turns and across turns (i.e., with multiple narrators) in Yamatji speakers.

Collaborative narration is also a feature of AE, where two or more speakers may jointly produce the story or exposition, with one prompting, corroborating, extending, clarifying and expressing agreement with the other. Malcolm and Rochecouste note that “In Aboriginal yarning situations listeners are free to contribute to the on-going talk and this is not seen as interruption but rather as helping the narrator to tell his or her story” (p. 272). While collaborative narration occurs in other forms of English (Norrick, 2000), and indeed can be a resource for people with aphasia (Olness & Ulatowska, in press), it is a significant feature of AE. Hence it may be important to include opportunities for this aspect of language in an assessment of an AE speaker, rather than focusing on monologic discourse sampling. This aspect of narration leads into so-called pragmatic features of AE discourse.

Pragmatic features

Pragmatic issues are relevant to both assessing and treating an aphasic client, and to talking with relatives and carers, and are central to all service-oriented interactions. In recent years conversation analysis has taught us much about conversational patterns in everyday communication between people with aphasia and others (e.g., Wilkinson, Beeke, & Maxim, 2010; Wilkinson & Wielaert, 2012), and yet the research has primarily concerned western European speakers. The exception to this is the work of Penn and colleagues who have explored conversations in the South African context (Penn, 2000; Penn, Frankel, Watermeyer, & Russell, 2010).

Table 1. Grice’s maxims (1975)

Maxim of quantity:

1. Make your contribution to the conversation as informative as necessary.
2. Do not make your contribution to the conversation more informative than necessary.

Maxim of quality:

1. Do not say what you believe to be false.
2. Do not say that for which you lack adequate evidence.

Maxim of relevance:

Be relevant (i.e., say things related to the current topic of the conversation).

Maxim of manner:

1. Avoid obscurity of expression.
2. Avoid ambiguity.
3. Be brief (avoid unnecessary wordiness).
4. Be orderly.

One framework often used in speech pathology contexts to assess pragmatic “skills” is that of Grice’s conversational maxims (Grice, 1975) – see Table 1. Linguist Michael Walsh (in preparation) discusses the cross-cultural relevance of these maxims, and in particular has noted their western/European basis and queried their relevance to Australian Aboriginal discourse. He proposes a number of different maxims for Aboriginal interaction, including the Maxim of intentional vagueness, which reflects the lack of explicitness in Aboriginal language use. As noted above, use of non-specific words and a reliance on inference is prominent in AE. This is of particular interest as it often runs counter to Grice’s maxims of relevance and manner and is often identified as “pathological” in assessment of individuals with neurogenic communication disorders. In fact, directness is often avoided in Aboriginal cultures – and stories/ recounts are built up gradually, drawing on numerous related facts and instances that may not be directly related to the current story. Researchers have noted the need for repeated interviews in qualitative research studies with Aboriginal people and have taken care to ensure relatively unstructured and casual “interview” environments more than is traditionally recommended in this approach (Marshall, Kendall, Catalano, & Barnett, 2008; Watson, Hodson, & Johnson, 2002). It not only takes time for a trusting conversational relationship to develop between the interviewer and interviewee, but the style of discourse is such that stories are told in a way where they often develop over time in terms of detail and explicitness. Clinicians need to be particularly aware of this in terms of both case-history taking and in assessing discourse.

Other pragmatic features of interest relate to turn-taking and the role of silence in interactions. The few conversational studies focused on Aboriginal language use have been in relatively remote communities where AE is only one of the languages spoken or where the language is a mix of a traditional language, Kriol (a creole or contact language developed from English and local Aboriginal languages) and AE. For example, in 1995, Walsh studied a group of speakers of Murrinh-Patha, which is a language spoken in the Daly River region in the Northern Territory. He reported a non-dyadic and continuous conversation style, with a tolerance for long periods of silence, when speakers were in the context of gatherings of people around a camp. In this context, there was much overlap of talk, with

speakers stopping and starting without reference to other speakers in the group – “broadcast talk”. Speakers tend not to address (or even face or look at) particular participants in these contexts (= “non-dyadic” communication). Speakers either seem to start up talking whenever they chose to, with little consideration for what other participants or prospective participants might be doing (= “continuous” communication). However, it must be carefully noted that Aboriginal speakers at times do direct their talk to particular people and also engage in turn by turn talk. But Walsh (1995) stresses the normality of “non-dyadic” and “continuous” patterns, as does Liberman (1985).

The role of silence has also been highlighted by Eades’ work (1993, 2000, 2004) and in later work by Mushin and Gardner (2009). In 1992, Eades developed a handbook for lawyers about Aboriginal English particularly in relation to courtroom interactions in which she made the following statement about the role of silence in AE:

Do not interpret silence as an Aboriginal speaker’s admission of guilt or ignorance, or even as evidence of a communication breakdown. Remember that silence is often used positively by Aboriginal people to think about things and to get comfortable with the social situation. (p. 493)

Furthermore, work by Eades (1982, 1991, 1993) highlights the role of relationships and authority, for specific Aboriginal speakers, in the legitimacy of imparting and the willingness to impart various types of information to specific interlocutors – information which to the English speaker would be seen as quite freely exchanged, but which for Aboriginal people may be subject to various controls.

As a practical guide to pragmatics of interaction, the Western Australian Centre for Rural Health (WACRH; n.d.) in Geraldton, Western Australia, has published discourse guidelines as part of an online cultural competence training module (Cultural Orientation Plan for Health Professionals, Module 3: Working with Aboriginal People). The guidelines highlight the differences in pragmatic style between Aboriginal and non-Aboriginal speakers (see Table 2). In addition to the above features, it is well acknowledged that Aboriginal speakers utilise multiple modalities to communicate, including sign language, manual gesture, and (in some traditional contexts) sand drawing (Wilkins, 2001). It is important that clinicians are aware of potential strengths that could be utilised by Aboriginal people with communication difficulties, and that such potential is included in assessment and treatment processes.

Aboriginal languages other than English

According to the 2011 Australian census, 11% of Aboriginal and Torres Strait Islander people speak a language other than English at home. Of these, 83% reported speaking English “well” or “very well”. Seventeen per cent reported not speaking English well. The assessment and treatment of speakers of traditional Aboriginal languages pose particular difficulties as interpreters are often impossible to obtain, with around 145 Aboriginal languages in use, out of an original 250 according to the National Indigenous Language Survey (Department of Communications, Information, Technology and the Arts, 2005). Most of these languages are no longer actively used in communities, except in the more remote regions of the country, though the influence of these languages is apparent in creoles and forms of Aboriginal English that have resulted from contact between English speakers and speakers of these languages in past generations as well as up to the present.

Traditional languages are very different from English. There

Table 2. Aboriginal and non-Aboriginal communication styles.

Non-Aboriginal communication style	Aboriginal communication style
When I arrive in a new place I walk up to people to meet them	When I arrive in a new place I stay back until I’m invited to approach
I speak to both men and women equally	It’s not always appropriate for me to speak to the opposite sex, depending on kinship relationships and lore
When meeting people I extend my hand in welcome and look at them eye to eye	I’m reserved when I meet people, will often stay silent and will make minimal eye contact
When I meet people I like to call them by their first name	I have more than one name and for some of our people it’s disrespectful to say their name without first finding out what name they prefer
I rely on verbal communication to understand what is being said	I rely a lot on body language to understand what is being said
I’m uncomfortable with silence, it often means people haven’t heard me	I’m comfortable with silence, it allows thinking time and time for others to speak
I will tell you most of my problems even though I don’t know you very well	Until I get to know and trust you I might tell you only part of my problem
If I disagree with what’s being said I will say so or ask for clarification	If I disagree with what’s being said I will often pretend I don’t know or walk away
When I say “yes” it means I have understood and agree	When I say “yes” it could mean many things including I don’t understand the question
Cultural Orientation Plan for Health Professionals, Module 3: Working with Aboriginal People. Reproduced with the permission of the Western Australian Centre for Rural Health (January 2013).	

is also considerable diversity between the Aboriginal languages in various parts of the country. However, suffice to say that the phonological systems are very different from English, with, generally, far fewer vowels, no fricative consonants at all and no voiced–voiceless distinction for stops. These languages typically do not have articles or prepositions and they also lack a distinct class of adjectives. However, grammatically, these languages use much more inflectional and derivational morphology than English does and personal pronouns often make many more distinctions than English does. Typically personal pronouns distinguish three persons (1st, 2nd, 3rd) and three numbers (singular, dual and plural), as well as other distinctions not made in English. Yallop (1993) provides a brief overview of the nature of the Aboriginal languages found in Australia.

Discussion and conclusions

The differences described here between Aboriginal English and Standard Australian English have significant

ramifications for the assessment and treatment of aphasia by clinicians within Australia. Discussions of such differences, which at times can appear subtle on a surface level, also have implications for aphasiologists dealing with language variation worldwide. As language specialists, aphasiologists (and indeed speech-language pathologists in general) working in clinical settings need to have some knowledge of language differences in order to be able to accurately assess language skills and diagnose “disorder” as opposed to “difference”. In the paediatric field of language disorders, there has been much controversy within Australia regarding the use of tests standardised on SAE speaking children, for example, and it has been suggested that non-standardised assessment methods may indeed better accommodate language difference and reveal an AE speaking child’s actual linguistic abilities (Gould, 2008a, 2008b, 2008c, 2009). In the context of working across languages, Roger and Code (2011) have discussed the pitfalls associated with in working clinically with bilingual patients. These include situations where online translations of assessment tasks elicit responses which may be perfectly appropriate to the communicative context created through an interpreter-mediated interaction, but do not reflect the “correct” response targeted by the speech pathologist. This results in responses being labelled as “inappropriate” or “incorrect”. Implications of inaccurate assessments of language competence at any level in a person with aphasia, i.e., phonology, morphology, syntax, semantics, pragmatics, may equally lead to mis-directed treatment attempts to change the person’s first language skills, which may decrease that individual’s communicative functionality and underutilise any retained skills. Treatment goals based on inaccurate assessment would also seem inappropriate to the person and their family – potentially further alienating Aboriginal people from services which are already under attended (Edis, 2002).

While differences at the levels of phonology, syntax and lexical semantics can appear relatively clear, it is the interaction of these levels with the pragmatic level and with socio-cultural factors which highlights important differences to be noted. Western methods of eliciting and analysing narratives, for example, may not be appropriate in an Aboriginal context. Elicitation techniques such as picture sequence cards, ordered to target a particular chronological order of events may well elicit discourse from Aboriginal speakers that is very different in structure from the targeted western narrative structure. As noted above, a western speaker’s pattern of integrating and presenting detail is very different from an Aboriginal speaker’s pattern. Hence, for a valid assessment of the speaker’s skill to be made, assessors must be aware of these differences. Conversational dynamics are very different as well; hence traditional analyses and subsequent advice to conversational partners would have to be modified.

