Literature Review:

Enhancing Allied health service to rural and remote Indigenous communities

Prepared by the Combined Universities Centre for Rural Health for WA Country Health Services

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1. 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 central element of CBR is the employment of community based workers. These workers have a wide and varied role, however, in simple terms they work with the health professional in the provision of functional rehabilitation services.

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.
2. Introduction

In 2002 WACHS 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 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 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 Straight Islander people (Spitz, 2002).

These suggestions have been echoed in recommendations of various projects 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 et al., 2004), a report 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.

In view of addressing these issues, and incorporating the recommendations and suggested solutions outlined above, WACHS is endeavours 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.

The aim of this literature review is to explore Community Based Rehabilitation (CBR), with particular focus on Community Based Workers. It will begin with a brief outline of the methodology that informed this investigation. This is followed by an account of the particular
challenges to the delivery of allied health services to rural and remote Aboriginal communities. Subsequently CBR and its applicability to the context of allied health service provision to rural and remote Aboriginal communities will be considered, with particular focus on Community Based Workers. Several case studies will be presented, exploring current utilisation of CBR models and the specific features of a Community Based workforce in each setting. Finally, key issues in the employment of Community Based Workers in the delivery of allied health services to remote Aboriginal communities will be outlined.
3. **Methodology**

A review of the available literature was undertaken looking at the delivery of allied health services to Aboriginal communities, and health service delivery models to Aboriginal communities, with particular reference to the application of Community Based Rehabilitation in Australia.

Several databases were searched to identify literature and project activity in this area. These included: Cinahl; Cochrane Library; Medline; Pubmed; ProQuest; and Google Scholar. Search restrictions were used to confine search results to those most relevant to the research topic. These included Australian publications only, published in the last 15 years (since 1990). A Google web-search was also undertaken to identify non-published material available on the World Wide Web, again limited to Australian websites.

A series of key words were used within the searches. These keywords were searched in combination to retrieve only the most relevant resources. Key words were grouped around three categories:

- **Allied health:** allied health assistant; generic allied health worker; allied health worker; rehabilitation assistant; physiotherapy assistant; occupational therapy assistant; speech therapy assistant; rehabilitation assistant; allied health service delivery models.

- **Community Based Rehabilitation:** Community Based Rehabilitation; CBR; Community Based Worker; Community rehabilitation; Community Co-worker; Community Based Disability worker; Community Based Rehabilitation worker; Community Worker; Community coordinator; and Support staff.

- **Indigenous Health:** Indigenous: Torres Strait Islander; Aboriginal Health Worker; community control; community controlled health services; community development; and community capacity building.

Additional search strategies included the review of the reference lists of the retrieved publications and personal communications with project staff currently working on relevant projects. This allowed for the identification of additional resources, of particular note several project reports.
By limiting searches to the Australian context, the search strategies produced a very limited number of resources, perhaps reflecting the emerging nature of the field. Several key project reports emerging from the experiences of Community Based Rehabilitation in rural and remote Aboriginal communities in the Northern Territory were identified (Curry, 1992, Curry, 1999, Curry, 2003, Glynn, 1996a, Glynn, 1996b, Glynn, 1996d, Glynn et al., 1999, Kinlock, 1992). Each of these reports are widely cited in literature around the development of Community Based Rehabilitation models for the delivery of services to rural and remote Aboriginal communities and are drawn on heavily in this literature review.
4. **Context: Summary of the key barriers to the delivery of allied health services in rural and remote Aboriginal communities**

In undertaking the task of developing a model of service delivery to provide and enhance allied health and rehabilitation services to Aboriginal people in remote communities, WACHS faces two of the most significant challenges in contemporary health care: rural and remote service delivery; and Aboriginal health. There are significant barriers to the provision of allied health and rehabilitation services to rural and remote Aboriginal communities. Though these are well documented and widely accepted, with the intention of highlighting issues of particular relevance, this section will provide a brief summary of the barriers to allied health service delivery in rural and remote Aboriginal communities.

Two key documents emerging from project activity in the Northern Territory, specifically Curry’s (1999) ‘Allied Health Therapy Services in Aged and Disability Care in Remote Aboriginal Communities of the Northern Territory: A Framework for Quality Service Provision’ and ‘Developing Partnerships Between Community Based Workers and Visiting Workers for the Delivery of Aged and Disability Services in Remote Indigenous Communities: An Intersectoral Discussion Paper (Glynn et al., 1999) provide a comprehensive account of the breadth of issues that impede the delivery of allied health services to rural and remote Aboriginal communities.

The issues identified by Curry (1999) and Glynn et al. (1999) can be grouped in 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, all of which are outlined below. These areas of concern are consistent with those widely accepted as barriers to all forms of service delivery to Aboriginal people, as detailed in the ‘Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples’ (Trewin and Madden, 2005) produced by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.

- **Workforce issues:** Several workforce issues hinder the delivery of allied health service to rural and remote Aboriginal communities. These include: difficulties in attraction and retention of staff; high staff turnover; high and stressful workloads; limited professional support and inadequate supervision; limited professional development opportunities, including postgraduate education opportunities and other training; and limited career...
pathways. While this list is extensive it in no way captures the workforce issues that hamper allied health service delivery in a rural and remote Aboriginal context. Collectively these issues result in an often inadequate allied health workforce unable to meet the needs of rural and remote communities.

- **Sub-optimal allied health therapy model of service delivery:** The literature suggests the current models of service delivery, specifically institution based and outreach services, for the provision of service to Aboriginal people are problematic and fail to adequately address allied health and rehabilitation needs. The nature of these services results in infrequent community visits and a lack of trust and rapport between the providers of outreach services and the community, which results in limited community acceptance and utilization of relevant services and discontinuity of service.

- **Cross Cultural issues:** The capacity of a service delivery model to incorporate the cultural frames of the population they serve is vital to its success. Different cultural understanding and knowledge, differing understandings of health and illness, institutional racism, distrust of the security services and service providers, the under representation of Aboriginal people within the allied health workforce, and culturally inappropriate therapy programs are just some of the key cross cultural issues that impede the delivery of health services to Aboriginal clients and significantly impact the utilisation and efficacy of these services.

- **Local knowledge of service:** Often remote Aboriginal communities have a limited awareness of the services available and when this knowledge exists, there is frequently a misconception of the prohibitive cost of these services to the consumer. Together, these often result in a lack of expressed demand for allied health services from the consumer.

