Enhancing Allied Health Services to Rural and Remote Indigenous Communities: Phase 1.

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2006
Acknowledgements

This project would not have been possible without the involvement of Allied Health staff working within the WA Country Health Service, and the cooperation of communities with whom they work. Thanks are extended to the project reference group. Disability Services Commission and the WA Country Health Service provided funding to support this project.

Definition of terms

AH Allied Health (including but not restricted to Physiotherapy, Occupational Therapy, Speech Pathology, Audiology, Dietetics, Diabetes Educator, Psychology, Podiatry)

ATSIHW Aboriginal and Torres Strait Islander Health Worker

CUCRH Combined Universities Centre for Rural Health

DSC Disabilities Services Commission

DOH Department of Health

FTE Full time equivalent employment

KAMSAC Kimberley Aboriginal Medical Services Advisory Council

Rural and Remote Those areas classified under Australian Standard Geographical Classification Remoteness structure as ‘Inner and Outer Regional Australia’ or ‘Remote and Very Remote Australia’

TA Therapy Assistant

WA Western Australia

WACHS WA Country Health Service
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1. Executive summary

1.1 Introduction

In 2002 the WA Country Health Service produced a discussion paper investigating rural and remote allied health workforce issues. This paper found current models of allied health service delivery struggle to meet the needs of Aboriginal and Torres Straight Islander people living in remote communities. The paper additionally identified the under representation of Aboriginal and Torres Strait Islander people within the rural allied health workforce and resources.

This project outlines current delivery of allied health services in remote communities and explores alternative service delivery models, with a focus on Community Based Rehabilitation. The project has included four phases of project activity, including:

- The formation of Project Reference Group;
- A Literature Review of alternative allied health service delivery models;
- Mapping of existing allied health services to remote Aboriginal communities within WACHS; and
- Documentation of identified case studies of allied health services provided to remote Aboriginal communities in Australia.

This project outlines current delivery of allied health services in remote communities and explores alternative service delivery models, with a focus on Community Based Rehabilitation, which has been identified as an appropriate service delivery model to enhancing the delivery of allied health services to Aboriginal communities.

1.2 Literature Review

A systematic literature review of alternative allied health service delivery models and Community Based Rehabilitation was undertaken. This literature review explored Community Based Rehabilitation as an appropriate model of service delivery to provide allied health and rehabilitation services to remote Aboriginal communities. It characterises the barriers to allied health service delivery in this context and considers Community Based Rehabilitation, with an emphasis on community based workers as a service delivery alternative.

1.3 Mapping WA Allied Health Services to Remote Communities

A survey of current allied health service provision to remote communities was undertaken in the Pilbara Gascoyne and Kimberley regions of Western Australia. The survey determined the characteristics of current services and factors that were seen to influence the delivery of allied health services to remote communities.

In terms of characterising the service, the survey showed that in these areas WACHS was the primary provider of the allied health services to remote communities. These services were generally provided through outreach visits, varying in frequency from once per fortnight to twice yearly. Speech Pathology, Occupational Therapy and Physiotherapy were the most regularly provided allied health services. A range of people within the community were identified as enhancing the work of the visiting allied health professionals in the delivery of therapy programs.
Several factors that influence the delivery of allied health services were identified including: the accessibility and availability of support staff for visiting allied health services; relationships between service providers and the remote community; allied health staff resources; infrastructure and community access.

1.4 Case Studies
In order to reflect the key elements of relevant models of therapy service, several case studies are examined. Case studies are divided into three categories of service delivery:

- The WACHS TA model;
- Community Based Rehabilitation and community co-worker models, including Katherine Regional Allied Health Project, FPA (NSW) Health projects, North West Queensland Primary Health Care CBW project and, TAs in the Murchison region of WA; and
- Aboriginal and Torres Strait Islander Health Workers.

Each case study outlines: the background of the particular project; recruitment and selection processes; the role of community based workers; training and supervision practices; and Limitations, Benefits and Lessons Learnt of the particular project framework.

1.5 Discussion: Considerations for the Development of a Community Co-Worker Model

Based on the literature review, the mapping of current allied health service delivery and the case study material, several considerations for the development of a community co-worker model for the delivery of allied health services to remote Indigenous communities emerged. These considerations fall under several broad categories, including: community engagement; allied health staff resources; title of the worker; employment conditions; education and training; the role of the community co-worker; interface with ATSIHW and TAs; and mainstream verus community based service delivery.

1.6 Conclusion

Phase two of the project will further develop some of the considerations emerging from this phase of the project. It will focus on establishing a framework and resources to support the implementation of assistants/health workers in Indigenous communities to enhance allied health services including: Philosophy of service delivery; cultural security protocols; equitable and sustainable employment structure; community engagement; role definition and scope; training requirements of AHP and assistant; supervision requirements; and recruitment.
2. Introduction

2.1 Rationale

In 2002 the WA Country Health Service produced a discussion paper investigating rural and remote allied health workforce issues. Several issues were identified around the provision of allied health services to Aboriginal communities, specifically:

- Current models of allied health service delivery may not meet the needs of Aboriginal and Torres Straight Islander people in remote communities; and
- Aboriginal and Torres Strait Islanders are under represented within the rural allied health workforce and resources (Spitz 2002).

The suggested solutions to these issues included: supporting the implementation of appropriate service provision models to Aboriginal and Torres Straight Islander communities; and engaging Aboriginal Health Workers and Aboriginal Liaison Officers in the provision and support of allied health services to Aboriginal and Torres Strait Islander people (Spitz 2002).

These suggestions have been echoed in recommendations of various project report including: the final evaluation of the WACHS and Disability Services Commission ‘Therapy Assistant Training Initiative’ project (Goodale 2005); and in ‘Addressing the unique needs and issues of Western Australian Indigenous people with disabilities’ (Murphy, Stopher et al. 2004), a report (still in draft form) produced by the Disability Services Commission and Edith Cowan University. The recommendations of both reports suggest the further investigation of the training of local Indigenous workers to work with current health service providers to improve access to Allied Health services for Aboriginal people.

This project aimed to explore and develop a service delivery model to provide allied health and rehabilitation services to Aboriginal people in remote communities across Western Australia. It has a particular focus on Community Base Rehabilitation, which relies on the use of community based workers and has been identified as an appropriate service delivery model to enhancing the delivery of allied health services to Aboriginal communities. Several phases of project activity will be employed to this end. This report represents the finding from phase one.