In assessing a person’s language skills, context is known to be central in how the person might communicate in a particular situation. In the same way that different conditions of eliciting language have been explored with English and European language speaking people with aphasia (e.g., Wright & Capiluto, 2009), speech pathologists are challenged with examining optimal ways of assessing Aboriginal peoples’ skills as appropriate and in a way that reflects true abilities. In a related but relevant article, Malcolm (1994) described the language behaviours of Aboriginal children in and outside the classroom (on the edges of the Western Desert in Western Australia) and found them very different. He identified different kinds

of discourse expectations of non-Aboriginal teachers which reflected both cultural differences between what each considered significant aspects of what should be discussed, plus the effect of an externally constructed context (i.e., external to the Aboriginal participants). Malcolm concluded that:

The discontinuity, as I see it, is always associated with the presence of Aboriginal communicators in a setting or speech event which is defined by non-Aboriginals. The key, if there is a key, to how Aboriginal people communicate, seems to me to lie in who defines the setting and determines the discourse pattern. There is therefore a commonality, in communicative terms between schools, classrooms, law courts, offices of government departments and anywhere where there are interactions in which the non-Aboriginal interlocutor defines the terms of communication. All of these settings will be associated with behaviour patterns which will not evidence the communicative competence of many Aboriginal people. (p. 150)

Malcolm also writes about teachers not being able to “set up appropriate conditions for them [the students] to communicate in a way which demonstrates the extent of their competence” (p.151). These statements are very reminiscent of comments made about the aphasia rehabilitation context which question the role of the traditional assessment and treatment situation as tending to demonstrate incompetence rather than the person with aphasia’s competence (Kovarsky, Duchan, & Maxwell, 1999; Simmons-Mackie & Damico, 2008, 2009).

While linguistic and sociolinguistic issues have been the focus of this paper, they must obviously be considered within the broader cultural context when working with Aboriginal clients. Issues such as construction of identity and disability within Aboriginal populations, co-morbidities, and attitudes to health services obviously need to be addressed when considering potential services (Armstrong, Hersh, Katzenellenbogen et al., 2015; Penn & Armstrong, in press). The centrality of such issues was noted by Ariotti (1999), for example, who wrote about “the social construction of Anangu disability”. In this paper, he discussed the importance of health providers taking into account historical, cultural and linguistic factors, in order to gain insight into their clients’ attitudes, customs, and beliefs. Similarly, Boddington and Räisänen (2009) discuss the holistic nature of Aboriginal definitions of health and explore the difficulties inherent in attempting to align western and Aboriginal definitions because of cultural differences.

In order to accommodate language variation in assessment and treatment practices, much work has to be done within the discipline of speech pathology and the “sub-specialty” of aphasiology. The notion of aphasia “assessment” itself and its associated paradigms need to be first re-examined in contexts such as the Aboriginal Australian one described in this paper if clients are to be provided with rehabilitation that is both culturally sensitive and informed. As with all investigations involving language and cross-cultural research and clinical practice, linguistic and cultural awareness on the part of practitioners is an integral first step.

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Educators' and carers' perceptions of Aboriginal children's communication and emergent literacy development

Gwendalyn Webb and Cori Williams

This paper presents the results of qualitative research into the perceptions of educators and parents/carers about Aboriginal children's communication and emergent literacy. Interviews with educators and parents/carers revealed three core themes: knowing the child and family; systemic factors; and individual factors affecting Aboriginal children's communication and development. Each core theme included sub-themes which are discussed in this paper. The findings of this research provide insights for speech-language pathologists working with Aboriginal people.

The links that exist between language development and literacy have been well documented. In the early childhood years, children's communication development is considered a precursor to their literacy skills and ongoing academic progress (ACECQA, 2009; Dickinson & Tabors, 2001; Zimmerman et al., 2009). Recent government policies and projects have been put in place to focus on enhancing early child development such as the National Quality Framework for early learning contexts (ACEQUA 2015). However, Aboriginal and Torres Strait Islander children's literacy and academic skills in general are lower than those of the non-Indigenous population (ACARA, 2015). This statistic comprises part of the "the gap" in equality which needs addressing in regards to health, education and socioeconomic outcomes for Indigenous Australians (Commonwealth of Australia, 2015). Despite recent government policies and projects to address the issue, it continues to be an area requiring attention. The gap is more pronounced in rural and remote areas, though it is still significant in urban regions of Australia.

Aboriginal and Torres Strait Islander children are less likely to attend early childhood education and care (ECEC) services, and if they do they are frequently in the minority context, where mainstream (non-Indigenous) culture and communication are dominant (Mason White, 2012).

In many places in Australia, Aboriginal children may be exposed to one or more Indigenous languages as their home language. In some areas a dialect of English, Aboriginal English (AE), may have been the main form of communication that the child has been exposed to prior to commencing formal schooling (Simpson & Wigglesworth,

2008). Communicating using AE in the local Aboriginal community is one way of maintaining cultural vitality, and is therefore important to Aboriginal people (Eckermann et al., 2010). Aboriginal English embodies cultural connection and identity for Aboriginal and Torres Strait Islander people (Harrison, 2004).

Few studies have considered communication and interaction in early childhood for this population (Ellis, Brooks, & Edwards, 2010; McLeod, Verdon, & Bennetts Kneebone, 2014). Culturally different ways of communicating need to be valued and considered for the impact they may have on children's progression into formal education. This paper describes the perspectives of Early Childhood Educators (ECEs), teachers and carers about issues relating to early childhood education, language and literacy development for Aboriginal children.

Method

A qualitative research design was adopted to address the research question for this current study, which forms part of a larger PhD study. Ethical approval was granted from a number of relevant organisations. These included the Curtin University Human Research Ethics Committee (Approval number: HR100/2012), the New South Wales Department of Education (SERAP number: 2014140), Kindergarten Union and the Regional Aboriginal Education Consultancy Group. The principles of conduct for ethical research with Aboriginal and Torres Strait Islander communities were adhered to (NHMRC, 2015). The research project was initiated by questions from members of the local Aboriginal community. The researcher, who is non-Aboriginal, then worked very closely with an advisory panel of experienced early childhood education and health professionals who work with the local Aboriginal community. This panel of experts provided guidance, support, and feedback about the research process and helped to ensure that respect and cultural integrity was considered throughout the process.

Participants

Participants recruited for this study included early childhood educators (ECEs), parents/carers of Aboriginal children, and both Aboriginal and non-Aboriginal adults working in the education system with children in their first year of formal schooling. The participants were recruited from the greater Newcastle area of NSW and were purposefully selected for their experience in working with individual Aboriginal children. Table 1 shows the numbers of participants and their roles. The inclusion of three separate sets of participants allowed for triangulation of the data.

KEYWORDS

ABORIGINAL

COMMUNICATION

EARLY CHILDHOOD EDUCATION

EMERGENT LITERACY

LANGUAGE

THIS ARTICLE HAS BEEN PEER-REVIEWED



Gwendalyn Webb (top) and Cori Williams

Table 1. Participant's roles			
Participants' roles	Aboriginal participants	Non-Aboriginal participants	Total
Early childhood educators	5	2	7
Parents/carers	8		8
School teachers		16	16
Total	13	18	31
Number of males	1	1	2
Number of females	12	17	29

Procedure

Participants were interviewed by the first researcher in the context of the education centre or school, to enhance comfort and minimise disruption to daily routines. Interview guides (Minichiello, Sullivan, Greenwood, & Axford, 1999; Patton, 2002) were used to ensure that questions were raised consistently across the interviews (see Appendix), however the questions remained a loose guide. Conversational and reflexive processes took precedence over structured interviewing so as to foster relationship building and connection and facilitate sharing. Aboriginal participants were introduced to the researcher by an Aboriginal community member or a member of the advisory panel, who provided authentication of the research. The parent participants were interviewed when their child was in ECEC, prior to school entry, so the conversations with these participants focused more on communication than literacy development.

The interview questions were developed from the literature (Malcolm et al., 1999; Oliver, Rochecouste, Vanderford, & Grote, 2011) and through consultation with the advisory panel. Interviews with the educators were audio-recorded and transcribed verbatim. Some parents expressed discomfort with being recorded in the interview context, so hand-written notes were taken during these interviews and read back to the interviewee to check the content and confirm the meaning.

The interviews were analysed using thematic analysis (Braun & Clarke, 2006). The researcher coded the participants' conversation into themes, some of which were based on theories from the literature (Dockett, Mason, & Perry, 2012). In the coding process, several themes also evolved out of the data, so a mixture of theoretical and inductive thematic analysis was employed in this process. Themes were confirmed by the second author and validated by the participants.

Results and discussion

Themes

Three main themes emerged from the interview data. The perceptions of the participants were that:

1. Knowing the child and their family informs practice of the educators and builds understanding.
2. Systemic factors affect Aboriginal children's communication and literacy development.
3. Child and family factors affect Aboriginal children's language and literacy development.

Within each core theme, several key concepts were identified; see Table 2.

Knowing the child and family

Educators and carers valued relationships formed at many levels for the impact these can have on a child's sense of belonging and inclusion in educational settings. Three key concepts within this core theme were identified.

Community involvement

Early Childhood Educators (ECEs), teachers and carers (C) emphasised the importance of engaging with the child's community and culture. The Aboriginal ECEs and carers expressed pleasure at the level of community involvement, and emphasised this as beneficial, as expressed by one Aboriginal ECE, who worked at an Aboriginal ECEC centre: "Extensively, everything that we want are available here ... lucky for us!" (ECE3).

Non-Aboriginal ECEs and teachers (T) acknowledged the importance of community involvement and provided examples of how the school or service was working towards engaging the community. "We have cultural activity days with community members. We've also had cultural awareness training and now we include the acknowledgement to country in our procedures and assembly" (T12).

Valuing language and culture

Respect for the Aboriginal child's heritage and culture was a theme which emerged from the data. Non-Aboriginal teachers discussed the need to acknowledge the child's culture and language. This was based on information provided during training either at university or post-graduation.