- **Access to service:** As with all remote models of service delivery, the provision of allied health services in rural and remote Aboriginal communities is impeded by client access. Poor access to transport, with limited, if any, access to public transport facilities, when coupled with vast distances means clients are often unable to attend therapy sessions.
Since the 1990s CBR, with an emphasis on Community Based Workers, has gained considerable recognition as an appropriate model of service delivery to tackle these barriers and provide effective and appropriate rehabilitation and therapy services to rural and remote Aboriginal communities.
5. Community Based Rehabilitation

Community Based Rehabilitation is an internationally accepted service delivery model for the provision of rehabilitation and allied health services at the community level. This section will explore: CBR and mainstream disability and therapy practice; the concept of CBR, Community Based Workers in CBR; and the strengths and weaknesses of CBR.

5.1 Community Based Rehabilitation and mainstream disability and therapy practice

As a service delivery model, CBR does not exist independently, but is designed to add to and enhance broader rehabilitation services (Glynn et al., 1999, Glynn, 1996b, Glynn, 1996d). Across much of Australia, there are three main approaches to rehabilitation services for rural and remote communities (Glynn, 1996b):

- **Institutional-based services** include rehabilitation services that are provided by specialised units, such as hospitals or aged care facilities. In general, clients either have to travel to these institutions to receive rehabilitation services, though this may also include some home visiting and out patient services.

- **Outreach services** entail the periodic delivery of rehabilitation services to rural and remote districts or communities by visiting health professionals from institutions or urban based services.

- **Community-based services** are provided within the community and focus on the delivery of community controlled rehabilitation services. Within these models the health professional ‘takes more of a trainer, support role as local people organize themselves to take up projects to meet rehabilitation needs as identified by the community’ (Glynn 1996c, p. 41).

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[Community Based Rehabilitation] cannot be considered as the only approach to rehabilitation and indeed would likely fail if it was. However, it appears that CBR is the one fundamental link missing in the chain of rehabilitation where all links are necessary for optimum outcomes (Glynn, 1996a)
Traditionally, mainstream service delivery models have tended to focus on the institutional-based and outreach services (Glynn, 1996b). Community Based Rehabilitation is an additional or supplementary model of service delivery that can complement existing models to maximize the goals of rehabilitation.
The concept of Community Based Rehabilitation

The concept of CBR was first developed by the World Health Organization in 1978 (Peat, 1997, Glynn, 1996b). Since its inception the governments of over 100 nations have committed to the CBR model (Kuipers and Allen, 2004b), and its recently revised definition, which states:

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CBR \text{ is 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).}
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‘Community Development’ within the context of a community development strategy as defined by the United Nations, refers to:

\[
The \text{utilization... of approaches and techniques which rely on local communities of units of action and which attempt to combine outside assistance with organized local self-determination and effort, and which correspondingly seek to stimulate local initiative and leadership as the primary instrument of change (Peat, 1997, UNESCAP).}
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The literature suggests CBR models have emerged in response to a variety of issues, such as: the prohibitive high cost, high technology orientation of institutional-based care; recognition of the inadequacy of the current rehabilitation infrastructure; and concerns that negative community attitudes and perceptions towards people with disabilities prevail (Peat, 1997, UNESCAP). At a consumer level, growing dissatisfaction with the existing hierarchical service system, and an increased awareness of the many social determinants of health and wellbeing are recognised as influential (Kuipers and Allen, 2004b, Peat, 1997, Glynn, 1996d).
Key elements of Community Based Rehabilitation

- Promotes active community involvement and empowerment, including the employment of community workers
- Provides accessible and immediate rehabilitation services for people in remote communities
- Uses current community resources and infrastructure
- Fosters information sharing between professional and community members
- Promotes self determination and decentralisation
- Encourages the use of appropriate technology
- Actively involves people with disabilities in existing community activities
- Increases the awareness of issues for people with disabilities within the community
- Operates on a low cost basis

(Curry, 1999)

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

CBR models generally seek to empower people with and without disabilities within the local community to take on service delivery roles with the intent of improving the quality of life of people with disabilities (UNESCAP). According to the ILO, UNESCO, UNICEF & WHO, a key objective of CBR is to ensure the empowerment of people with disabilities to ‘maximise their physical and mental abilities, have access to regular services and opportunities and become active, contributing members of their communities and their societies’ (ILO et al., 2002).
A central element of CBR is the employment of community based workers (UNESCAP, Kuipers and Allen, 2004b, Glynn et al., 1999, Glynn, 1996b, Glynn, 1996d, Curry, 1999, Cumaiyi and Glynn, 1999). These workers have a wide and varied role that will be considered at length in subsequent sections of this review, however in simple terms, they work with the health professional in the provision of functional rehabilitation services (Peat, 1997), including: physiotherapy; occupational therapy; speech therapy; orientation and mobility training; eye care and hearing service; medical; psychological counselling; and orthotics and prosthetics (Peat, 1997).

**CBR programs attempt to:**

- Change community attitudes and behaviours towards disability
- Empower persons with disabilities, enabling them to function in the community
- Transfer appropriate rehabilitation knowledge and skills to the community
- Assist in the change from users of services and participants in health programmes
- Establish partnership in the development and implementation of programmes
- Translate appropriate clinical knowledge to self-help skills
- Increase level of knowledge of contact people
- Develop appropriate rehabilitation services

(Peat, 1997)

Community Based Rehabilitation models are designed to be ultimately flexible, to allow the community to identify, and develop services around, community need (UNESCAP, Glynn et al., 1999, Curry, 1999). As such, CBR can take many forms, including: input and support by allied health professional; treatment and support by health workers and/or volunteers; facilitation of integrated education; self help groups; play groups; community support and pressure groups; training programs and community resource centres (Glynn, 1996b). Flexible, local programmes ensure community involvement and result in a variety of programme models which are appropriate for a specific context (UNESCAP).
5.3 Community Based Workers in Community Based Rehabilitation

As briefly outlined previously, the employment of Community Based Workers is a central feature of CBR (UNESCAP, Kuipers and Allen, 2004b, Glynn et al., 1999, Glynn, 1996b, Glynn, 1996d, Curry, 1999, Cumaiyi and Glynn, 1999).

