ENHANCING ALLIED HEALTH SERVICES TO RURAL AND REMOTE INDIGENOUS COMMUNITIES

A FRAMEWORK FOR THE IMPLEMENTATION OF A COMMUNITY BASED REHABILITATION MODEL

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Acknowledgements

Whilst this report represents in part the commitment undertaken within phase two of the project “Enhancing Allied Health Services to Rural and Remote Indigenous Communities”, it could not have been formulated without the extensive work undertaken in phase one of this project.

The literature review by Nicole Beattie and the report by Luke Wilkinson and Nicole Beattie have provided the basis for many of the conclusions drawn within this document.

Abbreviations

ATSI        Aboriginal and Torres Strait Islander
ATSIHW      Aboriginal and Torres Strait Islander Health Worker
AHW         Aboriginal Health Worker
CBR         Community Based Rehabilitation
CUCRH       Combined Universities Centre for Rural Health
DSC         Disabilities Service Commission
DOH         Department of Health
Rural and Remote Those areas classified under the Australian Standard Geographical Classification Remoteness structure as ‘Inner and Outer Regional Australia’ or Remote and Very Remote Australia’
TA          Therapy Assistants
WA          Western Australia
WACHS       Western Australia Country Health Service
Executive Summary

Developing a strategy to improve access to allied health services for Aboriginal people living in rural and remote communities, should be a simple process underpinned by equity and efficacy! Health policy articulates this requirement yet the challenge is in defining a model that reflects these principles, which can be trialed, evaluated and implemented.

This draft framework proposes (in part) key characteristics of such a model, however the framework also raises key issues that require further discussion. These issues are captured within the following recommendations:

Recommendations (for discussion)

1. The employment structure is reviewed and a determination on an equitable and sustainable structure be established.

2. Agreement is required on the level of acceptable English literacy and numeracy skills as essential criteria for a community based worker.

3. The structure and content of the existing WACHS Therapy Assistant training modules be reviewed and considered for adaptation to reflect a culturally acceptable application; units focused on mentoring visiting therapists in cultural security education; additional training modules targeting life and work skills; and, alternative modes of training, inclusive of practical ‘on the job’ learning to be explored.

4. The WACHS Therapy Assistant Supervision Guidelines to be reviewed and restructured to include culturally secure protocols and supervisory skills relative to an Aboriginal community context.
**Background**

The delivery of allied health and rehabilitation services to Aboriginal and Torres Strait Islander people living in rural and remote communities has long been challenged by issues such as geographic isolation; inadequate resources and an inconsistent or limited workforce. Indeed, literature reveals that the achievement of optimal rehabilitative outcomes is often compromised by:

- sub-optimal models of service delivery such as infrequent outreach programs, resulting in poor continuity of service, loss of trust and rapport and a decrease in service utilization;
- differing cultural values and beliefs leading to racism, distrust, differing cultural priorities and culturally inappropriate therapy programs which significantly impact service access and utilization;
- access impeded by limited transport and timely communication; and,
- high turnover of staff, high workloads and limited professional development opportunities. (Beattie, 2006)

In recognition of these issues, WA Country Health Service (WACHS) and Disability Services Commission (DSC) funded a project titled “Enhancing therapy services to Aboriginal communities – an assistant base model”, for the purpose of reviewing existing community based service delivery models to inform the development of a viable framework on which to build a model of sustainable and replicable allied health and rehabilitation services to rural and remote Aboriginal communities in WA.

At the outset, it was agreed that such a framework would require key components that would provide the best opportunity to achieving of the following health outcomes:
Enhanced appropriateness and effectiveness of therapy services in Aboriginal communities.
Enhanced access to therapy services in Aboriginal communities.
Increased access to training for assistants working in Aboriginal communities.
Increased capacity for allied health professionals to support and supervise Aboriginal assistants working with Aboriginal people.

Phase one of this project focused on a consultative approach with key stakeholders, plus an extensive literature review, inclusive of case studies on service delivery models related to allied health, community based rehabilitation and Indigenous health.

The project identified that a Community Based Rehabilitation (CBR) model of service delivery, with emphasis on community based workers, as a model that has gained recognition as an appropriate strategy to provide effective and appropriate rehabilitation and therapy services to rural and remote Indigenous communities.