I did Aboriginal Education as a subject. We learned about not discounting their language, acknowledging what they bring to the school and trying to incorporate this as much as you can. We should not correct them because we don't want to affect their self-esteem. (T3)

Aboriginal ECEs acknowledged the AE dialect that children used and related this to their real-life experiences. For example when the following Aboriginal ECE was asked "What do you think about the way Aboriginal children talk?" she replied: "It's interesting. Not all of them, but the majority have some lingo going that they talk and use at home" (ECE5).

Table 2. Core themes and key concepts			
Core theme	Key concepts		
Knowing the child and family	Community involvement	Valuing culture and language	Developing relationships
Systemic factors affecting Aboriginal children's communication and learning	Teacher experience and training in working with Aboriginal families and children	Teaching and learning strategies implemented in the classroom	Extra support provided at school for areas of need
Child and family factors affecting Aboriginal children's communication and learning	Health and well-being, including family life and the home environment	Cultural factors	Individual children's skills and strengths

Some non-Aboriginal participants demonstrated less knowledge about Aboriginal culture and language; their responses indicated a lack of awareness of Aboriginal English as a respected dialect. For example, some participants made judgements about how “well” the child spoke, and commented that they would “correct” a child’s speech. “Some speak like their parents would. Their talking sometimes improves as they spend time at preschool” (ECE6).

Developing relationships

Developing relationships at many levels was described by the participants as important. Non-Aboriginal ECEs and teachers described how they individually, and the service generally, were focusing on developing relationships with individuals and the community.

I’m trying. We are working with an Aboriginal lady... to help make connections. I think it is progressing well. The families are happy to come here and bring their children back. We try to make it as welcoming as possible. I think we have a good relationship with the community... We are working on developing relationships. (ECE8)

Systemic factors

The participants discussed many factors that affected Aboriginal children’s communication and emergent literacy skills. Some of these related to features of the educational system that the child and the participants were engaged in.

Teacher experience and training

Substantial previous experience in teaching Aboriginal children, and post-graduate training about Aboriginal culture and communication were mentioned by many teachers as an advantage in working with Aboriginal children. “I learned more after I graduated. I’ve done the courses on ‘Stronger, Smarter’. I’ve done ‘Sister Speak’. I’ve had lots of post-grad training and experience” (T1).

When asked about her previous experience or training in working with Aboriginal children, one teacher responded: “I’ve had nothing. If you could offer PD that was relevant to children in our class I’m sure staff would be interested in learning more about this” (T5).

Teaching/learning strategies

Teachers were asked about what strategies they used when teaching Aboriginal children literacy. Different teachers used a range of different strategies. Many acknowledged the importance of providing an environment rich in language experiences, providing lots of talking opportunities for children in order to support verbal language development as a precursor to literacy. Exposure to books and texts was also valued. Teachers reported using many different texts, including Aboriginal stories, to increase children’s exposure to different text types and vocabulary. “In my teaching I incorporate Indigenous stories into their rich reading experiences” (T3).

Many teachers also mentioned strategies of modelling and repetition, as well as incorporating Aboriginal culture into their teaching to make it meaningful. “We use a program aimed at Aboriginal kids. It encompasses a lot of what you do in the classroom: incorporate their culture into as many teaching moments as possible” (T7).

Occasionally an educator mentioned that there had been input or collaboration with members of the local Aboriginal community to support children’s learning experiences: “We have an uncle that comes in and does the Katang language

with us, which is really great, the kids absolutely love it” (ECE1).

The teachers mentioned using stories or narratives to help apply the learning. “I employ narrative a lot. I also expose them (the children) to rich texts in books. I talk about my family a lot and embellish the stories so it has some relevance to the children and their learning” (T16).

Teachers and ECEs also mentioned using other strategies such as visual aids or demonstrations to aid comprehension. Some emphasised the importance of developing the children’s confidence and independence.

It’s all about having fun with language and helping them to realise that its ok to make a mistake. I provide opportunities for them to be speaking in the classroom so for example we have a café corner in the classroom. We have lots of social play opportunities. We encourage positive role models, for example, they all have year six buddies. (T1)

Individual support in the school context

Many of the Aboriginal children were receiving extra support for literacy learning at school. Teachers discussed the individual children’s needs in this area and explained why extra support had been provided by the school. Some children had initially presented with low emergent literacy skills, while others had not progressed as expected. “Her vocab was not so good when she first came to school and as I said she needed one-to-one support for her reading” (T3).

Child and family factors

A variety of factors relating to the individual child and/or family were also discussed by the participants for their relevance to the child’s learning.

Health and well-being

Educators and carers acknowledged the impact of poor health on children’s learning.

Literacy has been very slow. He has had lots of time off school, really a lot. He has had a lot of time off with tonsillitis. His attendance has been much better since winter is over. So he has improved recently and is starting to blend words...He was really reluctant in attending initially. (T4)

Educators acknowledged that sometimes children’s attendance impacted on their learning: this may have been related to their health, as in the above example, or to important cultural factors. For example some families had to travel to visit relatives, so these children were absent more frequently than others.

Educators and carers, both Aboriginal and non-Aboriginal, mentioned the impact of family trauma on the child’s learning. The participants and the researcher both acknowledged the impact that trauma can have on children’s learning; however, the interview context did not lend itself to exploring this aspect in detail.

The home environment

The support that the family is able to provide was identified by teachers as important in helping the child to progress at school. Availability of support was interpreted as a positive factor:

She does have good support at home so they have followed through with activities to develop her literacy skills. (T5)

Numerous factors contributed to the perceived level of support available at home, one example highlighting the

influence of skills, confidence and experiences of family members:

Mum's literacy skills are low. So mum doesn't feel confident helping her. Some parents may not have had very positive experience at school so don't feel confident to support the kids. (T5)

Cultural factors

Teachers and ECEs occasionally commented on individual children's behaviours; however, they did not typically consider these to be related to culture. For example, a child may have been labelled as "shy", or the teacher noted that the child would not participate in telling news in front of the class. Cultural aspects such as "shame" (Harkins, 1990) were not mentioned by the participants in this study. Aboriginal discourse, world views and learning practices may differ from the discourses and learning practices encouraged in a system modelled on a western European style of education (Dunn, 2001; Ellis et al., 2010; Malcolm, 1994a, 1994b; Malin, 1990). Embedding supportive and appropriate learning opportunities into educational systems may be a challenge for educators who are not aware of some of the subtleties of differences in communication between Aboriginal and mainstream Australian culture.

Child's strengths

Many teachers indicated they valued a strengths-based approach in their teaching. They commented on individual children's strengths in particular areas, such as numeracy, literacy or group participation, and they stressed the importance of developing the Aboriginal child's self-esteem. "She has very strong numeracy skills; her numeracy skills are at the end of grade one level. She is very strong in that area" (T2).

Limitations

This qualitative study used thematic analysis to code and identify themes based on individual responses in interviews. Results must be interpreted with caution due to the small sample size. The ideas presented in this paper cannot be generalised to other similar populations without replication.

Conclusions

This research explored the perceptions of ECEs, teachers and parents/carers about Aboriginal children's communication and emergent literacy development.

Semi-structured interviews were analysed using a qualitative approach and three main themes were identified. These were: knowing the child and family, systemic and individual factors which affect Aboriginal children's learning and communication development. Subthemes or key concepts were identified as part of each theme. All participants drew on experience to explain their observations or perceptions. Importantly, it was noted that non-Aboriginal teachers also drew on theoretical knowledge of culture and history in an attempt to understand how they could better support the children's development.

The teachers acknowledged the value of experience and training in working with Aboriginal children and families. The awareness, knowledge and experience that a professional (educator or speech-language pathologist) holds about Aboriginal cultural ways of doing, learning and communicating may affect how successfully learning environments are cultivated to support children of Aboriginal culture. All professionals working with Aboriginal children need to be mindful of how children's behaviour and communication are interpreted, with respect to cultural values and practices.

The importance of developing respectful and supportive relationships to promote children's learning was emphasised at several levels. Teachers, ECEs and parents discussed successful relationships that had been developed personally, at the level of the child and their family, as well between the service (ECE or school) and the Aboriginal community. SLPs can learn from these comments to value the importance of fostering relationships at many levels in order to fully support Aboriginal children's learning.

Teachers and ECEs discussed many different classroom teaching and learning strategies used to enhance literacy development for Aboriginal children. It is important for speech-language pathologists (SLPs) who are collaborating with educators working with Aboriginal children to be aware of the variety of different teaching and learning strategies that teachers employ as well as the knowledge and experience of teachers with regards to these. At the same time, ECEs and teachers showed willingness to learn from members of the community about ways in which to improve their practice.

The information gained from this research has implications for SLPs working collaboratively with educators

Appendix 1

General areas for discussion during the interview with educators

Demographic information

1. How long have you been working in early childhood?
2. How long in this position?
3. How old are you? Choices of age categories:
4. What are your qualifications?
5. What experience have you had in working with Aboriginal children?
6. Are you Aboriginal?

Personal beliefs and experience

7. What do you think about the way Aboriginal children talk?
8. What do you do to help Aboriginal children develop their language?
9. What did you learn about language development in your training?
10. What did you learn about Aboriginal children and their language, during your training?
11. To what extent are you involved with the local Aboriginal community?
12. What strategies do you apply (if any) when teaching Aboriginal children literacy?
13. Do you think [child] communicates well for his/her age? (Explain why you think this.)

and Aboriginal children and families. It is important for SLPs to be aware of the various factors described in this paper, both systemic and personal, which may impact Aboriginal children's communication and literacy development.

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Development of student clinics in Indigenous contexts

What works?

Anne E. Hill, Alison Nelson, Jodie Copley, Teresa Quinlan, and Rebekah White

KEYWORDS

CULTURAL RESPONSIVENESS

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THIS ARTICLE HAS BEEN PEER-REVIEWED

Previous research has indicated that interprofessional student clinics provide culturally responsive access to health care for Indigenous Australians. The aim of this study was to determine the factors and approaches which support student learning in Indigenous contexts and facilitate positive outcomes for clients. Students (n = 36) and their clinical educators (n = 4) in two clinical contexts were participants. All students completed a survey about their placement experience and all clinical educators and students in one context participated in semi-structured interviews. Survey data revealed that 94% of students in context 1 and 78.5% of students in context 2 felt they were more skilled in working with Indigenous people following their placement. Interview data was analysed qualitatively and four main themes emerged: 1) structures and processes supporting placements; 2) the importance of relationships; 3) client-centred practice; and 4) interprofessional leadership. These factors should be considered in development of student clinics in Indigenous contexts in order to maximise outcomes for clients and students.