Broadly, a Community Based Worker provides aged and disability care including, but not limited too, working in collaboration with health professional to address the specific needs of the community (Curry, 1999). Owing to the flexibility of CBR, the specificity of need in any particular setting, and the experience of the Community Based Worker, their role may vary in complexity and expertise. According to Glynn et al. (1999) and similarly reflected in the work of Curry (1999) the Community Based Worker may include any number or combination of the following roles:

- **Consultant:** To provide consultative advice to outreach/visiting community workers about assessment and/or management. To advise on cultural and linguistic issues relevant to specific situations and clients.
- **Interpreter:** To improve direct communication between clients, families and service providers who do not share the client’s first language.
- **Therapy co-worker:** To contribute to the development of ongoing therapy programs for individual clients. To provide follow-up as negotiated i.e. rehabilitation activities, support activities (meals, walking program, respite, washing etc)
- **Educator:** Provide training to outreach/visiting Allied Health and community workers within the two way training framework to enable them to work more effectively in the community
- ** Advocate:** To act as an advocate for people with disabilities and frail aged within the remote community and to organizations able to provide services.
- **Case manager:** co-ordination of services for individual clients in collaboration with the outreach case manager.
- **Service coordinator:** To initiate or take active part in development of community based programs as relevant, coordinate allied health referrals
- **Practical service provider:** e.g. provide laundry, meals, cleaning assistance for carers, shopping
5.4 Strengths and Weaknesses of Community Based Rehabilitation

As with all service delivery models CBR has distinct advantages and disadvantages. Below is a summary of the key strengths and weaknesses identified within the literature as articulated in Peat (1997). This summary captures many of the issues raised in the works of Curry (1999) and Glynn (Glynn et al., 1999) emerging from the experiences of CBR in the Northern Territory specific to the context of rural and remote Aboriginal communities.

Disadvantages of Community Based Rehabilitation

- The dilution of care which can result from a lack of specialised training for service providers
- Difficulties with evaluation
- Possibilities of reducing the importance of professional services
- Problems in realizing
- Unreliability of community involvement
- Potential for government denial of responsibility for service provision
- Limitation of local resources
- Difficulties in large scale cooperation / coordination (Peat, 1997)

Advantages of Community Based Rehabilitation

- Partnership involving stakeholders in programme development and implementation
- Wide service coverage can be achieved
- Community interaction and empowerment
- Affordability cost effectiveness
- Build-up of manpower resources
- Comprehensive and holistic development
- Promotion of awareness / acceptance
- Sustainability
- Wise use of local resources
- Needs-based training (Peat, 1997)
6. Community Based Rehabilitation and rural and remote Aboriginal communities

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, this section explores: the appropriateness of CBR for rural and remote Aboriginal communities; why CBR; and finally the emergence of CBR in remote Aboriginal communities in the Northern Territory.

6.1 The appropriateness of Community Based Rehabilitation in rural and remote Aboriginal communities

As stated previously, for the most part, current rehabilitation services are limited to the institutional-based and outreach services. For many Aboriginal communities this consists of limited access to institutional services, involving the significant dislocation from community and disruption to cultural life, and periodic delivery of outreach services provided by non-Aboriginal health professionals possibly with an Aboriginal Liaison Officer or Health Worker (Curry, 1999, NWQPHC, 2006a, Cumaiyi and Glynn, 1999).

The literature suggests, or eludes to, the failure of these current models of service delivery to adequately address the needs of Aboriginal people living in rural and remote Australia (Glynn et al., 1999, Curry, 1999, Spitz, 2002). Curry (1999) found access to specialist disability services, such as allied health therapies and rehabilitation, in the Northern Territory to be insufficient, with inadequate staff numbers and / or outreach visits to effectively manage the rehabilitation of clients. Several indicators suggest the same can be said for rural and remote Aboriginal communities in Western Australia (Goodale, 2005, Spitz, 2002).

In addition, access to rehabilitation services by Aboriginal people in remote communities is limited not only by distance but by culture and language (Curry, 1999, Glynn, 1996b). The appropriateness of institutional and outreach services for Aboriginal people in rural and remote communities is a central issue of concern. Glynn et al. (1999) suggest that these mainstream models of service delivery are ‘linear’, ‘compartmentalized’ and ‘embedded within a culture that has a particular notion of work and its associated values which again have developed through centuries of cultural, political and religious history’ (p. 3). Central concerns include: institutional
racism; lack of community control; and the cultural appropriateness of health care (WIRED, Glynn et al., 1999).

[In Aboriginal communities a CBR model] can build community as well as provide more effective and efficient services for people with disabilities living and working in their own communities (Krefting and Krefting, 1996)

The last decade has seen an increased focus on Community Based Rehabilitation models as appropriate and relevant for the delivery of disability and therapy services to 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 (Cumaiyi and Glynn, 1999, Cunliffe, 2004, Curry, 1999, Curry, 2003, Read, 2006, Glynn, 1996d). According to Glynn et al. (1999), in the delivery of services to rural and remote communities, ‘it is crucial for outreach [and institutional] services to be provided in conjunction with community based services if optimum outcomes are to be effectively achieved’ (p. 3).

6.2 Why community based rehabilitation for rural and remote Aboriginal communities

Though CBR was developed for application in developing countries, the literature suggests these models have considerable relevance for rural and remote Aboriginal communities (Curry, 1999, Kuipers and Allen, 2004a, Cumaiyi and Glynn, 1999, Kuipers and Allen, 2004b, Krefting and Krefting, 1996). The broad arguments for the adoption of CBR for the delivery of services to Aboriginal people in rural and remote communities cited in the literature include: Increased community participation and control; improved access to health care; and the provision of culturally appropriate services.
Increased community participation and control; Improved access to health services

Decentralization of responsibility and resources is central to CBR models (Peat, 1997, UNESCAP). This shift facilitates community control and ownership of the health service delivery, promotes self determination and the active involvement and empowerment of the community (Curry, 1999, Glynn et al., 1999, Peat, 1997, UNESCAP). This movement towards community control has long been regarded as essential to Indigenous health programs.

Improved access to health services

In providing rehabilitation services within the community, the residents of the community have significantly increased access to these services (Peat, 1997, UNESCAP). The employment of a community based worker/s provides a continuity of services and programs, developed to meet the specific needs of the community, between outreach visits and establishes a conduit between the community and mainstream health services (Peat, 1997, UNESCAP, Glynn, 1996b).