CBR reflects the philosophy of primary healthcare defined by the United Nations' Declaration of Alma Ata (WHO, 1978), as promoting a holistic approach to the multiple determinants of health; equity in health care; a focus on health promotion and disease prevention; community participation and control over health services; application of accessible, affordable and acceptable technology, and health care based on best practice.

The concept of CBR is described as:

“… a strategy within general community development, for rehabilitation, equalization of opportunities and social inclusion of all children and adults with disabilities…CBR is implemented through the combined efforts of people with
disabilities themselves, their families and communities, and the appropriate health, education, vocational and social service (ILO et al., 2002, cited in Beattie, 2006)

The project recommendations articulated the need to develop a framework for a CBR model that was underpinned by key principles of service delivery that focused on community development and empowerment, a commitment to cultural security and reciprocal communication and learning. These recommendations are mirrored within two key strategic documents:

- **WA Health Aboriginal Cultural Respect Implementation Framework** (OAH, 2005); defines a strategy focusing on strategic partnerships to achieve services reform through cultural respect and partnerships; education, review and practice, and Aboriginal workforce development.
- **Foundations for Country Health Services 2007 – 2010 (Foundations)** (WACHS, 2006); describes a purpose to engage Aboriginal people in service planning, to promote cultural respect and to increase the numbers of Aboriginal people working within WACHS.

It is therefore timely that a Community Based Rehabilitation model, based on the utilization of local Aboriginal community based workers, is trialed within a supportive pilot program in WA.

**Introduction**

There have been a number of reports over the past few years that have identified and recommended solutions to addressing allied health service issues in rural and remote Indigenous communities. Some of these suggested solutions included:
• supporting the implementation of appropriate service provision to Aboriginal communities and engaging Aboriginal Health Workers and Liaison Officers in the provision and support of allied health services to ATSI people, (Spitz, 2002, cited in (Beattie, 2006); and,
• recommendations for further investigation of the training of local ATSI workers to work with current health providers to improve access to allied health services to Aboriginal people. (Goodale, 2005. Murphy et al., 2004. cited in Beattie, 2006)

The “Enhancing therapy services to Aboriginal communities – an assistant base model” project, recommended the establishment of a framework for the implementation of a CBR model that is characterized by the employment of local community based workers, with varied skills and roles to compliment allied health service delivery and tailored to meet community need.

This framework describes the elements of a CBR model for the delivery of allied health services that can be trialed, modified and adopted to meet the specific needs of rural and remote Aboriginal communities in WA. The framework also describes a philosophy of service delivery and cultural security protocols, and attempts to explore and define an equitable and sustainable employment structure that identifies the role and scope of a community based worker; recruitment strategies, and training and supervision requirements.

It is not possible to describe a standard model of CBR that could be applied in all rural and remote Aboriginal community settings. Individual community needs and capacity differ widely as does the availability of supportive infrastructure. Additionally,
“each Aboriginal community represents a distinct cultural group; this variability of cultural systems will influence the nature of a successful CBR (model) in that community. In short, what works for one community may not necessarily work in another.” (Beattie, 2006)

This framework articulates a CBR model that promotes the employment and training of locally based community members.

**Purpose and Scope**

Community Based Rehabilitation (CBR) does not exist independently of mainstream disability and therapy practice. Rather, it is designed to add value to and enhance broader rehabilitation services, aimed at maximizing the goals of rehabilitation (Beattie, 2006).

CBR provides a conduit for the delivery of basic rehabilitative and allied health care services to people living within the community, and facilitates people with disabilities to participate in and contribute to daily activities.

CBR focuses on improving the quality of life for people with disabilities, maximizing their potential as human beings and as active members of their community.

CBR also supports families and carers of people with disabilities and provides opportunity for social and emotional support, education and training.

Peat, 1997 (cited in Beattie, 2006) states that CBR attempts to:
1. Change community attitudes and behaviors towards disability.