Anne E. Hill (top) and Alison Nelson

Achieving health and well-being equity for Indigenous Australians requires culturally responsive and accessible health care, and necessitates a workforce well equipped to partner with local services to improve health outcomes (Anderson, Ewen, & Knoche, 2009; Australian Department of Health and Ageing, 2013). Addressing this gap requires concerted action across multiple layers of health service provision, including government services, community controlled organisations, and universities (Thomson, 2005).

Universities have a responsibility to ensure that their graduates acquire the necessary skills, knowledge and attitudes that will enable them to deliver culturally responsive care (Howells, Barton, & Westerveld, 2016). This includes providing experiences that support students to develop knowledge and practical skills to meet the needs of Indigenous Australians (Australian Department of Health

and Ageing, 2013; Indigenous Allied Health Australia [IAHA], 2015; Universities Australia, 2011). Clinical placements are an obvious vehicle for learning these skills and are an integral part of the undergraduate degree programs of most allied health professions (Howells et al., 2016).

Interprofessional student clinics can improve client outcomes, foster teamwork, and improve understanding of health professional roles (Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). Important features of interprofessional clinical experiences may include face-to-face meetings for therapy planning, joint goal-setting, and structured reflection on the interprofessional process (Copley et al., 2007). Interprofessional clinics have been identified as a culturally responsive way of providing services for Aboriginal and Torres Strait Islander peoples as service delivery is holistic and integrated, there is less burden on families to attend multiple appointments, and knowledge can be readily shared, resulting in a more contextualised approach to the family's needs (Nelson, McLaren, Lewis, & Iwama, in press). Initial learnings from student interprofessional clinics in Indigenous contexts have included the importance of long-term partnerships and removing structural barriers to services, such as locating children's therapy services in a school, which enables the development of effective partnerships with teachers and support staff (Davidson, Hill, & Nelson, 2013; Nelson, 2014).

In order to further develop these clinical placement opportunities, there is a need to clearly identify the factors and approaches which support sustainable and culturally responsive service delivery for Indigenous Australians. Therefore, this study sought to answer the following question: What factors and approaches support student learning in Indigenous contexts and facilitate positive outcomes for clients?

Method

This study involved a mixed methods approach and took place in two contexts in which interprofessional student placement models were in place. In both contexts, students worked together in occupational therapy (OT) and speech-language pathology (SLP) teams of two or more students and were supervised by an interprofessional team of one OT and one SLP.

Clinical contexts

Context 1: Aboriginal and Torres Strait Islander Independent School (Murri School)

The therapy service began in 1997 in response to a need identified by the principal and school board. The school is a

community-controlled entity with governance from key Indigenous community members. The therapy service has weekly interaction with both the principal and board members to ensure its responsiveness to cultural and broader school needs. The service commenced as an OT clinic at an urban school for students from prep to year 12 and evolved into an interprofessional SLP/OT clinic from 2011. This sessional (half-day/week for 12 weeks during each university semester) student clinic provides school-based interventions and is linked to a broader service delivery model which comprises other allied health services and a school-employed OT and SLP.

Context 2: Aboriginal and Torres Strait Islander Community Controlled Health Services (ATSICCHS)

Funding was obtained from the Queensland Regional Training Network (QRTN) to trial a student service in four clinics across south-east Queensland (SEQ). These clinics were all members of a regional body tasked with coordination of service delivery and workforce development in SEQ ATSICCHS. Students attended sessional ATSICCHS clinics in four locations where there was no existing established allied health service and focused on developing skill development programs for children from 3 to 5 years. However, service delivery design aligned with the already established clinical and cultural governance of the existing allied health services across the regional network, including a governance model which was driven by Indigenous leadership.

In both contexts, service delivery was designed using “strengths-based, action-oriented approaches to achieving cultural safety that can facilitate increased access to affordable, available, appropriate and acceptable health care” (IAHA, 2015, p. 8). Programs were designed with local Indigenous staff to incorporate activities with cultural meaning for children and families.

Participants

There were two groups of participants in this study.

Students

Students who completed sessional placements within these two interprofessional clinic contexts were invited to participate in this study. There were three subgroups of student participants, all of whom were undergraduate students in their third or final year or graduate entry masters students in their first or second year who attended a clinic in interprofessional teams: Group 1 included four SLP and four OT students attending a Murri School placement in 2013; Group 2 included 24 SLP and 24 OT students who had completed a placement at the Murri School between 2013 and 2015; Group 3 included 18 OT and six SLP students who attended an ATSICCHS clinic in 2014. Of all students approached to participate, the following consented: Group 1 – four SLP and four OT students; Group 2 – 13 SLP and four OT students; Group 3 – three SLP and eight OT (one of whom was Indigenous) students.

Clinical educators

All four clinical educators (CEs) who supervised the students, an OT and SLP CE in each context, agreed to participate in this study. All CEs were female and had a range of 2–35 years of experience in supervising students.

Procedure

Ethical approval to conduct the study was obtained from the relevant university ethics board. Students were invited

to participate in the study at the end of their placement. They were advised that their participation was independent of their clinical placement and would not impact in any way on their assessment grades. Students in group 1 completed semi-structured interviews as OT/SLP pairs (four pairs of two students). Students in all groups completed a post-placement survey.

Clinical educators completed semi-structured interviews as OT/SLP pairs. One clinical educator team (OT CE 1 and SLP CE 1) participated in two interviews, one in 2013 and one in 2016.

Data Collection

Survey tool

Student participants in all groups completed the 10-minute survey 1 week to 2 months following their placement. It involved 15 five-point Likert scale items asking questions about students' experiences of the learning environment, clinical skills development, knowledge of working with Indigenous people, supervision and feedback, and overall experience of their placement. Questions were also asked about the impact of the student placement on knowledge, attitudes and skills, for example, “I am more likely to consider working in Indigenous contexts in the future as a result of this placement”. Two open-ended response items on the positive and negative aspects of the placement were also included.

Interviews

Interviews were conducted by an independent researcher not associated with the student clinic. A semi-structured CE and student interview guide was used. Questions focused on the placement structure, teaching processes and practices, how these developed over time in context 1, and how students responded to these processes.

Data analysis

Data collected from 2013 to 2016 were pooled and analysed together.

Survey data

Quantitative survey data was grouped and descriptively analysed to provide percentages of student responses. Open-ended questions were analysed using content analysis.

Interview data

Interview data were analysed using a qualitative description approach (Sandelowski, 2000). Transcripts were reviewed by two of the researchers and initial coding categories were independently generated, then adjusted after comparison and discussion. A proportion of the data (approximately 20%) was then coded by one researcher for each data set (student and CE). Further discussion with the research team occurred and refinements to the coding categories were made. One researcher then coded the remainder of the student data and another researcher coded the CE data.

Results

Findings from the qualitative data are used to structure the results, with quantitative data from the surveys integrated throughout. Four main themes emerged. These were: 1) Structures and processes supporting placements; 2) The importance of relationships; 3) Client-centred practice; and 4) Interprofessional leadership.

Structures and processes

Eighty-six per cent of students felt they were adequately prepared by the university for their placement. CE and



Jodie Copley (top), Teresa Quinlan (centre), and Rebekah White

student participants agreed that it was important to receive a comprehensive orientation for the placement. In context 1, this orientation had evolved over time to include a cultural and community orientation from Indigenous board members in the school and 100% of students felt they received an adequate orientation for the placement. Students from context 2 also received a cultural and placement-specific orientation and they generally agreed that the orientation was adequate but 10.5% indicated they were either unsure or did not feel they had an adequate orientation. One student commented: "I feel that the orientation to this placement gave little speech related information and unfortunately the speech CE was not able to attend the orientation" (SLP student, group 3).

The need for clear expectations for interprofessional contact was expressed by both student and CE participants. CE responses indicated the importance of students having face-to-face time with each other outside of the clinic. In context 1, students were given a structured schedule on their first day that detailed their interactions with the clients as well as each other, including preparation and debriefing meetings. Students were expected to commit to a weekly two-hour meeting outside the clinic day.

We will negotiate it until everybody agrees before we leave...it's too easy to go, when one says that time doesn't suit me, "Well OK, maybe you can catch up later on", and then that student doesn't have the IP experience that we're after, so we keep going until we get a good compromise. (OT CE 1)

In contrast, a CE in context 2 commented:

We strongly encouraged this [the students to meet outside clinic time] but did not make it compulsory. We did reiterate the importance of checking with the team before sending session plans through, although we could tell that this hadn't always been done. (OT CE 2)

The process of establishing teams between OT and SLP students was also conducted in an explicit manner with the importance of being physically together highlighted so that each pair of students began to consider themselves as a team from the beginning. "Within the first hours they are put into their pairs, I mean physically put into their pairs, sitting together, so from the get-go when they are getting their caseloads they are already thinking as one" (SLP CE 1).

Students came to appreciate the importance of these meetings: "Initially I was resentful of attending so many feedback and planning sessions, however throughout I really appreciated the feedback and planning sessions as I believe this really enhanced my learning and collaboration with other students" (OT student, group 3).

In terms of more formal communication, students were given the clear expectation that all their interactions with the clinical educators and professional development needed to happen as a team. "So if you want to talk to us about a client, you come as a pair" (SLP CE 1). In context 2, students in one location had made an effort to communicate outside the clinic and this resulted in them being more prepared and organised, knowing their allocated roles, and working more effectively with the children. In the other location, where this student communication had been limited, students struggled with working as a team.

It was also seen as important to incorporate structures and processes which facilitated a safe learning environment, particularly in exploring students' roles and

practices with Aboriginal and Torres Strait Islander children. In context 1, students engaged in a weekly journal club as part of their clinic day. "In our journal club, we had a lot of focus on issues they needed to consider working with children from Indigenous backgrounds" (SLP CE 1). "I think people felt safe to share their feelings and their observations [in debriefing sessions]" (OT CE 1).

Students also reported positive outcomes from the journal club. "A lot of it was on cultural and community aspects that speech and OT can contribute ... it was quite good to bring that to awareness" (SLP student, group 1).

In context 2, some students met for tutorials and debriefing at the host Institute where they were able to interact with Indigenous staff: "the lunches and morning teas with the Institute gave a really positive feel for working in an Aboriginal and Torres Strait Islander Health service" (OT Student, group 3).

Another student commented: "I never felt uncomfortable to ask questions and was always given feedback when needed" (OT Student, group 3). However, in one clinic, students had difficulty attending the tutorials because of their university timetable and this restricted their learning of culturally responsive practice.