2.3 Project Outline

Project Aim
To enhance allied health services to Aboriginal people and communities.
Project Activity

In order to achieve this aim, the project included four phases of activity:

1. The formation of Project Reference Group to oversee the management and direction of the project

2. A Literature Review of alternative allied health service delivery models, with a focus on Community Based Rehabilitation;

3. Mapping of existing allied health services to remote Aboriginal communities within WACHS; and

4. Documentation of identified case studies of allied health services provided to remote Aboriginal communities in Australia.
3. Project reference group

3.1 Reference Group Membership

A project reference group was formed with representatives from a variety of organisations. Members included:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Location</th>
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<tbody>
<tr>
<td>Kate Spencer (Chair)</td>
<td>Senior Physiotherapist (Kimberley - Broome)</td>
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<td>Lisa Cameron</td>
<td>Senior Speech Pathologist (Kimberley - Derby)</td>
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<td>Jenny Poelina</td>
<td>Co-ordinator Centre for Aboriginal Primary Health care Education, Training &amp; Research (Kimberley Aboriginal Medical Services Council Inc KAMSC Inc)</td>
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<td>Bec Allen</td>
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<td>Gail Elliot</td>
<td>Regional Social Work Coordinator (Midwest Murchison - Geraldton)</td>
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<td>Luke Wilkinson (Project Officer)</td>
<td>Snr Speech Pathologist (Pilbara Gascoyne - Carnarvon)</td>
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3.2 Role of Reference Group

The role of the Reference Group was to consult and seek feedback from their respective organisations and regions on current allied health services, project direction, and disseminate project outcomes.
4. Literature Review

4.1 Background

A systematic literature review of the available literature looking at alternative allied health service delivery to Aboriginal people in rural and remote areas, and Community Based Rehabilitation was undertaken. Several databases were searched, including Cinahl; Cochrane Library; Medline; Pubmed; ProQuest; and Google Scholar, to identify research and or project activity in this area. Search restrictions were used to limited to Australian publications only, published in the last 15 years (since 1990), to confine search results to those relevant to the research topic. In addition, a Google web-search was also undertaken to identify non-published material available on the World Wide Web. Again, these searches were limited to Australian websites. Both search types were initially limited to resources pertaining to Aboriginal / Torres Strait Islander / Indigenous people, though the lack of available literature necessitated a broadening of the search strategy.

The Executive Summary of the Literature Review follows. For greater detail please see the full text (Beattie, N. (2006). Enhancing Allied Health service to rural and remote Indigenous communities: Literature Review. Geraldton, Western Australia: CUCRH, WACHS, DSC.)

4.2 Executive Summary

WA Country Health Services (WACHS) is endeavouring to develop a service delivery model to provide allied health and rehabilitation services to Aboriginal people in remote communities. A Community Based Rehabilitation model, with an emphasis on Community Based Workers, has been proposed as a viable framework.

There are significant barriers to the effective provision of allied health and rehabilitation services to rural and remote Aboriginal communities which fall into five key categories, including: Workforce issues; Sub-optimal allied health therapy model of service delivery; Cross Cultural issues; Local knowledge of service; and Access to service.

Community Based Rehabilitation, with an emphasis on Community Based Workers, has gained considerable recognition as an appropriate model of service delivery to overcome these barriers and provide effective and appropriate rehabilitation and therapy services to rural and remote Aboriginal communities.

In simple terms, CBR refers to the delivery of basic services to disabled people within their community, including all services necessary to improve the participation and functioning in daily activities of people with disabilities. The basic concept centres around the decentralizing of responsibility and resources, both human and financial, to community level organisations.

A key feature of CBR programs is the employment of a community based workforce. These Community Based Workers may have a wide and varied role, but generally work with health professionals in the provision of functional rehabilitation services. Central to the success of community based worker models is utilisation of a two-way learning system between the community based workers and visiting health professional. Within a two way learning model:
‘The health professional adopts a consultative role, develops training materials in consultation with the community, and trains the community disability worker in specific skills. The community disability worker trains the professional in community issues, activities and practices...’ (Glynn, 1996d)

According to the literature a two way learning approach is central to providing culturally appropriate service that acknowledges and works within the cultural parameters of the particular community group. It recognizes the need for, and fosters a sharing of knowledge and skills between visiting Allied Health and the Community Based Worker. It allows Community Based Workers to act as an intermediary or cultural translator to guide in the most appropriate ways to deliver services within that specific cultural niche, whilst learning about the Allied Health service. Conversely, it allows the visiting Allied Health staff to learn about the community, its culture and how services can be delivered in a more culturally secure manner.

As a service delivery model, CBR does not exist independently, but is designed to add to and enhance broader rehabilitation services. Traditionally, mainstream service delivery models have tended to focus on the institutional-based and outreach services. Community Based Rehabilitation is an additional or supplementary model of service delivery that can complement existing models to maximise the goals of rehabilitation.

Since the 1990s CBR has gained considerable currency as an appropriate model for the delivery of rehabilitation and therapy services in rural and remote Aboriginal communities. The emerging literature suggests that Community Based Rehabilitation offers an opportunity to address gaps in service delivery and provide rehabilitation services that meet the specific cultural and social needs of Aboriginal people in rural and remote communities. The arguments for the adoption of CBR for the delivery of services to Aboriginal people in rural and remote communities include: Increased community participation and control; the provision of culturally appropriate services; and improved access to health services.

The principles of CBR and the Community Based Worker have guided the development of models and projects in the delivery of health services to rural and remote communities in various health contexts around the country. Case studies cataloguing several of these projects, including: FPA Health projects; the North West Queensland Primary Health Care CBW project; Katherine Regional Allied Health Project; the WACHS state-wide TA approach; and TAs in the Murchison region of WA, reflect the diversity of the application of CBR models and the elements common to such service delivery frameworks.

In line with the case study material, several issues around the employment and utilization of Community Based Workers are evident in the literature, particularly arising from the experiences of CBR in the Northern Territory. The key issues identified in the literature and those identified within the case study material, include: recruitment, selection and community control; the role of the community based worker; working conditions; training; the title of Community Based workers; Community Based Rehabilitation as a comprehensive model; transferability of successful models; and barriers for Community Based Workers.
5. Mapping WA Allied Health services to Remote Communities

5.1 The Mapping Exercise

A survey assessing current allied health service provision to remote communities was distributed to service provision agencies in the Pilbara Gascoyne and Kimberley health service regions of Western Australia (see appendix A for survey tool).