2. Empower people with disabilities, enabling them to function in the community.

3. Transfer appropriate rehabilitation knowledge and skills to the community.

4. Assist in the change from users of services to participants in health programs.

5. Establish partnerships in the development and implementation of programs.

6. Translate appropriate clinical knowledge to self help skills.

7. Increase the level of knowledge and cultural security skills in contact people.

8. Develop appropriate rehabilitation services.

CBR models of service delivery to rural and remote communities around Australia demonstrate diversity in the application of the model, and the role, title, working conditions and training of those employed to provide the service. (Beattie, 2006).

This framework therefore should be considered for application in the following circumstances:

- the need for a CBR service is identified and articulated by both the community and the visiting therapist;
- the community is receptive and supportive of the service and participates in the service design, inclusive of workload requirement;
- key community stakeholders identify and express support for the community based worker;
• the community base worker is prepared to participate in an appropriate training program;
• appropriate infrastructure is made available to the community based worker;
• the allied health professional is familiar with and applies culturally secure protocols; and,
• there is a commitment to developing reciprocal proactive and appropriate communication processes.

CBR does not:
• replace or dilute specialized allied health care;
• reduce the number of scheduled outreach services by allied health professionals;
• remove the professional responsibility of the allied health professional; or,
• provide the broad range of health and / or clinic services that are provided by Aboriginal Health Workers (AHW).

Philosophy of Community Based Rehabilitation Service Delivery

The implementation of a sustainable CBR model is very much dependant on the application of a philosophy of service delivery. Key elements of this philosophy are imbedded within the principles of primary health care, the concept of community control, the development of a community base of local workers, and the establishment of minimum standards for services in remote Aboriginal health care, including aged and disability care (Curry, 1999).

Philosophy
Within the context of a CBR model for the provision of allied health and rehabilitation services to rural and remote Aboriginal communities, the philosophy of this model is defined as:

A Community responsive and co-ordinated application of culturally secure rehabilitative activities, aimed at restoring or achieving the highest possible level of functional independence of persons with a disability living in the community.

Principles
The principles underpinning the CBR model articulated within this framework, and reflected in work undertaken by (Curry, 1999) and (Beattie, 2006) promotes the following:

1. The interconnecting principles of equity, access, empowerment, community control and inter sectoral collaboration is the basis for all service development initiatives.
2. The community is empowered to determine an appropriate model of CBR service delivery that encompasses an understanding of social, emotional and cultural determinants.
3. The community participates in the development of and has control over a CBR service.
4. Service development promotes a holistic approach with a focus on health promotion and disease prevention.
5. There is an application of accessible, affordable and acceptable technology.
6. The delivery of health care programs is according to evidenced based best practice.
7. Local community based Aboriginal people are employed and trained according to identified community needs.
8. Central to service delivery is active community engagement of people with disabilities, and recognition of the role of families.
9. An appropriate communication strategy promotes reciprocal information sharing between visiting health professionals and the community.
10. The service is supported through effective leadership, mentoring, coordination and collaborative team work.
11. The service is appropriately resourced.
12. Health professionals are skilled in cultural security.
Cultural Security Protocols

To be completed

Role Definition and Scope

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 (Beattie, 2006). Although it is anticipated that key service delivery will focus on supporting physiotherapy, occupational therapy, speech pathology and podiatry outcomes, the role of a community based worker can be tailored to support other allied health disciplines and include the following broad functions:

- Provide a consultancy role to the visiting therapist about community protocols and activities.
- 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.
- Work collaboratively with visiting therapists, supporting the assessment of clients, informing care planning and the development of therapy programs that are culturally appropriate and meet the needs of clients.
- Deliver therapy programs and participate in the monitoring and evaluation of these programs.
- Provide information to the community about scheduled visiting therapy services and local therapy activities. Coordinate local access to visiting therapy services.
• Provide an advocacy role for clients and carers.
• Provide client escorts to and from the community when required.
• Participate in reciprocal education strategies aimed at improving skill development and cultural security.

The key message from the literature and case studies regarding the role of the community based worker is “…that the level and nature of employment needs to be negotiated in each particular setting, depending on the needs of the community, the parameters of cultural acceptability, the expertise of the community based worker and the needs of the visiting therapist” (Beattie, 2006).

The scope of the community based worker therefore should be:
• targeted to the particular needs of a client;
• culturally acceptable;
• specific to locally available resources;
• tailored to the availability of the therapy discipline; and,
• determined by the availability and skill profile of the community based worker.