[The tutorials and debriefing] helped students to be more in tune with expectations, have more opportunity to discuss their clinical reasoning, so they were just more immersed in the organisation's style of practice. The students [in the other clinic] did not have this experience because they couldn't fit [the tutorials] into their schedule. The SLP students had to rush off to get to a uni lecture before the [client] session had even ended. (OT CE 2)

Overall, 93% of students indicated that their appreciation and knowledge of Indigenous cultures and their awareness of the health issues faced by Indigenous people had increased as a result of their placement.

The importance of relationships

Responses from students and CEs reflected the importance of relationships with a variety of stakeholders involved in service delivery. It was important to ensure that clinical educators had developed a relationship with staff in the practice context over a period of time. This provided a solid basis for the clinical educators to introduce students into the context.

We've gradually built our own relationships with the principal, with the prep teacher and the year one teacher...we've spent quite a lot of time trying to cement those relationships within the environment. [Now] we're accepted there and feel more comfortable and we've established those bonds. (OT CE 1)

Developing relationships was more difficult in context 2 where the service was new. CEs in this context commented that they had not had time to form connections with other health staff at the clinics before running the programs.

Students were encouraged to spend time building relationships with the staff in the practice contexts and it was made clear that this was an important use of their time.

As a student, they would probably not do that without our encouraging and nurturing because they'd be on the product, you know, "I've got to complete this assessment..." We did give them a lot of reassurance that it was OK [to spend the time]. (OT CE 1)

Student responses reflected that they had learnt these skills over time, with 89% of students indicating they felt they had

developed skills in communicating effectively with Indigenous colleagues and/or clients during their placement. Importantly, students reflected not only on Indigenous cultures but also the impact of their own culture and societal positioning. "I realised how privileged I was to be able to study and have opportunities to pursue my dreams because of what my parents or my own society have given me" (SLP Student group 2).

Client-centred practice

Clinical educators described assisting the students to focus on the client as the centre of all their activities, rather than evaluation of their own professional skills. They did this by giving students more autonomy and constantly redirecting them to consider how their planned therapy sessions would impact on the children. "They switched from being a student to focusing on the client and managing their workload. It wasn't like 'you're being assessed'; it's about what's going to be best for our kids" (OT CE 1).

Student comments reflected this emphasis on client-centred care, including the importance of informal assessment processes. For instance, one student noted: "I learnt a lot about how cultural differences should be considered carefully in the planning and execution of therapy. I considered this 'discomfort' with testing and conducted all therapy or individual sessions informally" (SLP student, group 2).

In contrast, in context 2, some students had difficulty with this style of service provision because they were focused on accruing placement hours and this affected the appropriateness of their service provision.

[A couple of the students] were concerned their hours would not count as they needed assessment hours in particular. They were focused on testing during the group sessions rather than supporting the development of the children. (CE SLP 2)

Students were also expected to develop integrated goals and reports on the children's progress. Students reported the benefits of working in this way.

Working in a strengths based approach with my occupational therapy student made therapy so much more holistic and motivating...and how much their (OT) therapy plays a role in the goals I am trying to achieve. (SLP student, group 2)

Clinical educators described their expectation that the students move beyond their discipline-specific roles to support the child's needs. They also modelled being comfortable to seek information from the other discipline and work collaboratively to support their intervention goals in therapy sessions.

When we see a child who has more OT needs than speech pathology needs, we've gone "It's the child who's the important part, so now you need to learn more about OT, so you can assist". (SLP CE 1)

When students embraced role expansion in this way, the clinical educators reinforced their efforts and celebrated the value of this expansion. "And we always give them such positive feedback for that. When we have the speechie there and they're giving prompts for pencil grasp, for posture, we've done our job" (OT CE 1).

Interprofessional leadership

The cultivation of this interprofessional client-centred approach required leadership from the clinical educators to model teamwork practices and create a teamwork culture.

In context 1, these practices had been developed over several years and were well established. Clinical educators consciously modelled teamwork and trust in each other to the students throughout the clinic.

We have complete trust in the other's professional judgement, teaching and learning judgement, understanding of what the children need, understanding of what the students need...and that's what [the students] say to us, isn't it? "We watch you, we see how you discuss things, the respect you have for each other" (OT CE 1).

This trust extended to splitting responsibility for observing students' clinical sessions, so that both clinical educators did not always need to be present. They further split responsibility for reviewing the therapy plans generated by student teams, so that each clinical educator provided feedback on half of the interprofessional plans, thereby reducing their workloads.

We are not [both] always present, there might be a week go by when I haven't seen a session with one child, because I have been looking at sessions with someone else. There is no sense from the students' perspective that they are worried about that. (OT CE 1)

This was reflected in student responses, with 94% of students in context 1 reporting they received appropriate feedback and supervision. In context 2, 73% of students reported they received adequate feedback. These CEs reflected that, because they were new to working with each other, they quickly learned throughout the placement to include each other more when collaborating with students.

There was inconsistency in our feedback initially given that we were new to working with each other. Our feedback on session plans worked much better when we discussed it before sending it to students. This improved throughout the program as our relationship grew (OT CE 2).

Overall, 93% of students indicated that they were satisfied with the placement and it provided an environment conducive to their learning. One student comment exemplifies the variety of factors described above in creating an overall positive learning experience.

I feel I learned more in this placement than I have in any other. The knowledge shared by staff members surrounding cultural sensitivity was informative and their passion inspiring. I learned a lot about Indigenous culture and also a lot about how to ensure activities are culturally relevant. (OT student, group 3)

Discussion

This study sought to determine the practices and processes which support the development of clinics in Indigenous contexts. Data obtained from student surveys revealed that overall, 94% of students in context 1 and 78.5% of students in context 2 felt they were more skilled in working with Aboriginal and Torres Strait Islander clients as a result of their practical experience. This difference appeared to be due to the newer nature of context 2 and the need to establish opportunities for more integrated interprofessional practices. Students' negative responses were connected with university requirements, their stage of learning (i.e., earlier year levels) and their concerns about not learning specific clinical skills in this style of service provision. In contrast, context 1 included final or near-final year students and greater freedom to "take the pressure

off" students' development of particular clinical skills, allowing them to concentrate on establishing relationships as a legitimate part of their role in and precursor to their clinical effectiveness in this context.

Participant responses in this study aligned with previous research which has identified that building relationships with both colleagues and clients is critical to the success of health service provision with Indigenous people (Nelson & Allison, 2007). This research further extended this notion to include students as key drivers and participants in these relationships. Where this relationship was newer (context 2), students' roles in supporting children's skill development were less clear.

This study also illustrated several other key components of the IAHA cultural responsiveness framework (IAHA, 2015). Results reflected the importance of client-centred practice in this context and the centrality of culture in providing responsive care. This included gaining knowledge about the child and family's culture, the school and broader community's cultural values as well as students reflecting on their own culture and positioning (IAHA, 2015). The centrality of the child's and family's journey reflects previous literature which emphasises the importance of making connections with children and their families as part of an ongoing journey (IAHA, 2015; Nelson et al., in press).

The need for universities to better prepare students for placements in Indigenous contexts has been documented across a range of professions (Nelson, Shannon, & Carson, 2013; Paul, Allen, & Edgill, 2013). While students in this study felt they were well-prepared by the university, responses suggested that more experienced students were better suited to these placements and orientations needed to occur in an interprofessional manner. Findings also indicated that university clinical education requirements needed to be flexible and responsive to service provision models in an Indigenous context and to align curricula to allow student meetings outside of clinic time.

The modelling and structuring of interprofessional practice has been highlighted elsewhere (Copley et al., 2007) and was emphasised by students and clinical educators in this study. Notably, the use of interprofessional practice in this study was identified as a key component of providing culturally responsive care as clients were able to receive a more integrated and client-centred service. The importance of clinical educators developing their own relationships and ways of working with each other to truly demonstrate the value of interprofessional practice to students cannot be underestimated.

Limitations

While both contexts in this study are considered representative of student-led clinics in Indigenous settings, surveys and interviews with students and CEs in other contexts may have provided alternative perspectives. In addition, this study included students from the professions of SLP and OT only. Further research with students and CEs from a broader range of health professions would be beneficial. This study, and the broader service delivery model, was embedded within a cultural governance framework reflecting Indigenous community control. However, the focus of the study was on the responsibilities of students, universities and health services to provide culturally responsive care and, as such, feedback was limited to student and CE perspectives. Future research could include Indigenous voices through feedback and perspectives from clients, carers and Indigenous staff and leaders within the organisations.

Conclusion

Preparing students to work with Aboriginal and Torres Strait Islander peoples is critical to meet the growing needs of health care service provision. This study has identified that student clinics are likely to be more successful if there is attention to critical factors and clinic processes to support student learning in this context, and enduring relationships with the community. In addition, leadership in and modelling of an interprofessional approach is fundamental to ensuring client-centred care. It is through consideration of these factors that we can maximise outcomes for clients and for students.

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Aspiring to build culturally responsive, collaborative speech-language pathology services

Some ethical reflections for SLPs working with Aboriginal and Torres Strait Islander peoples

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KEYWORDS

ETHICS

INDIGENOUS AUSTRALIANS

SLP SERVICE PROVISION

Speech-language pathologists (SLPs) face ethical challenges when providing equitable services to Aboriginal and Torres Strait Islander peoples. We are conscious of the multitude of wise, expert and often silenced Australian Indigenous voices. Voices that should be sought, listened to, and used to inform policies. Indigenous Australians, with expertise and knowledge, working in collaboration with SLPs, can hope to create ethical practices, services and programs which are relevant, equitable and sustainable for Indigenous Australians.



Helen Smith (top) and Felicity Burke

In this edition of Ethical conversations, we hope to raise the awareness of speech-language pathologists (SLPs) about some current ethical challenges facing the profession when aspiring to provide culturally responsive speech-language pathology services for people who identify as Indigenous Australians.

Background reflections

As authors who culturally identify as European Australians, we fully acknowledge our perceptions and understandings are informed by our own culture and history. We have worked in remote regions of central Australia. This has afforded us an opportunity to gain some small knowledge and insights into the positive effects of health and education services based on equality and inclusiveness as well as true collaboration with local expert Aboriginal people. We have been enriched and grown, both personally and professionally, through opportunities to participate in transcultural relationships with people from Aboriginal cultural backgrounds. We are very aware that our own cultural heritage impacts any learnings, interpretations and insights we have gained through these experiences.