The survey was disseminated across the health regions via the Project Reference Group. It was completed by senior allied health practitioners, responsible for the delivery of therapy services to remote communities. A total of 27 respondents completed the survey.

The purpose of the mapping exercise was to collect data that would allow for a clear description of current delivery of allied health services to remote communities. Data was collected pertaining to: current service delivery; and factors that influence the delivery of allied health services to remote communities.

5.2 Current Service Delivery

Data was collected around several aspects of service delivery, specifically: demographic information; the agencies providing allied health services; structure of current delivery and levels of service; and service partners.

Demographic Information

The survey showed the Pilbara Gascoyne and Kimberley regional health services deliver outreach allied health services to 44 remote communities, 17 in the Pilbara and 27 in the Kimberley with a collective population of approximately 1700 people. Services are provided by seven regional health service units, including: Port Hedland, Tom Price, Karratha, and Carnarvon in the Pilbara; and Derby, Broome and Kununurra in the Kimberley. For a full list of communities visiting, including services provided, frequency and duration of outreach visits and travel details see Appendix B.

Agencies providing allied health services

The survey showed WACHS was the primary provider of the allied health services to rural and remote communities, with services generally provided by regional health services units. Other providers of allied health services include: Divisions of General Practice; the Department of Education; private allied health providers; and iHear (a private audiology/audiometry service provider).

Structure of Current Delivery and Levels of Service

Allied health service providers delivering services to remote communities provide both centre-based services and outreach services. Typically, an allied health team provide services to a number of communities, with populations ranging from 30 to 850 people.

The frequency of outreach visits varies from once per fortnight to one yearly. A number of communities are visited by allied health staff upon request only. Visits vary in length from 1 to 5 days, however, as many of the remote communities are some distance from the health service much of this time is often spent in transit. Typically, staff travel between 0.5 - 13 hours to access communities, with travel undertaken by car, plane or both. The time spent in remote communities ranges from 0.5 day to three days per visit, dependant on: remoteness and associated travelling time and access; community size; community need; and allied health staff resources.
While all communities provided with services receive Speech Pathology, Occupational Therapy and Physiotherapy, some have access to other allied health disciplines, including Dietetics, Diabetes Education, Podiatry, Audiology, Social Work and Psychology. Community access to disciplines is primarily dependant on allied health staff resources and community need.

Service Partners

A range of people based within remote communities work with visiting allied health professionals in the delivery of therapy programs. The survey showed Education Department staff play the most significant role, however additional assistance is provided by those employed by health agencies and members of the local community. The following table outlines the roles played by each of these groups:

<table>
<thead>
<tr>
<th>Community members</th>
<th>Role</th>
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| Education Department staff (Teacher Assistants and other school based personal) | - Assist with compliance for appointments  
- Arrange appointments  
- Community and family liaison  
- Conduct therapy programs |
| Community members | - Client family members (older siblings, parents, grandparents)  
- Community Council members | - Interpreting and translating  
- Conduct therapy programs  
- Assist with compliance for appointments  
- Community liaison |
| Health Agency Staff | - Aboriginal Health Workers  
- Clinic Nurse | - Assist with compliance for appointments  
- Conduct therapy programs  
- Transport staff and clients  
- Translate and interpret  
- Organise referrals  
- Arrange appointments  
- Assist with compliance for appointments  
- Advocate for the community and families  
- Educate on “What is Allied Health”  
- Transport staff  
- Act as liaison between the client and Allied Health staff  
- Organising appointments  
- Community liaison |
| - HACC workers  
- DSC Local Area Coordinator |
5.3 Factors that Influence the Delivery of Allied Health Services to Remote Communities

The mapping exercise allowed for the identification of several factors that influence the delivery of allied health services to remote communities. Factors of note include: the accessibility and availability of support staff for visiting allied health services; relationships between service providers and the remote community; allied health staff resources; infrastructure; and community access.

Accessibility and Availability of Support Staff

The accessibility and availability of local staff and community members to support the delivery of allied health services was seen by survey respondents as important to the success of remote service delivery.

In those communities where support was available from Education Department staff, health agency employees or community members, staff recognised these roles as vital to the delivery of an effective service. However, often visiting allied health professionals have limited or inconsistent access to support of this nature, and a large proportion of existing relationships are based on informal collaborations. Overall, there was no reported formal agreement between Allied Health services and the community or health clinic managers relating to the roles and responsibilities for service provision.

In the case of health agency staff, specifically ATSIHW and nurses, visiting AHP reported difficulty in accessing consistent support due to limited staff availability and resourcing. High workloads and a high turnover of the health workforce within many remote communities were identified as contributing to this limited access. One respondent summaries these contributing factors: “a large turn over of clinic staff; [the small] size of clinic... not enough clinic and support staff” (Allied Health respondent 1). Survey respondents suggested this lack of access to local health employees led to a poor local awareness of the services allied health offer, and in turn contributed to a poor uptake of services.

In order to best deliver allied health services to remote communities survey respondents identified the need for access to consistent and ongoing support from local staff and community members. In the words of one respondent: “(we need a) locally based allied health person or representative to organise community and clients, and provide follow up between visits” (Allied Health respondent 23).

Relationships between Service Providers and Remote Communities

Survey respondents indicated the success of allied health services in remote communities was dependent on “relationships with the [local] community; knowing community members and staff... networking and communication” (Allied Health respondent 19). Respondents identified key stakeholders, relationships with whom were central to successful service delivery, these included: local health agency employees, specifically ATSIHW, nurses and Disability Services Commission staff; visiting health providers, such as doctors; Education Department staff; and most importantly, community members.
Several barriers to establishing and maintaining good relationships with these key stakeholders were identified. The infrequent nature of allied health outreach visits and the high turnover of staff was clearly recognised as prohibitive, with one respondent noting “it is difficult to “get to know” the community when you only visit 2 times a year” (Allied Health respondent 20), and “Consistency of staffing, seeing familiar faces is important to teachers/clinic staff and clinic” (Allied Health respondent 17). Additionally, respondents cited the low morale and high stress levels of community based health providers, such as ATSIHW and clinic nurses, at some sites. The large workload of this workforce was seen as a barrier to establishing and maintaining successful relationships.

**Allied Health Staff Resources**

Limited allied health staff resources were also flagged as a significant challenge to the effective delivery of remote therapy services. In addition to recruitment and retention issues, such as high staff turnover, respondents identified a disproportionate community need relative to the availability of the allied health workforce.