The provision of culturally appropriate services

The nature of CBR facilitates a more culturally appropriate model of service delivery (Cunliffe, 2004, Curry, 1999, Peat, 1997, Glynn, 1996b). Integral to CBR models is a two-way learning system between the visiting health professional and the Community Based Workers representing the community at large. This fosters a sharing of knowledge and skills, and allows Community Based Worker to act as an intermediary or cultural translator to guide in the most appropriate ways to deliver services within that specific cultural niche. This community direction ensures the services provided are culturally appropriate.

What CBR means to rural and remote Aboriginal Communities

- Improved access to health services
- Equitable services
- Culturally appropriate service provision
- Increased community participation and control
- Adoption of an holistic view of health, as accepted by Aboriginal people
- Reciprocal information sharing between communities and health
- Service providers from intersectoral departments working together

(Glynn, 1996d)
6.3 The emergence of CBR in remote Aboriginal communities in the Northern Territory

**Early stages of CBR in the NT**

In the late 1980’s and early 1990’s several projects were undertaken, most under the Rural Health Support, Education & Training (RHSET) Program, looking at the prevalence of disability and needs of disabled people in rural and remote Aboriginal communities and appropriate models of service delivery to address this need (Curry, 1992, Kinlock, 1992). Several of these projects were needs assessments which consistently reflected the failure and apparent inability of standard mainstream services to meet the needs of remote Aboriginal communities (Curry, 1992, Glynn, 1996a, Kinlock, 1992, RHSET, 1996). Many of the service providers working with these communities and the communities themselves suggested community based, community controlled models of service delivery as a potentially more effective alternative (Curry, 1992, Kinlock, 1992, RHSET, 1996, Cumaiyi and Glynn, 1999, Glynn, 1996a). CBR was identified as a potential model of service delivery that could address the specific needs of disabled people in rural and remote Aboriginal communities.

During the same period there was a strong emphasis was placed on Community Based Rehabilitation internationally, reflected in publications around CBR by organisations such as the International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO) and the World Health Organization (WHO) (ILO et al., 2002, UNESCAP) and several international workshops including ‘Initiating Community Based Rehabilitation’ and ‘Community Based Rehabilitation – Crucial Issues’.

Guided by the findings in the Northern Territory of a high level of need in Aboriginal communities and the international focus on and a movement towards CRB internationally, the ‘Too Late Tomorrow: Explore Community Based Rehabilitation’ workshops were held across the Northern Territory in Belyuen, Darwin and Alice Springs in 1996. These workshops were designed to ‘explore the CBR model with consumers, carers and service providers, particularly those in remote Aboriginal communities’ (Glynn, 1996d). The goal of these workshops was to ‘find ways to implement CBR services in remote Aboriginal communities according to how consumers and carers perceived there need’ (p. 9).
Around the same time as, and subsequent to, the ‘Too Late Tomorrow: Explore Community Based Rehabilitation’ workshops CBR projects and supporting frameworks and guidelines emerged from the Northern Territory, stemming from an early CBR project in the Belyuen Community, NT.

**CBR in the Belyuen Community**

The CBR approach began in Belyuen in the early 1990’s. Developed over the course of several years, the specific CBR model utilised was a multifaceted approach to sustainable community development and service delivery. The impetus for this project, like ‘Too Late Tomorrow: Explore Community Based Rehabilitation’ workshops, was primarily the high level of need in the Belyuen community as set out in ‘Needs Assessment Report: people with handicaps and the frail aged in five Aboriginal communities’(Curry, 1992). The elements of the Belyuen CBR project included:

1994  The community received funding to build and support the **Imabulk Centre**. The construction of this facility was completed and the centre was opened in September 1995. Within a year this centre was providing a range of services to local residence including residential and respite accommodation, nutritional support for disabled people within the community, rehabilitation, disability service coordination and home help.

1994  A part time **CBR position** was funded within the community. This was the first position of its kind in Australia. The duties statement read: ‘To participate in the development of a rehabilitation service based within the community… in order to meet the needs of local residents with disabilities’ (Glynn, 1996c). This position was not filled for sometime.

1995  An agreement between the Commonwealth, Territory Health Services and the Belyuen Community Government Council was signed pooling program funding to ‘provide the community with a block grant with which the manage its aged care and health services’ (Glynn, 1996d)

1996  A part time **HACC Disability Worker** position was funded within the community. The duty statement read:
‘As a member of the community services team at Belyuen the Disability Worker will assist in community-based organisation and relevant external agencies with the coordination and planning of service supports to aged and disabled community members. The main job is to meet and talk with frail aged and disabled residents and their carers on a regular basis to discuss their health issues, conditions of accommodation and arrangements for caring’ (Glynn 1996 p. 128).

Following on from the Belyuen project

Several initiatives were undertaken looking at, learning from and further developing the CBR program in Belyuen. For the most part, these initiatives were designed to develop materials to support CBR in Belyuen and its wider application across the Northern Territory. Programs or initiatives of particular significance included:

1997 The employment of a Project Officer for the CBR RHSET Training Module Project. As the name suggests, this project was setup to develop training modules for CBR workers and supporting allied health professionals. This project involved extensive consultation with educational bodies and the Belyuen community to determine training need. Several topic areas were selected for development, these included: Gait Training; Communication; Activities of daily living; Wheelchairs; Pressure Care; Disability and Rehabilitation; Vision Impairment; Vocational Activity; Home Assessment; Social and Physical Impact of Alcohol on CBR; and Administration. Outlines for each of these models is available in Outlines for Community Based Rehabilitation Training Modules (Glynn, 1996b).

1995 Two positions were established within Darwin Rural Health, including a Disability Services Coordinator and Disability Services Project Officer. These positions were established to promote effective consultation and negotiations with remote community organisations regarding disability and aged care, and to support existing projects (Glynn, 1996d)
1996 The Allied Health Therapy Services in Aged and Disability Care in remote Aboriginal Communities of the NT: A framework for quality service provision project began. The project was supported by the Top End Division of General Practice and undertaken by Rob Curry. As the title suggests, this project focused on the development of guidelines and a suggested model for the provision of allied health services in remote Aboriginal communities. In 1999 these guidelines were published by the Top End Division of General Practice outlining the project and an appropriate model for service delivery in this context based on primary health care and community based rehabilitation philosophies.
7. **Case Studies in 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, intentionally or otherwise, in various health contexts around the country. In line with the purpose of this Literature Review the case studies presented in this section will 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. The case studies presented will include: 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.