The essential element that will underpin the success of the community based worker’s role within a CBR model is the development of a supportive and culturally secure structure.

The role of a community based worker does not replicate or replace that of an AHW, whose scope of activities is broad; often with a medical and / or clinic focus. AHWs undergo comprehensive training that skills them to work with a range of health professionals in the delivery of health care services to the community.
Within the context of this framework, the role of the community based worker simply focuses on community based rehabilitation through the delivery of structured allied health therapy.

This distinction is an important one to articulate with community members and other health care providers. Role confusion may place unrealistic expectations on the community based worker and will not only potentially place people at risk, but will quickly lead to burnout.

In some circumstances, an AHW may provide a dual role, however the job description and award structure should be clearly defined.

**Key Points:**
- The decision to initiate CBR must be based on a need that has been identified and articulated by the community and the visiting therapist.
- The role of a community based worker must then be communicated clearly to all community and service provider stakeholders

**Employment Structure**

A review of existing employment structures identifies potential alignment opportunities; however the pathways also present an element of risk given the complexities of existing Award structures and training models (see Award comparison table, appendix 1).

The following two models were considered:
Aboriginal Health Worker model

The Aboriginal and Torres Strait Islander Health Worker (ATSIHW) National Competency Standards and Qualifications Project, facilitated by The Community Services and Health Industry Skills Council, has reviewed national qualifications for ATSIHWs; a strategy consistent with the Aboriginal and Torres Strait Islander National Strategic Framework prepared by the Australian Health Ministers' Advisory Council (AHMAC). (CSHISC, 2006)

This project will provide a consistent competency framework between State, Territory and community sectors, ensuring greater clarity of the scope of practice of Aboriginal Health Workers.

These new standards and competencies propose to include new accredited levels of training (Certificate II entry level) with two streams - community care and practice, focusing on a broad suite of health topics. There are no units covering allied health however AHWs are able to access select units from the TAFE accredited Certificate III Health Service Assistant (Allied Health Assistant) as electives.

AHWs are employed in private and public sectors such as hospitals, community health services and Aboriginal community controlled organizations; working across clinical, social, environmental, community or mental health sectors.

Whilst the competency framework is considered an important step for developing a career structure for AHWs, evidence suggests that (English) literacy levels among children and adults in remote Aboriginal communities are seriously low (Schwab & Sutherland, 2004), therefore the potential for local Aboriginal people with the appropriate literacy skills to learn the required competencies is extremely limited.
The role of a CBR community based worker is different to that of an AHW; it is limited to specific tasks and does not provide broad health or clinical functions. There is the potential to develop a simplified community based worker role with basic on the job (level 1) AHW training and / or situation specific modules targeting identified community and allied health need. This structure could link to an AHW career pathway. However this strategy is challenged by the following issues:

1. There are chronic shortages of AHWs in rural and remote communities across Australia. What will be the impact on limited community resources where high vacancy rates of AHWs exist? Alternatively, will a simplified training and employment strategy be more acceptable to remote Aboriginal people looking for employment and / or career options?

2. Basic training that does not require standard literacy and numeracy skills is not part of the National Competency Framework.

3. Current WACHS policy requires AHWs to attain Certificate III as a minimum requisite to employment as a health worker.

4. If the role of a community based worker became ‘an elective’ to a qualified AHW, there is currently no financial incentive to qualify in this discipline, and the capacity to focus on allied health therapy support would potentially be challenged by existing workloads and differing priorities.

5. Given that the proposed role of the community based worker focuses on community based rehabilitation through the delivery of structured allied health therapy, the inequity between the salaries and training requirements of WACHS Therapy Assistants and AHW Levels 1 & 2 salaries (See Appendix 1 Comparison of Awards) should be considered.
Therapy Assistant model

WACHS has developed a state-wide approach to implementing the Therapy Assistant (TA) model that has established policy around supervision, a comprehensive training package consisting of a series of modules targeting specific disciplines; and a scope of practice document underpinning standardization of TA practice.

The WACHS TA model has shown to be effective in achieving:

- reduced time to reach client goals;
- improved throughput of caseload due to improved timeliness in achieving goals;
- improved coordination and knowledge at the local level;
- improved interface/communication between the therapist, clients, parent, teacher;
  and,
- improved marketing in an informal manner of therapy services for paediatrics.