Insufficient allied health staff resourcing can results in: infrequent outreach visits; limited or ineffective follow up; reduced opportunity to develop and maintain relationships within remote communities; and a high workload for existing staff, compounding staff retention issues. Respondents indicated that improved allied health staff resourcing would lead to a more effective service, specifically identifying an increased allied health full time equivalent (FTE) within regional health services and a greater dedication of this FTE to the provision of outreach services.

**Infrastructure**

Survey respondents identified issues around the availability and appropriateness of local facilities as impacting on the delivery of therapy services. Of particular note, in many communities a lack of space suitable for consultations was an ongoing issue.

Additionally, survey respondents identified a need for health service management to provide assistance in facilitating effective service delivery. Respondents identified a need for this assistance in relation to: adequate staffing; service delivery planning; and developing formal working understandings with other stakeholders.

**Community Access**

In addition to these resourcing concerns, the results of the survey highlight several access issues that were seen to limit the efficacy of service delivery in remote communities. These included: variable weather conditions and associated lack of access to communities; and transport issues, with respondents citing “limited transport options” (Allied Health respondent 26).
6. Case Studies

In order to reflect the key elements of relevant models of therapy service delivery, this section presents case study material drawn from: current WACHS allied health service delivery; Community Based Rehabilitation and Community Co-Worker models; and ATSIHWs. Where possible, case studies will include: a project background, outlining the project or model; details of the recruitment and selection; the role of the worker; training and supervision; and an account of the relevant limitation, benefits and lessons learned.

6.1 WACHS therapy assistants

Project Background

In recent years WACHS, and other providers of health services in country WA, have employed Therapy Assistants (TAs) as an enhancement to Allied Health service delivery in rural and remote areas (Lin, Goodale et al. 2005). By definition a TA is a “trained health workers who delivers therapy services to clients under the direction of an Allied Health professional” (Lin, Goodale et al. 2005).

Recruitment and Selection

Therapy Assistants positions are advertised and staff recruited via standard Department of Health procedure. A standard JDF, with the summary of duties divided into clinical, administrative and professional areas, guides the selection of applicants and supports this recruitment.

Role of the Therapy Assistant

The role of the TA is wide and varied, dependant upon the needs of the local community and the particular allied health discipline in which the TA is delivering services. Generally, the TA delivers therapy programs to clients - individual therapy - as directed by the supervising Allied Health professional, and maintains appropriate documentation. Additionally, the role of many rural and remote TAs includes an administrative component, including such tasks as typing, promotion, equipment cleaning and tracking. Some rural and remote TAs also conduct group therapy sessions and perform other duties including providing general assistance to the therapists and undertaking health promotion activities (Lin, Goodale et al. 2005).

Training and Supervision

WACHS has created a TA training package which consists of a series of 16 learning modules delivered via video-conferencing and distance education. The training package is designed to complement situation-specific on the job training which occurs locally and is supported by local supervisors. The training package is articulated with a Certificate III Health Service Assistance (Allied Health Assistance) qualification through West Coast TAFE, with the training providing formal credit toward the qualification (Lin, Birch et al. 2005).

Additionally, WACHS has developed TA supervision guidelines to direct the supervision of TAs. These guidelines included: a description of the frequency of supervision; the acceptable components of supervision; appropriate methods of supervision; and necessary skills of the supervisor (Lin, Birch et al. 2005).
**Limitations, Benefits and Lessons Learnt**

Several benefits have been attributed to the utilization of TAs in rural and remote areas, including: improved access to allied health services in communities with visiting allied health professionals; enhanced continuity of services during AHP staff turnover; and building a skill base within community enhanced continuity of services during AHP staff turnover; and building a skill base within community (Battye and McTaggart 2003). However, this model is limited in its appropriateness and applicability for expansion into remote indigenous communities. The current education and training package is not appropriate to a remote Aboriginal community context and would need to be restructured to reflect cultural security protocols and literacy and numeracy issues. Additionally, much of the support currently offered to TA in remote locations requires access to technologies, such as videoconferencing; often not readily available in remote Aboriginal communities.

### 6.2 Community Based Rehabilitation

The principles of CBR have guided the development of models and projects in the delivery of health services to rural and remote communities in various health contexts around the country. The following case studies catalogue some of these CBR initiatives, focusing on the use of Community Based Workers in the delivery of services to rural and remote communities and Aboriginal populations. These, and additional, case studies are further expanded in “Enhancing Allied Health service to rural and remote Indigenous communities: Literature Review” (Beattie 2006).

The case studies presented will include:

- Katherine Regional Allied Health Project
- FPA (NSW) Health projects
- North West Queensland Primary Health Care CBW project and,
- TAs in the Murchison region of WA.

#### 6.2.1 Katherine regional aboriginal health and related services Inc

**Project Background**

The Katherine Regional Allied Health Project (KRAHTP) is a Commonwealth funded project under the Rural Health Services Program, delivered by Katherine Regional Aboriginal Health and Related Service in the Northern Territory. The project commenced in 2001, aimed at increasing the delivery of physiotherapy, occupational therapy, speech therapy and podiatry services, to the aged and disabled people in six remote communities in the Katherine Region.

The key objects of the project included: increase key allied health therapy and related services to remote clients; increase capacity of remote communities to care for their aged and disabled people; develop innovative new community partnerships; build a best practice support system for remote staff; and demonstrate accountability to key stakeholders.

A central feature of the KRAHTP model is the utilization of community co-workers. Five community co-workers are employed, providing a link between the community and allied health services, with more active recruitment currently underway.
Recruitment and Selection
The project team reported significant difficulties employing community based workers, identifying a number of issues that contributed to this difficulty, including: a lack of project funding to employ community based members and the resulting need to source funding from other organizations (and the communities awareness of this); a lack of clearly defined career path for the community based worker; and from the perspective of the community, the loss of social security benefits resulting from paid employment (Cunliffe 2004).

Role of the Community Based Worker
The role of the community co-worker included: language interpreting; offering community orientation to the visiting Allied Health workers; assisting in obtaining informed consent from clients who are seen by the visiting health; increasing the awareness of available Allied Health services; coordinating referrals for the allied health visitors; promoting culturally secures services; offering activity based interventions and respite under direction of Allied Health. These community based workers were reported to be employed on casual basis and paid commensurate to a level 1, Aboriginal Health Worker.

Training and Supervision
A key concern of the KRAHTP project team regarded the education of community co-workers and the lack of a defined career path. It was reported within the KRAHP, the role of the community based worker is not that of an Aboriginal Health Worker nor a Therapy Assistant, though it includes elements of both. As a result, the project team ‘struggled to find appropriate training modules’.