We recognise one of the major challenges faced when considering this topic was our difficulty collaborating directly with SLPs who identify as Indigenous Australians. According to the Australian Bureau of Statistics 2011 census, only 0.26% of audiologists and speech-language pathologists identified as being Aboriginal or Torres Strait Islander (Mason, 2013). We are conscious of the multitude of wise, expert and often silenced Australian Indigenous voices, indigenous voices which should be found, and listened to, and used to inform our policies. Indigenous

Australians with expertise and knowledge, working in collaboration with SLPs can hope to create ethical practises, culturally competent services and programs which are relevant and sustainable (Lowell, 2013). Therefore, we welcome comments and responses to this discussion from Aboriginal and Torres Strait Islander people and communities to progress, deepen and further inform our conversation in future issues.

Culture is central

“Culture is central to Aboriginal and Torres Strait Islander health and well-being” (IAHA, 2015, p. 7). For services to be culturally responsive the values, beliefs and philosophies must be learned and appreciated for each person, group, family, and community (IAHA, 2015). It takes time to build trust, safety, knowledge, and to develop relationships which integrate respect and a collaborative approach to make services culturally responsive to needs. Taking the time required moves us toward services which fundamentally create environments, processes and practices which are explicitly and consciously culturally inclusive (IAHA, 2014). Indigenous Allied Health Australia (IAHA) has developed a cultural responsiveness framework with six key capabilities: respect for centrality of culture; self-awareness; proactivity; inclusive engagement; leadership and responsibility and accountability (IAHA, 2015, p. 13). These capabilities can be used as the basis for beginning to build a culturally responsive workforce.

Speech Pathology Australia’s Code of Ethics states “we do not discriminate on the basis of race” (Speech Pathology Australia, 2010, p. 1). As a profession, if we aspire to building culturally responsive collaborative services with Australia’s First People, exploration of the implications of this seemingly simple statement is required. Culturally responsive service provision requires SLPs to recognise, understand and acknowledge the history of Aboriginal and Torres Strait Islander peoples. It requires SLPs to accept this history and the impact on Indigenous Australians for reconciliation and healing to be fostered. It requires deep reflection by SLPs on the ongoing impact of historical and current events, systemic policies and attitudes on the health and well-being of Aboriginal and Torres Strait Islander peoples.

Cultural education and cultural interpreters

Currently variable cultural education opportunities for practising clinicians, inadequate use of and potential lack of

access to health literate linguistic and cultural interpreters and co-workers (IAHA, 2014; Lowell, Schmitt, Ah Chin, & Connors), and lack of cultural competence educators and culturally appropriate resources (Lowell, Lotfali, Kruske, & Malin, 2011) all contribute to inaccessibility of speech-language pathology services for Indigenous Australians. A narrative approach to ethical reflection may help us to create and provide future services which are beneficent and prevent harm (Speech Pathology Australia, 2010). This would involve firstly recognising past injustice, then identifying current barriers and finally envisaging how truly linguistically and culturally accessible services, through a culturally responsive and collaborative approach, may look (Lowell, 2013).

Models of collaboration

Michelle Lincoln (personal communication, 2016), shared some exciting research projects currently being conducted in partnership with Indigenous Australians. For example, Aboriginal and Torres Strait Islander peoples carers and stakeholders are being asked “What does a culturally appropriate service look like?” (Aboriginal Health & the National Health and Medical Research Council of NSW, 2016). Another example shared is current research through collaboration with the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women’s Council (an Indigenous human services and advocacy organisation in Central Australia) asking “What makes a good life for people with disability?” from an Indigenous Australian’s perspective in remote central Australian communities. In the Northern Territory, Anne Lowell shared an example of collaborative research between Charles Darwin University and Yalu Marrgithinyaraw, Galiwin’ku, the “Growing up children in two worlds: Building Yolngu skills, knowledge and priorities into early childhood assessment and support” project. This project uses collaborative research to build recognition of Indigenous Australian early childhood strengths, priorities and knowledge in communities in north-east Arnhem Land. The intent of the research projects is to ensure the creation of culturally responsive and collaborative services.

Accessible services

We would contend that inclusive engagement means encouraging, fostering and enabling Aboriginal and Torres Strait Islander people to say what makes a good service for them. We need to listen and learn what safe and culturally accessible services might look like for many diverse groups and individuals. The Speech Pathology Australia Code of Ethics upholds autonomy. Inclusive engagement means we can maximise autonomy. There appears to be an uneasy marriage between the Speech Pathology Australia Code of Ethics aspiration for justice, “We strive to provide clients with services consistent with their need” (Speech Pathology Australia, 2010, p. 1) and the reality of SLP services, particularly for many Indigenous Australians. Diverse culture, languages, geographic locations and financial considerations all contribute to inequities of access to speech-language pathology services for Indigenous Australians (Wylie, McAllister, Davidson, & Marshall, 2013). This is even more apparent for Indigenous Australians from rural or remote settings (IAHA, 2015; Lowell, 2013).

Language

We need to listen and learn what communication and language needs might look like for many diverse Indigenous groups and individuals. Many SLPs have commented on the lack of valid standardised tests for both children and

adults (Lowell et al., 2011; Amanda O’Keefe, personal communication). The lack of appropriate assessment tools and frameworks may in turn lead to misdiagnosis with both over and under diagnosis of disorder being problematic.

The Contemporary Uses of Aboriginal Languages research project (Lowell, Gurimangu, Nyomba & Yingi, 1996), written collaboratively, explores the extensive language teaching and learning strategies employed by Yolngu (people from north-east Arnhem Land) to support communication development in children. The report highlights sources of cross-cultural miscommunication that may arise through lack of recognition of the sociolinguistic difference between non-Aboriginal and Yolngu children. Cross-cultural miscommunication in turn is often viewed from a deficit model by the non-Aboriginal culture rather than celebrating the inherent strength and cultural appropriateness of the Yolngu way.

The Australian Psychological Society (APS) recently recognised the damaging perception of deficit versus difference. In September 2016 the APS issued a public, formal apology to Aboriginal and Torres Strait Islander peoples apologising for, among other areas, “The inappropriate use of assessment techniques and procedures that have conveyed misleading and inaccurate messages about the abilities and capacities of Aboriginal and Torres Strait Islander people” (APS, 2016).

Physical environment

Amanda O’Keefe, an experienced clinician working in Darwin, highlighted how the built environment can unintentionally prevent people from receiving the care they need. Her example was the multi-storey, highly air-conditioned hospital in Darwin. Many people from remote communities make their way outside to be in a warmer, more familiar natural space. This makes it harder for staff to find patients when they are required for investigations and treatments. In turn, this may lead to unintended delays in care. The old Darwin Hospital with verandas and windows for fresh air fostered a more accessible healing environment and an easier way to ensure people could be found and provided with the care they required. When building new services, the impact of the built environment needs to be part of the conversation. All health professionals have a responsibility to ensure that their workplace is inclusive, welcoming and acknowledging of Aboriginal and Torres Strait Islander peoples.

Access to community-based services

The Speech Pathology Australia Code of Ethics states we are an evidence-based profession and we value accountability and responsibility. Some successful culturally responsive models of speech-language pathology service delivery have occurred across Australia in the past. Unfortunately, these tend to be isolated and stopped when project funding or government service policies change. For example, in the mid-1990s in east Arnhem Land, community-based hearing programs were established which employed local co-workers in collaboration with remotely based SLPs. With changes in models, first the co-worker funding was lost, followed by the remotely based SLP services. Now there is a single “remote” SLP for the whole of the Top End of the Northern Territory based in an allied health team working with a key case worker, using a fly-in fly-out model. This means that people discharged from hospital after an acute event may wait 6–8 weeks before they receive follow up in their local community (Anne

Lowell, Amanda O’Keefe personal communication). IAHA highlights the importance of having both health workers and health services available in rural and remote communities (IAHA, 2015). Culturally responsive services and interventions take time to design and implement.

Models of care

Increasingly, research has shown that Indigenous Australians working within their own communities and groups have the skills to bridge gaps and increase successful outcomes. A number of strategies have been suggested to improve the accessibility of services for Australian Indigenous people (Australian Human Rights Commission, 2013). Strategies include: embedding services within local communities; employing Indigenous staff; developing the cultural competency of non-Indigenous staff; developing links and partnerships with Aboriginal and Torres Strait Islander communities and Indigenous organizations; improving the availability, provision and distribution of meaningful and relevant information; providing culturally relevant practice especially in planning, assessment and case management and support phases. Many programs with Indigenous Australian liaison officers/allied health professionals and training of Indigenous Australian community members have produced sustainable and ongoing successful outcomes for individuals and groups (Dew et al., 2012; Dew et al., 2014). SLPs engaging in “fly-in fly-out” or “drive-in drive-out” models of service need to reflect carefully if considering engaging with Aboriginal and Torres Strait Islander communities briefly, inconsistently and/or on a short-term basis on the balance between “doing good” and the potential of “doing harm” if these strategies are unable to be followed through.

Our challenge

What do SLPs, aspiring to build culturally responsive ethical speech-language pathology services, need to consider? Firstly, we need to acknowledge that we need to do more. We should respect of Australia’s First Peoples history, cultures, languages and beliefs and make the commitment to collaboratively build culturally responsive speech-language pathology services. This goal needs to come from the levels of individuals, services and organisations.

As a professional association we should aspire to proactive and collaborative planning with Indigenous Australians, government planners and policy-makers in a conscious effort to move towards more accessible, culturally responsive speech-language pathology service provision for Aboriginal and Torres Strait Islander peoples wherever they are living in Australia. Increasing our own self-awareness, respect and proactive work in this area can pave the way for ongoing positive actions into the future. We need to advocate for time and adequate funding to build consistent collaborative, respectful, trusting relationships and negotiate culturally competent service delivery.

Indigenous Allied Health Australia, Speech Pathology Australia, and many other organisations have made this commitment and continue to agitate for action. A recent example of “saying it out loud” at an organisational level is the University of Sydney’s commitment to incorporating cultural competence at a whole-of-university level, and within their strategic plan (University of Sydney, 2016). In-depth and specific training is needed for SLPs across Australia that acknowledges the historical context for

Indigenous Australians, fosters an understanding of the social determinants of health, and incorporates cultural awareness training, cultural safety training including time to reflect, and training in the use of linguistic and cultural interpreters and in intercultural collaborative practice.

As clinicians and researchers we need to collaborate in the development of culturally responsive assessment and intervention tools, resources and service delivery models that recognise and build on the strengths of Aboriginal and Torres Strait Islander peoples. By challenging our own assumptions about the world, we can celebrate how much we can learn and benefit from our colleagues and clients and be enriched through the insights they may share about Indigenous ways of learning and being.

