

Evolution of a remote paediatric disability program

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Indigenous Australians experience disability at almost twice the rate of non-Indigenous Australians. Indigenous children with a disability have been described as 'doubly disadvantaged' and many children and their families experience significant barriers to accessing services. Despite high rates of disability in childhood, remote Indigenous communities across the Top End experience a chronic lack of disability services, including access to specialist allied health.

The Remote Paediatric Therapy Program (RPTP) was developed in response to growing inequities in disability service provision between urban and remote areas of the Top End. RPTP was established as a pilot program in 2010, with the program's unique design reflecting a scarcity of literature around Indigenous children with disabilities and provision of services for this population.

RPTP's initial aim was to provide intensive, multi-disciplinary intervention for children with disabilities. In the early years, the team travelled frequently and widely across the Top End to consult with children, families and schools in a number of remote communities.

Initial evaluations of the program were completed in 2010 and 2012, via survey of key community contacts (KCs). Survey results highlighted that RPTP's capacity to provide therapy intervention was limited, given the large geographical area, high rate of childhood disability across the Top End and infrequency of RPTP visits to each community. This feedback highlighted the need for RPTP to shift focus from providing therapy to building capacity of key community partners.

Using learnings from the initial years, the program has evolved to become a support structure for KCs, who are a regular presence in community and form close working relationships with children and families. The most recent evaluation (2014) identified the success of RPTP in building capacity of KCs to work with children with a disability. This is done through joint community visits, case conferences, mentoring, videoconferencing and resource development.

Given the complexity of paediatric disability in the remote context, the learnings and principles from RPTP should be considered in the rollout of the NDIS in the NT. Many allied health professionals have little or no experience in paediatric disability or working in remote communities. Adequate support structures, such as RPTP, are essential in ensuring safe and evidence-based practice for this vulnerable population.