Limitations, Benefits and Lessons Learnt
The key concerns around this project centred on the availability of appropriate training packages for the community based worker and recruitment and selection difficulties.

6.2.2 Family planning NSW

Project Background
Family Planning New South Wales (NSW) is a non government organisation specialising in providing practice-based reproductive and sexual health services. In response to concerns around the appropriateness of existing services for Aboriginal women, in 2002 two Aboriginal Community Liaison Workers (ACLW) positions were created to mediate between the community and health professional (Beange; Read 2006).

Recruitment and Selection
The community was actively engaged in the development of the ACLW positions, and were involved in the recruitment and employment process. It was seen as essential for the ACLW to be accepted to all members of the community such as elders, service providers and other social figures. While ATSIHW were identified as most suitable and appropriately trained personnel to fill the ACLW position it was not possible to find trained or available ATSIHWs (Beange; Read 2006).
Role of Community Based Worker

The position description included: making appointments, supporting clients; managing client follow up; coordinating community activities, such as group sessions, one-on-one education and recreational activities; advising on cross cultural issues; transporting clients; and assisting in reviewing appropriate resources for use by clients and the community (Beange; Read 2006).

Training and Supervision

There were no prerequisite training for the position, but a focus was on communication skills. Training opportunities were available, but this was to be undertaken at the workers discretion.

Limitations, Benefits and Lessons Learnt.

The employment of ACLWs was a successful venture, resulting in an increased number of referrals and higher rates of screening consultations and follow up. The project team attributed much of this success to the strong and ongoing engagement of the community across the project.

6.2.3 North West Queensland primary health care

Project Background

NWQPHC is a Division of General Practice that provides services to communities living in North West Queensland. NWQPHC has implemented a community based worker model of therapy services to enhance the delivery of allied health services. The model focuses on the employment and training of local community members as community based workers to work in the community, enhancing the provision of allied health services and improve continuity of care (NWQPHC 2006).

Role of the Community Based Worker

There are several categories of Community Based Worker, including: CBW Physical Activity Promotion; CBW Massage Therapy; and Healthy Lifestyle Promotion. Broadly, the role of each is to support the existing services provided by NWQPHC allied health staff and strengthen the health service, the community and other service providers (NWQPHC 2006).

Training and Supervision

The training expectation for the community based worker varies for each of the different categories ranging from no specific requirements, a Senior First Aid Certificate or the undertaking of a Certificate IV course. Training is inline with the specific duties of the position.

6.2.4 Therapy Assistants in the Murchison region of Western Australia

Project Background

Inline with the employment of TAs to aid in the delivery of allied health services to rural and remote Western Australia, a TA was employed in the Murchison region of Western Australia in 2002. From the outset the model in the Murchison varied from the broader WACHS TA model. Perhaps the most marked difference was the cultural orientation: the TA was an Aboriginal woman, accepted by the local community and was employed to deliver therapy services to a largely Aboriginal population (Jackson 2006). A specific service delivery framework evolved from the WACHS TA model to suit the needs of the TA and the needs of the Indigenous community that she provided services to (Jackson 2006).
The role of the Community Based Worker

While the role of the TA was based on the WACHS TA framework, it was considerably broader. In addition to the standard role, the role of Murchison TA included a large element of cultural brokerage and mediation, linking mainstream Allied Health services to the community (Jackson 2006). This role required a specific cultural knowledge and a greater degree of autonomy than that in mainstream practice.

Training and Supervision

The training and supervision of the TA varied from that within the mainstream WACHS framework owing to the specific role of the TA and the more equitable relationship between the allied health therapist and the TA which underpinned this model (Jackson 2006).

The TA was a qualified Aboriginal Health Worker and Teachers Aide but had no formal qualification in the delivery of Allied Health services (Jackson 2006). TA training was provided ‘on the job’ with the support of the Allied Health professional.

While the TA participated in some of the training models developed for the mainstream TA stream, these tended to clash not only with some of her cultural understandings but the content was also at times inappropriate for use within her community group (Jackson 2006).

Limitations, Benefits and Lessons Learnt

This model has proved effective in the delivery of Allied Health services to this region, with the TA continuing to guide practice and provide services to the Aboriginal people within the Murchison region (Jackson 2006). However, the model was applied to a single worker and would need significant development for broader application.

6.3 Aboriginal Torres Strait Islander health workers (ATSIHW)

Project Background

For many years Aboriginal and Torres Strait Islander Health Workers have been recognised as a vital component of the Indigenous health workforce. Emerging in the 1950’s, the workforce has grown substantially and is acknowledged as a crucial component of strategies aimed at improving Indigenous health (ECU; Government_of_Western_Australia).

In Western Australia alone there are roughly 160 employed ATSIHWs. Of these, 29% work in the Kimberley region, 20% in the South East, 23% in the Perth metropolitan, and 21% Pilbara and Mid-West regions (Government_of_Western_Australia). ATSIHWs are employed in both the private and public sectors; in hospitals, community health services and Aboriginal community controlled organizations.

Role of the Community Based Worker

The role of ATSIHWs is diverse and varied. Broadly, the key components of the role may include: linking the community and mainstream health care providers; primary health care; immunisations; community health and education; patient transport and education; cultural brokerage; environmental health; administration, management and control; and policy development and program planning (Government_of_Western_Australia). The specific role of ATSIHWs depends upon the level of training the worker has undertaken, community need and available supervision.
Training and Supervision

Recently, a review of the national qualifications for ATSIHWs was undertaken in the ATSIHW National Competency Standards and Qualifications Project. This project has established a new standardise qualification framework for ATSIHW, which is currently with the National Quality Council (NQC) for endorsement.

Under the revised qualification framework, accreditations for ATSIHWs will include: Certificate II in ATSI Primary Health Care; Certificate III in ATSI Primary Health Care; Certificate IV in ATSI Primary Health Care (Practice); Certificate IV in ATSI Primary Health Care (Community Care); Diploma in ATSI Primary Health Care (Practice); Diploma in ATSI Primary Health Care (Community Care); Advanced Diploma in ATSI Primary Health Care (Practice); and Advanced Diploma in ATSI Primary Health Care (Community Care). Qualifications generally require the completion of a number of core units, supplemented with electives which are often directed towards specific local health issues.