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Webwords 57

Aboriginal and Torres Strait Islander peoples: Rights, reading and moving out of the shadows

Caroline Bowen



Since 1994, the United Nations International Day of the World's Indigenous Peoples has been observed annually on 9 August. Its supporters aim to promote and protect the rights of some 370 million indigenous individuals across 90 or more countries, and to recognise their achievements and contributions. In the mix of key constituents are indigenous peoples' fundamental roles in tackling global issues like environmental protection, social justice, and the survival and ongoing evolution of their dynamic, living and distinctive cultures, customs and languages. Promoting its 2016 theme, the right to education, Secretary General Ban Ki-moon emphasised that the UN would not achieve its ambitious sustainable development **goals**¹ without addressing the educational needs of Indigenous peoples.

The right to education is protected by both the *Universal Declaration of Human Rights*, and the *UN Declaration on the Rights of Indigenous Peoples*. Its Article 14.1 reads, "Indigenous peoples have the right to establish and control their educational systems and institutions providing education in their own languages, in a manner appropriate to their cultural methods of teaching and learning." In general accord, successive Australian governments have pledged to achieve better results for Aboriginal and Torres Strait Islander people, but right now, things mostly look **dismal**². Within the ten Australian government legislatures, 38 Indigenous members (14 of them women, and all of them Aboriginal) have been appointed, beginning with Senator Neville Bonner (Liberal, Qld) in 1971. Of these members of parliament, 22 were elected to the Northern Territory assembly, six to the Australian federal parliament, four to the parliament of Western Australia, three to the parliament of Queensland, one each to the parliaments of Tasmania and New South Wales, and one to the Australian Capital Territory assembly. Currently, Linda Burney (Labor, NSW) is in the House of Representatives, and Patrick Dodson (Labor, WA) and Malarndirri McCarthy (Labor, NT) serve in the Senate.

The government's priority areas for reform include: reducing incarceration rates and black deaths in custody, getting children to school and adults into work, fostering safe communities, and addressing **health**³ and mortality issues – all within culturally responsive frameworks. Thinking Australians are alert to the complex, nuanced interconnections between education and health, unemployment, disempowerment and depression, school refusal, child protection, and young people with developmental language disorder (DLD or #DevLangDis) (Bishop, Snowling, Thompson, Greenhalgh, & the CATALISE-2 consortium, 2016), or low or non-existent literacy skills, who get caught up in the criminal justice system, including **youth detention**⁴.

"EMPOWERMENT. *Noun: The process of becoming stronger and more confident, especially in controlling one's life and claiming one's rights.*"

Oxford English Dictionary

The overrepresentation of Indigenous people, and people with language and literacy difficulties in the nation's prisons and in custodial remand, encapsulated in Nathaniel Swain's **Three Minute Thesis**⁵, plagues the collective SLP consciousness in this country. That feeling of having to do something about it has propelled the likes of Tasmanian Australian of the Year Rosalie Martin, Professor (and blogger) Pamela Snow, Professor (and blogger) Sharynne McLeod, and of course Nathaniel Swain himself, into action in the forms of advocacy, political lobbying, research, teaching, and clinical and educational interventions. The biannual Productivity Commission report on Overcoming Indigenous Disadvantage, released in November 2016, drove home mercilessly the necessity for such action, indicating that while the figures for infant mortality, some educational outcomes, and household income had improved, rates of violence, incarceration, mental illness, and suicide continued to balloon.

Senate submission by Indigenous Allied Health Australia

A proactive stakeholder organisation, Indigenous Allied Health Australia (IAHA) was impelled to speak up in 2014, producing a forceful **submission**⁶ to the Senate enquiry into speech pathology services in Australia. They say that it is simply down to the individual speech pathologist to deliver culturally responsive health care, explaining that cultural responsiveness is a strengths-based action-orientated approach to building cultural safety.

"BEING CULTURALLY RESPONSIVE *places the onus back onto the speech pathologist to appropriately respond to the unique attributes of the person, family or community they are working with. Self-reflection and reducing power differences are central to being culturally responsive; therefore, making assumptions based on generalisations about a person's ethnic, cultural or social group is unacceptable. Part of the challenge of becoming culturally responsive speech pathologists is learning to reach beyond personal comfort zones and being able to comfortably interact and work with people, families and communities who are both similar and markedly different.*"

IAHA, 2014, p. 7

The IAHA submission authors pinpoint the needs for: acknowledgement of SLPs' capacity and potential to

address, collaboratively with stakeholders and other professionals, multiple determinants of the health and well-being of Aboriginal and Torres Strait Islander individuals, families and communities; research into the prevalence of speech, language and communication disorders in Aboriginal and Torres Strait Islander peoples across the lifespan; and research into, and development of, culturally valid assessment tools and culturally responsive assessment approaches. They also recommend provision of additional resources in schools to ensure appropriate development of Standard Australian English as a second dialect or language, comparable to that provided to migrant populations acquiring English as an additional language.

On the higher education front, they press for culturally responsive speech-pathology-based resources to support the implementation of the Health Workforce Australia (HWA) Aboriginal and Torres Strait Islander health curriculum **framework**⁷ into all Australian university speech pathology programs, and the desirability of culturally responsive speech pathology education. In this connection, they stress the necessary development and resourcing of evidence-based strategies aimed at recruitment, retention, education and support of Aboriginal and/or Torres Strait Islander speech pathology students and graduates.

They further call for research funding to investigate the skill-mix, health professions and service delivery models required to best meet the speech pathology requirements of Indigenous Australians across urban, rural, remote and very remote areas. Exhibiting courageous optimism they advocate an overhaul of the incentive structures that drive health service delivery (e.g., Medicare), to ensure that Aboriginal and Torres Strait Islander people have equitable access (available, appropriate, acceptable and affordable) to speech pathology services. Tub-thumping SLPs, frustrated by long wait-times for sketchy services, and a litany of other barriers to the delivery of evidence-based practices, can become shrill in pointing out that such equitable access to adequate assessment and intervention **eludes**⁸ the bulk of the Australian population. They also give their tubs a fair hammering when the topic of the excellent September 2014 Australian Senate **report**⁹, "Prevalence of different types of speech, language and communication disorders and speech pathology services in Australia" is mentioned, because, at the time of writing (November, 2016), it had still not been handed down.

Listening on Twitter

If, as a profession, we are to further our capacity to deliver culturally responsive care in Aboriginal and Torres Strait Islander preventive health, health, education, and community contexts, we must listen attentively to a representative range of Aboriginal and Torres Strait Islander voices. Indigenous Australians don't need other Australians to tell them what their communities need or to force "solutions" on them; they know their communities, their needs, and the keys to solutions.

One good place to listen is in Twitter. Where Webwords had expected rants and rhetoric, she got pleasantly understated humour, hard facts, practical suggestions, a strong sense of community, and a feeling of being welcome. The same applied to the atmosphere around a gently persuasive **webinar**¹⁰ on becoming a more confident teacher of Indigenous studies by Professor Peter Buckskin @BuckskinPeter, Dr Kaye Price, Dr Peter Anderson @pj_and, and Mark Tranthim-Fryer @marktf.

Informative and interesting individuals to follow in Twitter include Bronwyn Fredericks @BronFredericks, Pro Vice-Chancellor (Indigenous Engagement), CQU; Marcia Langton @marcialangton, Foundation Chair of Australian Indigenous Studies, The University of Melbourne; lawyer Antoinette "I am the solution" Braybrook @BraybrookA; writer and actor Nakkiah Lui @nakkiahlui; and Indigenous advocate Nyunggai Warren Mundine @nyunggai. Look at their followers to decide who else you want to hear from. You might appreciate ABC Indigenous @ABCIndigenous; Aboriginal Literacy @Aboriginal_Lit; Aboriginal Songlines @Songlines_au; ANU Indigenous @ANU_Indigenous; First 1000 Days @First1000DaysOz; Indigenous Aboriginal Health @NACCHOAustralia; Indigenous Allied Health Australia @IAHA_National; IndigenousX Pty Ltd @IndigenousXLtd; Koori Mail @koorimailnews; the Lowitja Institute @LowitjaInstitut; More Aboriginal and Torres Strait Islander Teachers Initiative @MATSITI with its 2016 **Report**¹¹; and WGAR News @WgarNews.

"DISEMPOWER. *Transitive verb: to cause (a person or a group of people) to be less likely than others to succeed; to prevent (a person or group) from having power, authority, or influence; to deprive of power, authority, or influence; to make weak, ineffectual, or unimportant."*

Language and literacy

The blurb for Stan Grant's essay, *The Australian Dream: Blood, History and Becoming*, says that Grant (2016¹²):

"writes Indigenous people back into the economic and multicultural history of Australia. This is the fascinating story of how fringe dwellers fought not just to survive, but to prosper. Their legacy is the extraordinary flowering of Indigenous success – cultural, sporting, intellectual and social – that we see today. Yet this flourishing co-exists with the boys of Don Dale, and the many others like them who live in the shadows of the nation. Grant examines how such Australians have been denied the possibilities of life, and argues eloquently that history is not destiny; that culture is not static. In doing so, he makes the case for a more capacious Australian Dream."

Strong language and literacy abilities open doors. Relegation to the shadows of the nation may be the devastating outcome for the myriad Aboriginal and Torres Strait Islander children with untreated DLD, those (with and without DLD) who do not become competent readers, and many of those who lack appropriate reading instruction in the first three years of school. An unacceptable proportion of these children are destined for the school to prison pipeline (Christie, Jolivette, & Nelson, 2005), and for many abject generational disadvantage is their lived experience. We do not have precise figures for DLD, illiteracy, or reading disability, among Aboriginal and Torres Strait Islander peoples, across the lifespan, but the indicators are that the prevalence is high. If you cannot function adequately in the areas of language and literacy, opportunities drift away. If you cannot function adequately in the areas of language and literacy, and you live in poverty, opportunities are thin on the ground.

As an evidence-based profession, speech-language pathology has the tools, and hopefully the knowhow, to engage directly with educators, community leaders, the burgeoning Aboriginal and Torres Strait Islander middle

class (Grant, 2016), and Aboriginal and Torres Strait Islander children to ensure that reading instruction in schools follows the recommendations of literacy experts in Australia (Rowe, 2005), the UK (Rose, 2006), and the US (National Reading Panel, 2000). We can also keep on, and on, making the case for teacher educators to follow the same guidelines when teaching prospective teachers what and how to teach (Snow, 2016; Stark, Snow, Eadie, & Goldsmith, 2016), and for robust, public evaluation of curricula and programs designed for and delivered to Aboriginal and Torres Strait Islander people (Productivity Commission, 2016).