While all of these case studies are based loosely on the basic principles of CBR they are diverse in nature and approach. Some are intentionally modelled on the earlier NT initiatives and the CBR ideology firmly embedded in their practice. Others however, are clearly community based in their orientation though lack the frameworks to clearly articulate this. The case studies also differ in scale and scope; some project or models are large scale and operate at a state health service level, while others are context specific and have evolved in a particular location to meet the specific needs of the local community. Similarly, their stage of completion or level of implementation varies considerably. Further, the amount and type of information available outlining each project or model is also highly inconsistent. These factors influence the type of information and the level of detail each case study will contain. However, where possible and relevant, case studies will include: a project background, outlining the project or model, the application of Community Based Workers and the underpinning philosophy; details of the recruitment and selection of Community Based Workers; the role of the Community Based Worker; training and supervision; and an account of the relevant limitation, benefits and lessons learned.
7.1 FPA Health projects

Project Background
FPA Health, also known as Family Planning NSW, is a non-government organisation which provides reproductive and sexual health services in New South Wales. In 2002 FPA undertook a project in Coonamble aimed at identifying and reducing barriers to Aboriginal and Torres Strait Islander women’s uptake of cervical and breast screening programs by improving access to GPs (Read, 2006, Beange). A key element of this project was the engagement of Community Based Workers are consultants and facilitators (Read, 2006).

In the formative stages of the project, consultation with the Coonamble community and Aboriginal health care providers highlighted ‘the critical importance of the employment of an Aboriginal worker who could be an effective advocate and cultural broker as part of the primary-care team’ (Read, 2006). The active engagement of this Community Based Worker, known as an Aboriginal Community Liaison Worker (ACLW) in this context, was a key strategy for the successful participation of the community (Read, 2006, Beange).

Though the project was relatively short, it generated significant interest in the Community Based Rehabilitation model, and the use of Community Based Workers in the delivery of health care services to Aboriginal people in this region. Several other projects have since been taken up in the region utilizing common frameworks.

Recruitment and selection
It was initially intended that the Community Based Worker within the project would be a consulting Aboriginal Health Worker from the local Aboriginal Medical Service (AMS). However, while Coonamble had an AMS Committee, an AMS had not been established and no Aboriginal Health Worker was available for the project (Read, 2006). From subsequent consultation with the local stakeholders, a community liaison worker was posed as an alternative (Read, 2006, Beange). Subsequently, an appropriate local woman was identified to fill the role. This ‘recruitment and selection’ process was guided by ongoing consultation with local Aboriginal healthcare providers and the community.
The project management team determined the formal qualifications or training were not a prerequisite to employment. The essential criteria for employment were instead ‘communication skills and the ability to work across disparate groups’ (Read 2006 p. 5).

*Role of the Community Based Worker*

Within the framework of this project, the Community Based Worker had a largely administrative and supportive role, acting as a cultural broker between the local community and the health care service.

The specific duties of the Community Based Worker included the following: making appointments, supporting and transporting Aboriginal women to the FPA Health clinic; assisting with reminder and recall for the follow up of clients; helping to organise suitable community activities, which may include group sessions, one-on-one education and recreational activities; advising other members of the team on cross-cultural issues; driving clients to and from health education sessions; maintaining and managing a list of local contacts; and assisting in reviewing appropriate resources for use by clients and community (Read, 2006).

*Training and Supervision*

The project management committee determined that while training opportunities should be available to the Community Based Worker they were not vital to the position (Read, 2006, Beange).

In the literature pertaining to this project there is no documentation relating to supervision practices.

*Limitations, Benefits and Lessons Learnt*

According to Read (2006) the employment of Aboriginal Community Based Workers was critical to the success of the Coonamble project. Read (2006) suggests the benefits of retaining Aboriginal staff from within the community included: improving service provision to Aboriginal women; and adding to community knowledge about reproductive and sexual health issues.
In the paper ‘Working with an Aboriginal Community Liaison Worker’, Read (2006) cites several specific lessons learnt in the delivery of the project. These included:

- Employing an Aboriginal Community Liaison worker enabled our clinical service to improve access and follow up for aboriginal clients.
- The recruitment and employment process for the Aboriginal Community Liaison Worker needs to be conducted with the support and collaboration of key community members.
- The responsibilities of the Aboriginal Community Liaison Worker need to be clearly defined so that areas of responsibility are clear.
- An Aboriginal Community Liaison Worker contributes advocacy and cultural brokerage skills in organising health promotion activities that target Aboriginal women.
- An Aboriginal Community Liaison Worker assists with identifying culturally appropriate material for health education purposes.
- The inclusion of an Aboriginal Community Liaison Worker in a healthcare team provides an advocate and teacher who can increase the capacity of the other team members to work with Aboriginal people (Read, 2006).

7.2 North West Queensland Primary Health Care (NWQPHC)

Project Background
NWQPHC is a Division of General Practice that provides services to communities living in North West Queensland. One project the NWQPHC is currently undertaking the implementation of a Community Based Worker (CBW) Model, funded by the Department of Health and Ageing Regional Health Service (Central West), to enhance the delivery of allied health services in the Diamantina Shire (NWQPHC, 2006b).

This NWQPHC CBW model is built on a primary health care philosophy. The specific principles articulated by NWQPHC include: shared learning between community members and NWQPHC staff; working from the community level up; encouraging community activity; fostering community engagement, awareness and action; and recognising community development as a fundamental goal (NWQPHC, 2006b).
The existing model for the delivery of allied health services in the Diamantina Shire consists of outreach visits by Dieticians, Physiotherapists, Psychologists, Podiatrists, Speech Pathologists and Occupational Therapists on a six weekly basis (NWQPHC, 2006b). The implementation of the CBW model involves 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 improving continuity of care (NWQPHC, 2006b).

Recruitment and selection
This project is still in the early stages and little information is available pertaining to the recruitment and selection of the Community Based Worker. According to the NWQPHC Project Officer, as of the 6/4/06 one position was currently active, with others commencing over the next few months (Personal Communication, 2006).

Role of the Community Based Worker
Broadly, the role of the Community Based Worker is to support the existing services provided by NWQPHC allied health staff and strengthen the link between them, community members and other service providers within the Shire (NWQPHC, 2006b). However, within the model there are several categories of Community Based Worker, including: CBW Physical Activity Promotion; CBW Massage Therapy; and Healthy Lifestyle Promotion. Each category has a specific role (outlined in the position JDF); as such these will be outlined separately.