A review of the WACHS TA model identified that it is not explicitly a CBR model, however the role of TAs, who deliver rehabilitation and therapy services within a community, is that of a community based worker.

TAs are described as ‘trained health workers who deliver therapy services to clients under the direction of an allied health professional’ (Lin et al. 2005, cited in Beattie, 2006). They are required to have ‘generic’ skills targeting communication, time management, driver’s license, commitment to professional development and to have an understanding of diversity. TA’s have access to a training program consisting of on the job training and a series of modules targeting specific disciplines, which enables participants to receive formal credits towards Certificate 111 Health Service Assistant (Allied Health Assistant).
Whilst it’s acknowledged that the TA model is more closely aligned with the philosophy of CBR and the role of a community based worker, the following issues require consideration:

1. 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.

2. The mode of delivery of TA training is often through videoconferencing – a technology that is not readily available in remote Aboriginal communities.

3. TA’s are employed under the Health Service Salaried Officers State Industrial Agreement 2004 - Level 2. The salary range is equivalent to an AHW level 2 / grade 2. Whilst a community based worker alignment with this structure provides equity in the context of allied health support work, it does not provide equity of remuneration within the context of AHWs.

Proposed employment model

Whilst there will continue to be much debate about the ‘best fit’ of the proposed CBR model within existing structures, it is clear that no one model will fit all community profiles.

It has already been identified that flexibility and cultural appropriateness is the key to implementing a successful ‘model’. It is also clearly identified that the Award structure will need to be debated if a robust employment structure is to be achieved. With these considerations, the following options are proposed:

1. If the need for a CBR service has been identified within a community that has an existing (certified) AHW is in place, negotiations with key community stakeholders, the AHW and the therapist is required to identify the actual therapy role needed; the capacity of the AHW to provide the service, and the training
needs. Recognition of additional skills should be awarded additional remuneration.

2. Where there is no AWH employed and the need for CBR has been identified, an appropriate recruitment and training strategy for a community based worker should be implemented. Dependant on the skill set of the proposed community based worker, adapted formalized modules and/or workplace training based on the existing WACHS Therapy Assistant model should be offered.

3. There needs to be a mechanism for recognition of prior learning should the community based worker choose to enter into an Aboriginal Health Worker career pathway.

4. Community based workers should be remunerated at an equivalent level to WACHS Therapy Assistants (HSU level 2), which provides the best potential for the establishment of a service that gives Aboriginal community based workers an opportunity of employment that is equitable to those employed in an established ‘like’ service.

Central to the concept of CBR is the decentralization of responsibility and resources, both human and financial, to community level organizations. Beattie’s (2006) literature review identified that:

“….. community control and ownership of the health service delivery, promotes self determination and the active involvement and empowerment of the community……this movement towards community control has long been regarded as essential to Indigenous health programs…..it is crucial for outreach and institutional services to be provided in conjunction with community based services if optimum outcomes are to be achieved”
The employment of a community based worker ideally fits with an incorporated community based organization. This could be through the local clinic, school, local Government or any other appropriate body. In the absence of this structure, the community based worker could be employed through WACHS or an Aboriginal Medical Service, however both employment structures must also establish a locally based management / support structure that participates in and contributes to the establishment and support of the community based worker. Line management should be a consultative strategy between this structure and the WACHS delegated manager.

**Recommendation:**
The employment structure is reviewed and a determination on an equitable and sustainable structure is established.

**The recruitment and selection of a Community based worker**

Lessons learned and described within the literature review clearly demonstrate the importance of community control in the process of recruitment, selection and managing the community based worker. Evidence suggests that community control of a CBR initiative promotes community participation, and guidance in the recruitment and selection process will facilitate a community acceptable applicant, thus contributing to the sustainability of the project. (Beattie, 2006)

Standards in terms of formalized recruitment and selection processes many not be appropriate within the context of employing community based workers. Whilst some people may have the literacy skills to formally apply and submit to an interview process, there may be suitable applicants who may not have such skills; may have never
participated in an interview process; or may never, nor their families, experienced a workforce role.