Webwords 57 is at www.speech-language-therapy.com with live links to featured and additional resources.

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Links

- <https://sustainabledevelopment.un.org/sdgshttp://www.alfred.org.au/News.aspx?ID=553>
- <http://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2016>
- <https://www.health.gov.au/internet/main/publishing.nsf/Content/natsih-plan>
- <http://pamelasnow.blogspot.com.au/2016/11/could-better-reading-skills-save-lives.html>
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- <http://health.gov.au/internet/main/publishing.nsf/Content/aboriginal-torres-strait-islander-health-curriculum-framework>
- http://www.speechpathologyaustralia.org.au/spaweb/Document_Management/Public/Advocacy.aspx
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- <https://www.quarterlyessay.com.au/essay/2016/11/the-australian-dream>

Webwords acknowledges traditional owners of Country throughout Australia, and pays respects to Aboriginal and Torres Strait Islander cultures, communities and Elders.



Around the journals

Scull, J. (2016) **Effective literacy teaching for Indigenous students: Principles from evidence based practices.** *Australian Journal of Language and Literacy*, 39(1), 54–63.

Anne Murrie

In the light of the ongoing gap in literacy attainment between Indigenous and non-Indigenous students in Australia, Scull outlines six principles to guide the successful implementation of early literacy programs, particularly in the context of remote communities. These principles include: maintaining first language while building skills in English; valuing and respecting community knowledge and experience; providing responsive, tiered learning support; recognising the complexity of literacy learning; expert teaching and ongoing professional learning; and investing in evidence-based programs. Scull discusses three early intervention language and literacy programs which are currently being trialled in remote communities with positive outcomes: the Abecedarian Approach Australia, which is an early language and literacy program with a focus on 0–3-year-olds; Literacy Acquisition for Pre-primary Students (LAPS), which is aimed at up-skilling preschool staff in using specific small group teaching procedures for literacy; and Reading Recovery, which is a widely used intervention program for children who have not attained the expected level in reading after one year of instruction.

The author provides a set of principles with a strong theoretical foundation for building literacy skills in Indigenous children, and I believe these would be strongly endorsed by teachers working in the field. Though not acknowledged in the article, the challenge may be in the practical implementation of recommended actions in such complex contexts, for example: monitoring ear health; supporting regular school attendance; attracting and retaining experienced teachers; and so on. That said Scull's work contributes to an important and ongoing conversation in Australia.

Gilroy, J., Donnelly, M., Colmar, S., & Parmenter, T. (2016). **Twelve factors that can influence the participation of Aboriginal people in disability services.** *Australian Indigenous Health Bulletin*, 16(1), 1–9.

Abigail Lewis

The National Disability Insurance Scheme (NDIS) is currently being rolled out across Australia, changing the way services are perceived and funded. As part of this process the National Disability Insurance Agency (NDIA) is tasked with ensuring people with disabilities are informed, empowered and financed in order to obtain the services they require to improve their outcomes. Currently, Aboriginal people have significantly higher rates of disability than the non-Aboriginal population and yet have considerably lower rates of participation in disability services than the non-Aboriginal population.

Dr John Gilroy, a Koori man, and his colleagues used an Indigenous research methodology to discover the factors that influence participation of Aboriginal people in disability services. The team interviewed 67 participants (seven identified as being Aboriginal) from a mainstream non-government organisation (NGO) and an Aboriginal NGO using focus groups and individual interviews. Transcripts were analysed using a grounded theory approach and 12 factors emerged: conceptualising disability; family and kin; colonisation and trauma; racism; choice of workers; choice of organisations; community connections; trustworthiness of mainstream services; multiple agency intervention; trusting workers; mobility; and affirmative action policy. These factors are interrelated and entrenched in services. It is apparent that the NDIS offers an exciting opportunity to improve services for Aboriginal and Torres Strait Islander peoples. However, this will be possible only if (to paraphrase from the Australian Psychological Society's recent formal apology) we are able to:

- listen more and talk less;
- follow more and steer less;
- advocate more and comply less;
- include more and ignore less; and,
- collaborate more and command less (Australian Psychological Society, 2016).

Reference

Australian Psychological Society. (2016). *Media statement: Thursday 15th September*. Victoria: Author. Retrieved from http://www.psychology.org.au/news/media_releases/15September2016/.

Robinson, G., Mares, S., & Arney, S. (2016). **Continuity, engagement and integration: Early intervention in remote Australian Aboriginal communities.**

Australian Social Work, early online. doi: 10.1080/0312407X.2016.1146315

Angela Lawless

Aboriginal and Torres Strait Islander children are significantly overrepresented in the child protection system, compared to non-Indigenous children, and the gap is widening. This paper addresses the issue of early intervention in NT remote communities where over 30% of the Territory's population are Indigenous and more than half of the Indigenous population lives in rural and remote communities. The authors draw lessons from the implementation of a program for 4–7-year-olds known as Let's Start. This group intervention for Aboriginal families comprises 2-hour sessions over 10 weeks with parent only discussions followed by interactive semi-structured sessions including the children. Despite experiencing major life events including family death by suicide and family violence, 50–60% of parents attended 60% or more of the sessions.

The paper presents two cases to illustrate the factors, capacities and practices that support or hinder the

engagement required for therapeutic interventions. The families described were parenting in adverse circumstances with multiple and complex needs. Despite indications of developmental delay, or neglect and abuse, a number of the children referred to the program had not been assessed or treated by the multiple community services. Their problems lie below the “threshold for statutory intervention” until a crisis occurs. The cases also reveal the lack of coordinated support for parents, which compromise

the care they are able to provide, particularly at critical transitions, e.g., family reunification. The authors note the lack of integration between service systems – health care, education, NGOs and child protection – which form a frayed patchwork of services exacerbated by fly-in fly-out service delivery. The authors call for integrated services that are grounded in the communities. In particular, they advocate for preventative engagement with families over time rather than as response to crisis.

Resource review

Taylor, K., & Guerin, P. (2014). *Health care and Indigenous Australians: Cultural safety in practice* (2nd ed.). South Yarra, Vic.: Palgrave Macmillan; pp. 220; ISBN-13: 9781420256871; \$72.95; <http://www.palgravemacmillan.com.au>

Frances Cochrane

Cultural safety “requires care to be determined by the recipient of care. It is not restricted to culture as indicated by ethnicity. It requires health professionals to reflect on their own cultural identity and on their relative power as a healthcare provider” (p. 11). Taylor and Guerin’s second edition of *Health Care and Indigenous Australians: Cultural Safety in Practice* provides an invaluable resource for all health professionals and students. This easy-to-read book introduces the concept of cultural safety in relation to Indigenous health issues and is an excellent starting point for clinicians and students for understanding this sometimes complex area and also how to apply the principles to everyday practice. As highlighted by the authors, health professionals have the opportunity to contribute to enhancing health outcomes for Aboriginal and Torres Strait Islander peoples through creating culturally safe environments. The Australian Nursing and Midwifery Accreditation Council and the Royal College of Nursing have endorsed the cultural safety approach outlined in this book.

Both authors have considerable experience in intercultural health care practice and working in remote communities of Australia. Although nursing professionals are the primary audience of this book, the content, reflection activities, scenarios and critical thinking tasks are able to be easily applied to all health professionals, including speech pathologists. This second edition includes statistical and models-of-care updates, as well as the inclusion of chapters on health policies related to these populations and Indigenous health priorities.

The 14 chapters in the book address topics such as definitions and terminologies, cultural frameworks for health, determinants of health, the current status of health

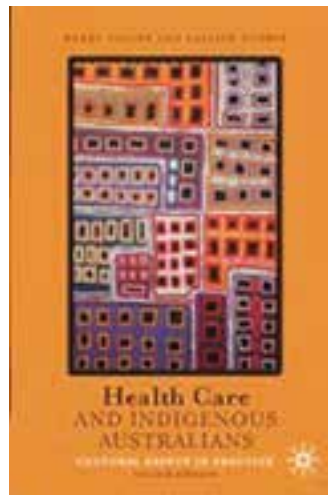
in Aboriginal and Torres Strait Islander populations, models of health, intercultural interactions and current workforce issues. One chapter is also dedicated to Indigenous health in a global context which provides comparison and discussion of health care service delivery and the health status of Indigenous populations in Canada, New Zealand and the United States of America. The final chapter covers

one of the most important components of cultural safety: reflection on practice.

Of greatest value in this book are the thoughtfully constructed scenarios, learning and critical thinking activities embedded within each chapter. A wide variety of resources including directions to websites, DVDs and readings are also included in each chapter. The authors have also considered how the content and activities can be applied to the reader’s local context, by providing “Making it local” suggestions within each chapter for contemplation by the reader. For example, the authors challenge the reader to find out information such as the traditional land where the reader lives and local health issues and their contributing

factors. Readers are also encouraged to identify possible experiences of institutional racism during student clinical placement, and become familiar with local Indigenous controlled health services.

For speech pathologists, topics of particular interest include ageing, dementia and disability, and the influence of Indigenous health beliefs for these areas of practice. Intercultural assessments are also discussed, particularly the “cultural bias that renders most standardised tests ineffective or inappropriate” (p. 100) for Aboriginal Australians. One of the activities in this section requires readers to review current assessment tools, to identify any cultural bias in these tools and what the consequences of this bias may be for assessment. The section on “Communication with Indigenous language speakers” also warrants attention from speech pathologists. Included in this section are subtopics exploring body language, health literacy and rapport development. Overall, this book is an excellent foundational resource for all practising health professionals, students and education providers.



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The *Journal of Clinical Practice in Speech-Language Pathology* is the major clinical publication of Speech Pathology Australia. Each issue of *JCPSLP* aims to contain a range of high quality material that appeals to a broad membership base. *JCPSLP* is published three times each year, in March, July, and November.

Issue	Copy deadline (peer review)	Theme*
Number 3, 2017	13 April 2017	Speech-Language Pathologists in Mental Health Contexts
Number 1, 2018	1 August 2017	Developmental Language Disorders
Number 2, 2018	1 December 2017	Entrepreneurship in Speech-Language Pathology

* articles on other topics are also welcome

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Each issue of *JCPSLP* contains a set of articles relating to a particular theme, as well as a selection of articles reflecting broader speech pathology practice. The Editorial Board selects a theme for each journal, and these themes can be suggested by members of Speech Pathology Australia at any time. Manuscripts on any topic relevant to speech pathology practice can be submitted to *JCPSLP* at any time.

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