Limitations, Benefits and Lessons Learnt

The ATSIHW workforce has been identified as a central element of contemporary Indigenous health care. This recognition and the widespread utilisation of ATSIHWs has resulted in a number of policy efforts to improve the training, status and conditions of employment of ATSIHW. These efforts are not without challenges, particularly in the development of national training and practice frameworks.

ATSIHW has a specific niche in the delivery of health care services that varies considerably from that of the community co-worker. The ATSIHW model has limited applicability as a framework for community co-worker models of allied health service delivery.
7. Discussion: Considerations for the Development of a Community Co-Worker Model

Based on the Literature Review, the mapping of current allied health service delivery and the case study material, several considerations for the development of a community co-worker model for the delivery of allied health services to remote Indigenous communities emerged. These considerations fall under several broad categories, including: Community engagement; Allied health resources; Title of the worker; Employment conditions; Education and training; Role of the community co-worker; Interface with ATSIHW; and Mainstream versus community based service delivery.

7.1 Community Engagement

To promote the success of a community co-worker model a strong and highly collaborative relationship between the community and the visiting health service is imperative. A strong relationship encourages community engagement, and in turn contributes to community up-take and utilisation. This relationship should be forged with both the community and local service providers, including, but not limited to: community councils; local community members; local interest groups; and local health services.

Where community co-worker models have been most successful the local community has been engaged at all stages of the development and delivery of the initiative. Community councils have been consulted in the: development of a specific model to suit local need; the identification of an appropriate person to fill the co-worker role; and the line management of the co-worker.

7.2 Allied Health Resources

The successful establishment and ongoing management of a community co-worker model requires an investment of adequate allied health staff resources. To provide the model with the best chances of success, the visiting allied health team should be stable with a long-standing history within the community. This team should have a regular visiting schedule (at least 6 weekly) to ensure community co-workers have adequate support and to ensure a strong rapport with the local community. Additionally, staff should be adequately training both in the management of the co-worker and in culturally appropriate work practice.

7.3 Title of worker

The literature and case study material suggest the title given to community workers is an important consideration in the development of a community co-worker service delivery model.

Several titles have been given to workers who fill this community based role, including: Therapy Assistant; Allied Health Assistant; Community worker; Community Based worker; Aboriginal community Liaison worker; Support worker; Aged and Disability worker; and Community Consultant Liaison Officers. There are several concerns with many of these titles. Firstly, many of them do not accurately reflect the diverse role or necessary autonomy of the community based worker. Secondly, several infer and reinforce unequal power relationships between allied health staff and the community worker.
Advocates for Community Based Rehabilitation use the term “Community Based Worker” or “Community Co-Worker” as it: implies the role located in the community; it gives recognition to the work component in that setting with that population; and avoids immediate assumptions regarding power and authority. The use of the term worker within a team suggests a peer relationship, and recognises that peers work and learn from each other. The project reference group identified “Community Co-worker” as appropriate when referring to the community workers in the context of the delivery of therapy services to remote Aboriginal communities.

7.4 Employment Conditions
Several issues around the employment conditions of community co-workers are worthy of note, specifically: remuneration; community resources; and supervision and support.

Remuneration
The rate of payment of community co-workers should reflect their level of expertise; the specific role they are employed to fulfill; the likely variability of the needs of their client base; and the needs of community overall. Several existing award structures may be appropriate however; none of these accurately reflect the role of the community co-worker and as such have a limited applicability.

Relevant awards include the:
- Health and Disability Support Workers Western Australian Government Award 2001;
- Health Workers Community and Child Health Services Award 2000;
- Liquor Hospitality and Miscellaneous Union - Department of Health Aboriginal and Ethnic Health workers Federal Agreement 2005; and
- WA Health Service Union Award 2006

Community Resources
The availability of local infrastructure and resources to support the role of the community co-worker has been identified as important in the success of this model. Specifically, the availability of: appropriate consulting space; reliable telephone, fax, computer and other communication facilities; and cars or other transport.

Supervision and Support
Community based workers require supervision and support. Accounts from some community based workers, reflected in the case studies, suggest contact with supervisors for supervision and support purposes should occur often as once a one day a fortnight. This far exceeds scheduled outreach visits for many communities; alternative supervision arrangements should be explored.

7.5 Education and training
The education and training required to support a community co-worker model of service delivery is multifaceted, involving three training stands: formal training for community co-workers; formal training for allied health staff; and informal two-way learning.
Formal Training for Community Co-Workers

Training is essential in providing community co-workers with the appropriate knowledge and skills to allow them work effectively. While there are several existing training packages that overlap areas of the work of community co-workers, specifically the WASCH TA training package and ATSIHW training, neither are ideal. There is a real need to develop a formal training framework for the community co-worker that accurately reflects their role. Inroads to developing such a package have been made in both the Northern Territory and in Queensland, in support of several CBR projects though these are incomplete and would need further development.

A disadvantage identified in the development of a new ‘stand alone’ community co-worker training package is the lack of defined career path for community co-workers. This was clearly identified as problematic by the Project Reference Group and was similarly noted in the literature.

Formal Training for Allied Health Staff Working with Community Co-Workers

Just as training is essential for the community co-worker there is a need to ensure the allied health staff who are to be working with community co-workers to receive appropriate formal training to support the community co-worker. This training may take several forms, from supervision and cultural security training, to training articulated with a accredited training provider, such as: Certificate IV Train the Trainer; Masters of Public Health; Masters of Remote Health Practice; or Community Based Rehabilitation short course.

Two-Way Learning

The long term success of a community co-worker model is reliant on a system of informal two way learn between the visiting AHP and the community co-worker. By this training model, allied health staff and the community co-worker are both teacher and learner. The AHP has a role in providing the co-worker with appropriate ‘on the job’ training. The role of the community co-worker involves the transmission of appropriate cultural and local knowledge. This exchange respects the existing knowledge of both parties and facilitates a more effective service delivery.

7.6 Roles and function of worker

The role of the community based worker within a CBR model is wide and varied, depending on the particular needs of the community and the expertise of the community based worker and allied health professional. The specific role of the co-worker may include any of the follow tasks:

- Consult/liaise with visiting AHP regarding client assessment or management issues;
- Deliver therapy programs and participate in the monitoring and evaluation of these programs;
- Provide an interpreter service between the visiting therapist and members of the community;
- Identify residents of the community who require therapy services, and refer appropriately;
- Inform the community about scheduled visiting therapy services and local therapy activities;
- Coordinate local access to visiting therapy services, including providing client transport;
- Advocate for clients and people with therapy needs within the community;
- Provide client escorts to and from the community when required; and
- Educate visiting allied health professional.
Given that any of these tasks may contribute to the role of a community co-worker, there are concerns that co-workers maybe expected to provide services without the adequate training to do this effectively. Additionally, it is important that expectations place on individual workers is realistic, at the risk of workloads becoming too large and unduly stressful.