The recruitment and selection decision is primarily a collaborative decision of key community members, the potential community based worker and the health service provider, so it is therefore essential that the recruitment and selection process is flexible, fully engaging, culturally appropriate and in line with the CBR philosophy.

The essential criteria for employment should articulate:

1. Knowledge of local languages
2. Evidence of community acceptance with demonstrated ability to talk to different groups within the community
3. Ability to work in a cross cultural environment, including working in partnership with visiting therapists
4. Ability to be flexible and work cooperatively in a team
5. Positive attitude to children, aged people and people with disabilities

(Suggested Job Description Form; Appendix 2)

Whilst it is desirable that a community based worker will have reading and writing skills in order to maintain appropriate documentation and undertake some administrative functions, it is acknowledged that these skills may not be evident in some applicants who may demonstrate strength in the essential criteria. Therefore, a decision is required on the level of acceptable English literacy and numeracy skills, as essential criteria for a community based worker.

Recommendation:
Agreement is required on the level of acceptable English literacy and numeracy skills as essential criteria for a community based worker.

Regardless of the suggested employment structures, the recruitment, selection and appointment process is described within the following flowchart:
Enhancing Allied Health Services To Rural And Remote Indigenous Communities: A Framework For The Implementation Of A Community Based Rehabilitation Model

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Education and Training


This was supported by Glynn 1996d, (cited in Beattie, 2006) who further states: “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 worker trains the professional in community issues, activities and practices…”

A two way learning approach is central to delivering culturally secure and sustainable services.

Community based worker
The skills and experiences of potential community based workers are as varied as the geography and demographics of the community in which they may be employed. Similarly, the needs of each community differ widely as does the existence of local infrastructure and support networks. It is therefore not possible to define a single education and training strategy that will ‘fit’ the training requirements of all community based workers.

However the clear focus of this project is to improve access to allied health services through locally placed community based workers. Therefore the choice of training
MUST be aligned with the needs of the client, existing skills of the worker and the available resources.

People wanting to become community based workers will have a broad range of life and work skills that shape their learning styles. An exploration of such skills will inform a training option that will acknowledge the gifts and attributes that the community based worker brings to the role, whilst providing an opportunity to develop a training strategy that will build knowledge and competency required.

The training package structured around adult learning principles supported by supervision and on the job training, should compose of two basic elements:

1. Flexible units targeting specific allied health disciplines plus interpreting and advocacy skills.
2. Units focused on preceptoring visiting therapists in cultural security education.

Other optional training could include a selection of life and work skills targeting topics such as behavioral management and conflict resolution, decision making, time management, negotiation, information processing, resource management and technical skills.

‘On the job’ training provides opportunity for the professional therapist to work with the community based worker, to define, demonstrate and observe skill development targeting precise activities designed to achieve specific health outcomes for individual clients. Therapists will always be professionally responsible to their own practice, and that which they delegate to the community based worker. They are therefore accountable for the provision of appropriate ‘on the job’ training and determine the level
of competency of the community based worker, and the breadth of therapy activities they are deemed competent to undertake.

Should the WACHS Therapy Assistant training package be considered for adaptation, a strategy that engages AHWs, Aboriginal TA’s, therapists and educators should be considered. The current training program consists of six modules that can be delivered by videoconference and through distant learning packages. These modules cover working with people with disabilities; phonology, fine motor, play skills, early intervention and working with adults and seniors. It is acknowledged that this training program and its delivery mode is not tailored to meet the needs of a community based worker in a remote Aboriginal community, nor does it meet the needs of therapists who will be required to learn supervisory skills and cultural security protocols, appropriate to an Indigenous environment.

There will be a need to review the existing training TA modules and the mode of delivery, inclusive of the development of additional modules that specifically target cultural security and life skill development applicable to a community based worker living in a rural and remote Aboriginal community.

**Recommendation**

- The structure and content of the existing WACHS Therapy Assistant training modules is reviewed and adapted to reflect a culturally acceptable application.
- Units focused on mentoring visiting therapists in cultural security education
- Additional modules targeting life and work skills are developed.
Alternative modes of training, inclusive of practical ‘on the job’ learning is explored.