- CBW Physical Activity Promotion: This role involves increasing the community’s participation in physical activity. The duties revolve around the planning, promotion, implementation and evaluation of local sport and physical activity (NWQPHC, 2006b).

- CBW Massage Therapy: this role is supporting the visiting Physiotherapy service. The specific duties include: attending clinics on a six weekly basis; schedules and providing massage support service to clients between clinics; and maintaining patient files (NWQPHC, 2006b).
CBW Healthy Lifestyle Promotion: this position is designed to assist NWQPHC staff with the rollout of the Barcoo Wellness Challenge. The key objective of the position is to sustain community motivation and participation in the Wellness Challenge by planning, promoting and co-ordinating activities in your community on a regular basis (NWQPHC, 2006b).

Training and Supervision
The training expectation (though only briefly outlined) for the Community Based Worker varies for the different categories worker, inline with the specific duties to be carries out by the position.

- Physical Activity Promotion CBW is required to ‘complete and maintain a Senior First Aid Certificate and undertake professional development, where necessary’ (NWQPHC, 2006b).

- Massage Therapy CBW is required to complete a Certificate IV in Massage. NWQPHC covers the cost of this training. The course is six months full-time or twelve months part-time course and can be completed via distance education, plus practical experience. If the CBW does not complete the course or ceases employment with NWQPHC within the first year of course completion, they will be required to repay the training costs (NWQPHC, 2006b).

- CBW Healthy Lifestyle Promotion: Not specific training is outlined for this position.

Limitations, Benefits and Lessons Learnt
As the project is still in the initial stages of implementation there is no literature around the limitations or benefits of the model.

7.3 Katherine Regional Allied Health Project

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 Services. The project commenced in 2001 aimed at increasing the delivery of allied health therapy services, specifically 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.

This project was modelled on Curry’s ‘Allied Health Therapy Services in Aged and Disability Care in Remote Aboriginal Communities of the Northern Territory: A Framework for Quality Service Provision’, customised to meet the specific needs of the residents of the Katherine region (Cunliffe, 2004). The model is heavily based on primary health care and Community Based Rehabilitation philosophies (Cunliffe, 2004) and includes advocacy, community capacity building, health promotion, enabling and mediating, in addition to individual treatment (Cunliffe, 2004).

A central feature of the KRAHTP model is the utilization of Community Based Workers, or Community Co-workers as they are known in this context (Cunliffe, 2004). These Community Based Workers are conceptualised as the link between the community and allied health services (Cunliffe, 2004).

Recruitment and Selection
The project team reported significant difficulties employing community based workers (Cunliffe, 2004). The project team identified a number 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
There is no account of the role of the Community Based Worker within the KRAHP project available in the literature. However, discussions with a KRAHP project member detailed the range of duties that the community based worker may undertake. These 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 the community as to what allied health are and the services available; coordinating referrals for the allied health visitors; promoting culturally secure 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 KRAHP project team regarded the education of Community Based Workers and the lack of a defined career path for these workers. Cunliffe (2004) suggests, within the KRAHP, 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’ for the Community Based Workers (Cunliffe, 2004).

Limitations, Benefits and Lessons Learnt
The key concerns around this project centred on the availability of appropriate training packages for the Community Based Worker, as outlined above, and recruitment and selection difficulties. In the course of the delivery of the project the KRAHP team came to recognise the difficulty of identifying and retaining appropriate staff: ‘while we acknowledge that the community based workers are an integral part to ensuring the sustainability of the project, the key to this is ensuring that the right person is employed as the Community Based Worker, and that process will take significant time’ (Cunliffe, 2004).

7.4 WA Country Health Service TA state-wide approach

Project Background
WA Country Health Service (WACHS) is the state government provider of health services for much of country West Australia (WA). 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, specifically physiotherapy, occupation therapy and speech pathology, in rural and remote areas (Lin et al., 2005b). By definition a TA is a ‘trained health workers who
deliver therapy services to clients under the direction of an allied health professional’ (Lin et al., 2005b)

Since 2004 WACHS has developed a WA-wide approach, or TA model, including policy around supervision, a comprehensive training package, and a scope of practice document as a means of standardising the practice of TA across rural and remote Western Australia (Lin et al., 2005b, Goodale and Lin, 2005). Though not explicitly a Community Based Rehabilitation model, TAs are essentially Community Based Workers who deliver rehabilitation and therapy services to a community from within that community, as such the WACHS state-wide approach can be conceptualised as a CBR program.

In a census undertaken at the beginning of 2005, 98 TA positions were identified in country WA, with a further 23 positions vacant. Half of TAs were based in towns away from their supervising therapists, and half in the same location. Most of the TAs workforce work part-time across multiple allied health disciplines and are employed by a number of agencies. The Department of Health is the largest employer of TAs, however the department of education, DSC and other agencies, such as Catholic Education also employs TAs (Lin et al., 2005b).

Recruitment and Selection
In the WACHS TA project in the Midwest Murchison health region a standard JDF was created. This JDF was designed to reflect the breadth of TA practice, with the summary of duties divided into clinical, administrative and professional areas. Five essential criteria were identified as standard, including:

- Effective oral, written and interpersonal communication skills
- Effective time management skills
- Commitment to ongoing training and professional development
- Positive attitude to people with varying cultural, social and economic backgrounds and to people with disabilities
- Possession of a current drivers licence.
Additionally, the employer was given the opportunity to select further essential and desirable criteria relevant to the local setting (Goodale and Lin, 2005). Based on the JDF, WACHS developed standardized interview questions to further standardise recruitment processes.

*Role of the Community Based Worker*

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 et al., 2005b).

As part of the standardisation of TA practice in WACHS, a TA scope of practice document has been developed by WACHS to define the roles and responsibilities of both TAs and allied health professionals. Some key principles that were used in developing a rural and remote TA scope of practice were: the TA must work with a current program or screening tool; and the TA carries out activities under the supervision of an allied health professional, and is not able to interpret results, diagnose clients or be solely responsible for planning therapy programs (Lin et al., 2005a). The scope of practice guidelines are linked to the WACHS policy on the use of TAs which is presently under review (Lin et al., 2005a).