7.7 Interface with ATSIHW

The Project Reference Group and the broader literature identify a need to consider the interface between ATSIHW and community co-workers. While ATSIHW represent a workforce that may potentially act in the position of community co-worker this is problematic in several ways, specifically: the variance in role; the need for both many in remote communities; and the differing training and remuneration requirements.

Variance in Role

While there are some areas of overlap, the roles of community co-workers and ATSIHWs vary considerably. As reflected in the case study material, ATSIHW fill a broad range of duties with a focus on clinical activity and community health. The scope of the role of the ATSIHW is incredibly broad and somewhat generalist. ATSIHW are highly trained and are required to work in very independently with limited supervision and direction. The role of a community co-worker is limited to the delivery of, and facilitation of the delivery of, allied health services. While this includes a broad range of duties it is a clear divergence from the role of the ATSIHW.

Need for both Positions

A need for both ATSIHW and community co-workers in remote Indigenous communities is evident in much of the literature. ATSIHW are often the only health workforce that are based within the community and offer ongoing primary health care. Additionally, they provide an important cultural mediation with mainstream medical providers, specifically doctors and nurses. The role of the ATSIHW most often does not extend to supplementing allied health services. In the absence of community co-workers this creates a gap in access to ongoing allied health and rehabilitation services for many in remote Indigenous communities.

While it is conceivable that ATSIHW have fill this gap, generally, their capacity to do so is severely limited. The ATSIHW workforce is already overextended in many locations, with high workloads and associated high stress levels, and significant workforce shortages.

Differing Training and Remuneration Requirements

Owing to the variance between the roles of ATSIHW and community co-worker the positions have differing training requirements. The extended scope and autonomy in the role of the ATSIHW require significant training, and a remuneration package that appropriately recognises this. The more focused and directed role of the community co-workers on the other hand requires less formal training, and remuneration should be proportionate.
7.8 Mainstream versus community based service models

Community based models of health service delivery, such as community co-worker frameworks, are firmly rooted within a Primary Health Care Framework. The basis tenants of this philosophy include: equity, access, empowerment, community control and inter sectoral collaboration as the basis for all service development initiatives; a holistic orientation, with a focus on health promotion and disease prevention; and the active engagement of local communities (Curry 1999; Beattie 2006).

Any health service working with these community based models must have the capacity to appropriately support their Primary Health Care orientation, often representing a shift away from the traditional medical model that underpins current mainstream health service delivery models. The maintenance of traditional model will ultimately undermine community based initiatives and reduce the efficacy of service delivery.
8. Conclusion

This report represents the phase one of the ‘Enhancing Allied Health services to Rural and Remote Indigenous communities’ project. This phase of the project has focused on outlining current delivery of allied health services in remote communities and explores alternative service delivery models. It has included four areas of project activity: the formation of Project Reference Group; a Literature Review of alternative allied health service delivery models; the mapping of existing allied health services; and the documentation of relevant case studies. The various areas of project activity have highlighted some of the key considerations relevant to the future development of a community co-worker service delivery model for remote Indigenous communities. Specifically, this has included: community engagement; allied health staff resources; title of the worker; employment conditions; education and training; role of the community co-worker; interface with ATSIHW; and mainstream versus community based service delivery.

Phase two of the project will further develop some of these considerations. It will focus on establishing a framework and resources to support the implementation of assistants/health workers in Indigenous communities to enhance allied health services including: Philosophy of service delivery; cultural security protocols; equitable and sustainable employment structure; community engagement; role definition and scope; training requirements of AHP and assistant; supervision requirements; and recruitment.
9. References


Murphy, R., K. Stopher, et al. (2004). “Addressing the unique needs and issues of Western Australian Indigenous people with disabilities - Summary Booklet.”


Appendix A.
Mapping of WACHS allied health services to remote Aboriginal communities

We are attempting to identify and define the factors influencing the provision of Allied Health Services in an outreach framework to remote aboriginal communities. The purpose of this mapping document is to;

- document existing Allied Health service to WA remote communities,
- define what are some of the factors limiting the effectiveness of those services for the community and for the visiting allied health.

<table>
<thead>
<tr>
<th>Name of Community</th>
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<tbody>
<tr>
<td>WACHS Health District and Region</td>
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<tr>
<td>Site at which servicing Allied Health are based</td>
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<tr>
<td>Average Population of Community</td>
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<tr>
<td>Health staff and infrastructure located in the community</td>
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Allied Health Travel to the community (please tick)

<table>
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<tr>
<th>Car</th>
<th>Travel time (one way)</th>
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<table>
<thead>
<tr>
<th>Plane</th>
<th>Travel time (one way)</th>
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</tbody>
</table>

Allied health services

Please provide data were relevant on the following table to help us understand how frequent the Allied Health services are delivered, for how long and the % of Clinical and HP. This is under fully AH staffed conditions.

Please return to:
Luke Wilkinson via email luke.wilkinson@health.wa.gov.au
Fax 08 99410563
Ph 08 99410565
Or post to PO BOX 417 Carnarvon 6701
By 15th April 2006
### Enhancing Allied Health Services to Rural and Remote Indigenous Communities

<table>
<thead>
<tr>
<th>Allied Health Services (Please tick if visiting service provided)</th>
<th>Organisation Providing Service (e.g. WACHS, Division of GP etc)</th>
<th>Visit schedule for community (Weekly, Month, Yearly)</th>
<th>Duration of visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Dietetics</td>
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<tr>
<td>Diabetes Educator</td>
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<td>Physiotherapy</td>
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<td>Podiatrist</td>
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<td>Audiologist</td>
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<td>Social Worker</td>
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<td>Psychology</td>
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<tr>
<td>Speech Pathology</td>
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</tbody>
</table>

Do AH utilise community members in it’s service delivery? If so, please describe.

What factors do you think limits the provision of effective Allied Health services to this community? Please detail.

What factors do you think enhance the provision of Allied Health services to his community? Please detail.