Allied Health Therapist

It has been clearly identified that allied health therapists visiting and providing outreach services to people living in remote Aboriginal communities require knowledge of cultural security. They are also required to consult with the community based worker to ensure culturally secure protocols are applied to the planning and implementation of all therapy programs within the community.

Whilst the existing WACHS Therapy Assistant Supervision Guidelines promotes supervisory skill development, there is a need to include culturally secure protocols and supervisory skills relative to an Aboriginal community context.

Recommendation:
The WACHS Therapy Assistant Supervision Guidelines to be reviewed and restructured to include culturally secure protocols and supervisory skills relative to an Aboriginal community context.

Terminology

The name or title of the community based worker has been the subject of discussion between the states and territory where differing models of community based service delivery have been trialed and implemented. Wilkinson & Beattie (2006) identified case studies describing a number of different terms for the community based worker, including;
• Therapy Assistant
• Allied Health Assistant
• Community worker
• Community Based worker
• Aboriginal community Liaison worker
• Support worker
• Aged and Disability worker
• Community Consultant Liaison Officers

Wilkinson & Beattie (2006) also identified views about terminology and power relationships within the working environment, and that there was resistance in the utilization of terms such as “Therapy Assistant” as it reinforced the community based role as simply assisting the therapist, rather than community based services that focus on community development, advocacy, illness prevention and early intervention.

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 recognizes that peers work and learn from each other.

(Wilkinson & Beattie, 2006)

The reference group for phase one of this project preferred terminology describing the community based worker as a “Community Co-worker”. This name identifies the role that a community base worker can fulfill, such as: consultant/liaison, therapy co-worker,
practical service provider, interpreter, and advocate. The allied health therapist may also view the “Community Co-worker” as a flexible team member, as situations may arise where different Co-workers could be required to fulfill varying roles; for example when different language, kinship, gender issues or family and community demands may determine who is the most appropriate co-worker to fulfill which role.
References

AIRC. (2000). Health Workers - Community and Child Health Services Award Retrieved 23/11/06, from


# APPENDIX 1

## COMPARISON OF AWARDS (determined only to AHW grade & level 3)

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<th>Award</th>
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<td><strong>Aboriginal Health Worker Level 1</strong></td>
<td>Currently Practising Conditional Aboriginal Health Worker* means an Aboriginal Health Worker employed by the Health Department of Western Australia before the implementation of the career structure, providing a limited range of direct primary health care services and not being eligible to be classified at Levels 2 to 5 inclusive.</td>
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<tr>
<td><strong>Aboriginal Health Worker Grade 1</strong></td>
<td>An employee who possesses a relevant Certificate of which the course content is less than 12 months duration in total. The work may include but is not limited to:  - Aboriginal Health  - Environmental Health  - Aged Care  - Counselling  - Liaison  - Mental Health  - Alcohol Care/Rehabilitation</td>
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<tr>
<td><strong>Therapy Assistant</strong></td>
<td>An employee who completes a series of training modules, situation specific, via distant learning and supervision. Modules can be credited to Certificate 3 Health Service Assistance (Allied Health Assistance). Training is usually less than 12 months. (HSU level 2)</td>
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</tbody>
</table>