*Training and Supervision*

The WACHS TA training package consists of a series of TA training modules covering the breadth of TA practice (Lin et al., 2005a). These training modules are delivered via video-conferencing and distance learning to maximise the reach of the package. The training package is designed to complement situation-specific on the job training which occurs locally and is supported by local supervisors. In the development of the training package, a partnership was established with a WA registered training organization, West Coast TAFE, which enables participants to receive formal credit toward a certificate III Health Service Assistance (Allied Health Assistance) qualification (Lin et al., 2005a).
In 2005 WACHS wide TA supervision guidelines were developed based on minimum supervision requirements arising from the Midwest and Murchison Therapy Assistant Project. These guidelines included:

- **A description of the frequency of supervision;** The guidelines specify a minimum requirement of supervision once per fortnight and observation of the TA a minimum of once every three months (Lin et al., 2005a).

- **The acceptable components of supervision;** The components of supervision can include discussion on programs or administrative issues, observation of the TA, or program demonstration (Lin et al., 2005a).

- **Appropriate methods of supervision;** Supervision methods may occur face to face, by phone, videoconference, video recording, or email (Lin et al., 2005a).

- **Necessary skills of the supervisor;** The guidelines specify that supervisors must have skills in supervision. Training was provided to supervisors through a “train-the-trainer” approach. A training workshop on supervising TAs was developed and delivered face-to-face to therapist representatives from each WA country health region (Lin et al., 2005a).
Limitations, Benefits and Lessons Learnt

TAs as a workforce add to the services provided by allied health professionals in rural and remote areas, improved access to allied health services in communities with visiting allied health professionals. 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 (Lin et al., 2005b). The WACSH state-wide TA approach is an effective mechanism for standardising the practice and core skills of TAs working in rural locations.

7.5 TAs in the Murchison region of Western Australia

Project Background

As part of the movement towards the employment of TAs to enhance delivery of allied health therapists within WACHS, a TA was employed in the Midwest Murchison region of Western Australia in 2002 to deliver services to communities within the Murchison Shire. From the outset the model in the Murchison varied from the broader WACHS TA model and was inherently built upon the principles of Community Based Rehabilitation. Perhaps the most marked difference was the central importance cultural appropriateness. The TA was an Aboriginal woman, accepted the local community as part of that community, and was employed to deliver therapy services to a largely Aboriginal population (Jackson, 2006).

There is no published information pertaining to this model of service delivery and the following case study is presented on the basis of personal communication with the allied health therapists providing outreach services in this region.

As the WACHS TA model evolved it became apparent to the supervising therapists and the TA that the existing WACHS TA model was inappropriate for the particular context, and an alternative framework or model was designed to suit the specific needs of the TA and the needs of the community that she was to serve (Jackson, 2006). The customised model allows for a
more holistic approach, inline with Community Based Rehabilitation models with a primary healthcare and health promotion focus (Jackson, 2006).

Recruitment and selection
No information on the recruitment and selection for this initiative was available.

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 delivering individual therapy to clients, carrying out administrative duties and delivering group therapy, the role of the 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. The duties of the TA in this context include (Jackson, 2006):

- Working with the allied health therapists in the assessment of clients and subsequently informing the development of therapy programs that are both culturally appropriate and meet the clinical needs of the client.
- Delivering the negotiated therapy programs to clients between visits from the allied health therapists.
- Acting as a consultant to the allied health therapists, advising on cultural and linguistic issues to guide practice.
- Educating the allied health therapists to enable them to work more effectively in the community.
- Developing independent relationships and networks with other professionals within the community to enhance the accessibility and utilization of allied health therapy services. The TA is expected to educate people within these networks about the programs in place, and provide feedback to the allied health therapist on how they are working within the community.

Training and Supervision
The training and supervision of the TA in this context 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. This training was most intensive in the first 6 months, with the AHP sitting in on the TAs sessions with clients to guide and model her practice (Jackson, 2006). After this time, it was determined by the allied health therapist and the TA that she had acquired sufficient skills and was able to work with clients independently (Jackson, 2006). However, training was ongoing with an additional 18 months of shared travelling time within the region, in which additional training and support was provided (Jackson, 2006).

While the TA participated in on 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). In accessing these training modules the TA needed a high level of support from her AHP to ‘translate’ and put these modules into context (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).

The allied health therapists suggested that this model would benefit from an articulation of ‘on the job’ practical training with formal qualifications (Jackson, 2006).
8. Key issues in the utilization of Community Based Workers

Several issues around the employment and utilisation of Community Based Workers are evident in the literature, particularly arising from the experiences of CBR in the Northern Territory. This section will catalogue and explore the key issues identified in the literature and those identified within the case study material, including: 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.

8.1 Recruitment, selection and community control

Both the literature and the case study material speaks of the importance of community control in the process of recruiting, selecting and managing Community Based Workers (Cunliffe, 2004, Read, 2006, Glynn et al., 1999, Curry, 1999). This is inline with the overarching principles of CBR of which community ownership and investment are central components (Peat, 1997, UNESCAP).

‘To date the development of community based workers has not always arisen out of community controlled initiatives but rather a recognized need for outreach workers to improve the effectiveness of their services’

(Glynn et al., 1999)

In a wider political context, Aboriginal community control of health services is acknowledged as an element of self determination, essential to long-term improvements to the health status of Aboriginal people (Glynn et al., 1999, Curry, 1999, Trewin and Madden, 2005). In terms of CBR, community control of the initiative ensures community participation, involvement and subsequently contributes to the sustainability of the project (Peat, 1997). Community participation in the process of employing Community Based Workers may work to alleviate some of the issues around retaining the appropriate person reported in the literature and in the case study material. Community guidance in this process will work to ensure an informed appointment choice and that the selected applicant is acceptable to the community.
“It is evident here that community control of such programs is essential. On a practical level everything is enormously easier if people have a sense of ownership of projects and take responsibility for their success of failure.”
(NPY, 1997)

However, Glynn et al (1999) warns ‘communities vary in their readiness or inclination for community controlled services’, she suggests in ‘in the absence of formally incorporated or community controlled services strategies for maximizing community participation and control over outreach services need to be developed’ (p. 53).

8.2 The role of Indigenous Community Based Workers

As outlined previously, the role of a Community Based Disability worker within a Community Based Rehabilitation model can be wide and varied, dependant on the expertise of the Community Disability Worker, the allied health therapists working within the community as well as the particular needs of the community.