---

**Please return to:**  
Luke Wilkinson via email luke.wilkinson@health.wa.gov.au  
Fax 08 99410563  
Ph 08 99410565  
Or post to PO BOX 417 Carnarvon 6701  
By 15th April 2006
## Appendix B: Demographic Data from Allied Health Mapping Exercise

<table>
<thead>
<tr>
<th>Community Health Service</th>
<th>Central Health Site</th>
<th>Population</th>
<th>Travel time (hours one way)</th>
<th>Allied Health Services</th>
<th>Frequency of visit (in weeks)</th>
<th>Duration of visit (including travel time) in days</th>
</tr>
</thead>
<tbody>
<tr>
<td>WACHS Pilbara Gascoyne - Pt Hedland</td>
<td>Parnpajina (serviced by AH visiting Newman)</td>
<td>50</td>
<td>Plane 1.5 hr or Car 4.5 hr</td>
<td>OT, PT, Pod, SP, Aud</td>
<td>2 4 17</td>
<td>1 2 1</td>
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<td></td>
<td>Nullagine</td>
<td>160-250</td>
<td>Plane 2 hrs</td>
<td>Aud OT, PT, SP</td>
<td>26 Upon Request</td>
<td>1</td>
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<tr>
<td></td>
<td>Punmu</td>
<td>150</td>
<td>Plane 2 hrs</td>
<td>Aud OT, PT, SP</td>
<td>26 Upon Request</td>
<td>1</td>
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<tr>
<td></td>
<td>Parngurr</td>
<td>120</td>
<td>Plane 3.5 hrs</td>
<td>Aud OT, PT, SP</td>
<td>26 Upon Request</td>
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<tr>
<td></td>
<td>Kunawarritji</td>
<td>80-120</td>
<td>Plane 3.5 hrs</td>
<td>Aud OT, PT, SP</td>
<td>26 Upon Request</td>
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<td>Yandeyarra</td>
<td>300</td>
<td>Car 2 hrs</td>
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<td>Strelly</td>
<td>50-60</td>
<td>Car 1 hr</td>
<td>Aud OT, PT, SP</td>
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<td>Mumbultjurri</td>
<td>25</td>
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<td>Marble Bar Goodabiny</td>
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<td>Jigalong</td>
<td>250-400</td>
<td>Plane 3.5 hrs</td>
<td>OT, PT Aud SP</td>
<td>13 26 Upon Request</td>
<td>1</td>
</tr>
<tr>
<td>WACHS Pilbara Gascoyne - Tom Price</td>
<td>Innawonga/Bellery Springs</td>
<td>25</td>
<td>Plane 1.5 hrs + Car 0.5 hrs</td>
<td>OT, PT, Pod, SW, SP</td>
<td>2</td>
<td>1</td>
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<tr>
<td>WACHS Pilbara Gascoyne - Carnarvon</td>
<td>Burringurrah</td>
<td>160</td>
<td>Car 8 hrs or Plane 2 hrs</td>
<td>OT, SP DT Diab Ed PT</td>
<td>6 6 8 Upon Request</td>
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<td>Community Health Service</td>
<td>Central Health Site</td>
<td>Population</td>
<td>Travel time (hours one way)</td>
<td>Allied Health Services</td>
<td>Frequency of visit (in weeks)</td>
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<td>WACHS Pilbara Gascoyne - Karratha</td>
<td>Onslow</td>
<td>850</td>
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<td>PT OT SP</td>
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<td></td>
<td>Youngaleena</td>
<td>30</td>
<td>Car 2 hrs Plane 1 hr</td>
<td>PT OT SP</td>
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<td>WACHS - Kimberley - Derby</td>
<td>Bayulu</td>
<td>225</td>
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<td></td>
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<tr>
<td></td>
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<td></td>
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<td>Imintji</td>
<td>60</td>
<td>Car 3 hrs</td>
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<td>Dodnun</td>
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<td></td>
<td>Biliiluna - Katjunka</td>
<td>200</td>
<td>Car 11 hrs</td>
<td>OT, PT, SP, DT, Pod, Aud, SW</td>
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<td>1</td>
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<td></td>
<td>Balgo - Katjunka</td>
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<td>Car 11 hours + plane 2hrs</td>
<td>OT, PT, SP, DT, Pod, Aud, SW</td>
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<td></td>
<td>Mulan-Katjunka</td>
<td>150</td>
<td>Car 11 hours + plane 2hrs</td>
<td>OT, PT, SP, DT, Pod, Aud, SW</td>
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<tr>
<td>Community Health Service</td>
<td>Central Health Site</td>
<td>Population</td>
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<td>Allied Health Services</td>
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<td>WACHS - Kimberley - Broome</td>
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<td>Bidyadanga</td>
<td>950</td>
<td>Car 2hrs</td>
<td>PT SP OT, Pod DT Aud, SW</td>
<td>4 6 8 13 Upon Request</td>
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<tr>
<td>Beagle Bay</td>
<td>250-300</td>
<td>3 hours</td>
<td>OT, PT, Pod SP DT Aud, SW</td>
<td>4 6 13 Upon Request</td>
<td>1</td>
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<tr>
<td>One Arm Point</td>
<td>350-400</td>
<td>Car 3 hours</td>
<td>OT, PT DT, Pod, SP Aud, SW</td>
<td>8 12 Upon Request</td>
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<tr>
<td>Lombadina/ Djarindjin</td>
<td>350</td>
<td>Car 3 hrs</td>
<td>OT, PT DT, Pod, SP Aud, SW</td>
<td>8 12 Upon Request</td>
<td>1</td>
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<tr>
<td>WACHS Kimberley - Kununurra</td>
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<tr>
<td>Warmun</td>
<td>400</td>
<td>Car 2 hrs</td>
<td>DT OT, PT, SP Pod SW</td>
<td>4 8 ? 26 Upon Request</td>
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<tr>
<td>Yiyili</td>
<td>250</td>
<td>Car 5 hrs</td>
<td>OT, PT, Pod DT, SW</td>
<td>26 Upon Request</td>
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<tr>
<td>Ringer Soak/ Kundat Djaru</td>
<td>120</td>
<td>Car 3.5 hrs or Plane .75 hrs</td>
<td>OT, PT, SP Opt DT, SW</td>
<td>26 52 Upon Request</td>
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<tr>
<td>Kalumburu</td>
<td>400</td>
<td>Plane 1 hr</td>
<td>OT, PT, SP DT Pod, Aud, SW</td>
<td>2 10 26</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Oombulgurri</td>
<td>150</td>
<td>Plane 0.5 hr</td>
<td>OT, DT, PT, SP Pod (Wyndham) SW</td>
<td>13 8 26</td>
<td>1</td>
<td></td>
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