Prepared by the Combined Universities Centre for Rural Health for WA Country Health Services. For more information contact: CUCRH, PO Box 109, Geraldton, WA, 6531. Phone (08) 99560200 Fax: (08) 99642096 Email: [janh@cucrh.uwa.edu.au](mailto:janh@cucrh.uwa.edu.au)
<table>
<thead>
<tr>
<th>Wage</th>
<th>Aboriginal Health Worker Level 2</th>
<th>Aboriginal Health Worker Grade 2</th>
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</thead>
<tbody>
<tr>
<td>$34,026 - $35,538</td>
<td>Qualified Aboriginal Health Worker* means an Aboriginal Health Worker employed by the Health Department of Western Australia who provides a broad range of direct primary health care services and possesses as a minimum, the Advanced Certificate in Aboriginal Health Work, obtained through an accredited education provider or an alternative qualification acceptable to the employer and the union.</td>
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<tr>
<td>$30,617 - $32,139</td>
<td>An employee who provides a broad range of direct primary health care services and is able to work without direct supervision and/or an employee who possesses a Certificate with Medication Certificate Grade 1 and/or Advanced Certificate of which the course content covered a 12 month period or equivalent, from an accredited education provider in a relevant field, and/or is an Enrolled Nurse. The work may be, but is not limited to:</td>
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<tr>
<td>$35,689 - $39,540</td>
<td>• Aboriginal Health</td>
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<td>• Environmental Health</td>
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<td>• Aged Care</td>
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<td>• Liaison</td>
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<td>• Alcohol Care/Rehabilitation</td>
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<td>• HACC</td>
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<thead>
<tr>
<th>Wage</th>
<th>Aboriginal Health Worker Grade 3</th>
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<tbody>
<tr>
<td>$36,361 - $39,158</td>
<td>Senior Aboriginal Health Worker* means an Aboriginal Health Worker employed by the Health Department of Western Australia who provides</td>
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<tr>
<td>$32,139 - $38,500</td>
<td>An employee who has a highly developed knowledge, skill and capacity for self directed application and is involved in the delivery of primary care, and this may involve supervision of others involved in primary care, and/or</td>
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<tr>
<td>$35,689 - $39,540</td>
<td>• Aboriginal Health</td>
</tr>
<tr>
<td></td>
<td>• Environmental Health</td>
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<td></td>
<td>• Aged Care</td>
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<td></td>
<td>• Alcohol Care/Rehabilitation</td>
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<td></td>
<td>• HACC</td>
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</tbody>
</table>
specialist and/or supervisory and/or co-ordination services and possesses as a minimum, the Advanced Certificate in Aboriginal Health Work, obtained through an accredited education provider or an alternative qualification acceptable to the employer and the union.

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<thead>
<tr>
<th>Wage</th>
<th>$41,022 - $44,318</th>
<th>$35,979 - $43,025</th>
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</thead>
</table>

possesses a degree by an accredited training provider in the field of Aboriginal Health, and/or a Medication Certificate Grade 2. The work may include but is not limited to:

Aboriginal Health
- Environmental Health
- HACC
- Counselling
- Health Promotion
- HIV/STD Co-ordination
- Health Education
- Alcohol Rehabilitation
- Mental Health Work
- Nutritional Health

Such work shall be the provision of primary care or the supervision of work of a manual or domestic nature or of primary care.
APPENDIX 2

Suggested Job Description Form: Community Co-worker

Key Responsibilities
Work with the allied health therapist in the delivery of promotion, prevention and intervention therapy related programs to individuals and community groups, and provide cultural direction and interpreting for the allied health team.

Summary of duties
1. Provide a consultancy role to visiting therapists about community protocols, cultural matters, customs and activities
2. Provide translation for community members to ensure clients and families are able to clearly communicate their problems and needs and fully understand the information being given.
3. Provide direction to the therapist about the culturally appropriate way to go about working in the community
4. Identify community residents in need of therapy services, and refer appropriately
5. Talk with key members of the Aboriginal community about the therapy services and the scheduled visits
6. Work with visiting therapists in the assessment of clients, care planning and the development of therapy programs that are both culturally appropriate and meet the needs of clients and their families.
7. Deliver therapy programs as defined by the therapist

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8. Report changes in individual or group behavior; identify therapy delivery problems and work with the therapist to change or improve service delivery methods
9. Work with the therapist to develop and provide culturally appropriate health promotion and prevention health programs
10. Travel with the therapist and provide client escorts to and from the community when required
11. Liaise with clients, caregivers, health service staff, community groups, teachers and therapists to promote a co-ordinated service
12. Deliver and retrieve equipment, and store securely
13. Record or verbally report therapy activity
14. Ensure confidentiality of clients and workplace information at all times
15. Attend training courses as required
16. Participate in planning, implementation and evaluation of therapy supported programs
17. Perform other duties consistent with the position as negotiated by the therapist

Essential Criteria
- Knowledge of local languages
- Evidence of community acceptance with demonstrated ability to talk to different groups within the community
- Ability to work in a cross cultural environment, including working in partnership with visiting therapists
- Ability to be flexible and work cooperatively in a team
- Positive attitude to children, aged people and people with disabilities
Desirable Criteria

• Understanding of issues affecting people with disabilities
• Ability to read and write
• Previous experience in health, community services or a related field
• Current drivers license
• Current First Aid certificate