The role of the Community Based Rehabilitation may include any number and/or combination of the following: consultant; interpreter; therapy co-worker; educator; advocate; case manager; service coordinator; practical service provider; Ngankari; Malpa (Glynn et al., 1999). It is unlikely that any one worker will have the capacity to act in all of these roles, and Glynn et al (1999) suggests that ‘the expectation that workers can be all things to all people can be a detrimental one’ (p. 11).

Additional considerations around the specific role of the Community Based Worker need to take into account the cultural systems and practices within the community, such as avoidance behaviours and men or women’s business. These issues have particular validity in many remote Aboriginal community and influence to duties a Community Based Worker is able to undertake and the contexts within which these duties are appropriate. Glynn et al (1999) suggests ‘the flexibility to employ more than one person on a part time or casual basis is therefore important’ (p. 11).
The ‘take home message’ from the literature and the case study material, regarding the specific role of the Community Based Worker is that the level and nature of employment needs to be negotiated in each particular setting, depending on needs of the community, the parameters of cultural acceptability, the expertise of Community Based Worker and the needs of the visiting therapist. Similarly, varying roles may foster diverse training requirements.

8.3 Work conditions for the Community Based Worker

There are several considerations around the working conditions of the Community Based Worker, specifically around payment, and the supervision and support available.

Both the case studies and the literature suggest that the level of payment of the Community Based Worker is a real issue, impacting the recruitment and retention and as such the sustainability of CBR programs. The literature suggests the level of payment for Community Based Workers is often low and does not accurately meet the expectations of the role. Further, Community Based Workers often struggle with the impact of payment on Social Security payments. It is suggested that an appropriate level of payment be negotiated within each setting to reflect the level of expertise of the worker and the specific role they are employed to fill (Curry, 1999, WIRED, Glynn et al., 1999). Appropriate pay scales include that of entry level Aboriginal Health Workers or Allied Health Therapy Assistants (Read, 2006, WIRED, Cunliffe, 2004, Glynn et al., 1999).

Though little detail is provided in the literature, the issues of supervision and support available to the Community Based Worker is also relevant. Consistently, the literature suggests Community Based Workers are often under significant pressure from the community and are faced with unrealistic expectations and high work loads (Cunliffe, 2004, Curry, 1999, Curry, 2003, Glynn, 1996d, Glynn et al., 1999, Krefting and Krefting, 1996, Read, 2006, WIRED). This suggests the issues of supervision and support warrant further investigation.
8.4 Training of Community Based Workers

Several issues around the training of Community Based Workers emerged from the literature and were supported in the experiences within many of the case studies. These issues can be broadly categorised as relating to: the availability of training; appropriate training models; and a defined career path.

Availability of training
The Community Based Worker, in remote Aboriginal communities, is a relatively new and emerging workforce. It is broadly acknowledged both in the literature and the case studies that there are limited training materials to appropriately support this workforce (Cunliffe, 2004, Curry, 1999, Curry, 2003, Read, 2006, KRAHRS, Jackson, 2006). Though there are similarities, the role of the workers varies slightly from that of a Therapy Assistant or an Aboriginal Health Worker, and as such the training available for these groups is presently inadequate (Glynn, 1996b, KRAHRS).

As a component of a RHSET project, in 1996 the Territory Health Service funded a Project Officer Position (filled by Robyn Glynn) to develop training modules for CBR Workers in remote Aboriginal communities. The topics selected for development included: Gait Training; Communication; Activities of daily living; Wheelchairs; Pressure Care; Disability and Rehabilitation; Vision Impairment; Vocational Activity; Home Assessment; Social and Physical Impact of Alcohol on CBR; and Administration. Though there is an online RHSET record of the completion of the grant in 1997, no information pertaining to these modules is available in the literature and warrants further investigation. Alternatively, the parallels between the role of Aboriginal Health Workers and the expected role of the Community Based Worker raise questions around the relevance and continuity of the Aboriginal Health Worker training framework for Community Based Workers working in remote Aboriginal communities; this too is worth further consideration.
**Appropriate Training models**

By all accounts the most suitable teaching and learning model within a CBR program framework is a ‘two ways’ or ‘shared learning’ approach (Beange, Curry, 1999; Glynn, 1996d; Glynn et al., 1999; Jackson, 2006; KRAHRS, Peat, 1997; UNESCAP). 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.

**A defined career path**

Though is it not explored in depth, the need for a clearly defined career path for the Community Based Worker is touched upon throughout the relevant literature. Perhaps owing to the formative nature of the workforce and associated training, no clear career path currently exists. However by all accounts the CBR model would benefit from an articulation of both formal and ‘on the job’ training with a recognised qualification (Jackson, 2006; Beange, Cunliffe, 2004; Glynn et al., 1999). Aligning Community Based Worker training with existing Aboriginal Health Worker accreditation is a possible way of creating an appropriate and established career path.

8.5 **Title of Community Based workers**

While Glynn et all (1999) suggests the title that best reflects the told of the Community Based Worker is difficult to find, it is considered by many, particularly advocates for Aboriginal health through self determination, as vitally important. The term Assistant, inline with WACHS Therapy Assistant is seen by some, in the context of Aboriginal people, as suggestive of subordination and inferiority (Personal Communication). Glynn et al. (1999) suggest some more appropriate titles including: Co-worker; Community Based Disability (CBD) worker; Community Based Rehabilitation (CBR) worker; Community Worker; Community Based Worker; Community coordinator; Project workers; or Community senior (Glynn et al., 1999).
8.6 CBR as comprehensive model

While Community Based Workers are a key element to Community Based Rehabilitation, they are not the total sum of the framework so to speak. The literature suggests the efficacy of Community Based Workers within the community is constrained if all elements of the CBR model are not realised (Curry, 2003, Glynn et al., 1999). In addition to the employment of Community Based Workers, the key elements of CBR models include:

- Community Control: it is suggested throughout the literature that CBR programs need to involve and include the community at all stages of development and implementation (Curry, 2003, Glynn, 1996a, Glynn, 1996d, Peat, 1997, UNESCAP), and that CBR programs ‘should not be adopted by the authorities who impose programs’ (Glynn et al., 1999)

- The empowerment of people receiving services, including the employment of people receiving services, their families and cares to facilitate an increased awareness and change of attitude within the community around disability and increasing the capacity of the individual to function within the community (Peat, 1997)

- A two way learning process to promote the development of long term and sustainable of skills and knowledge within the community, developing community capacity and an up-skilling of allied health professionals in methods of culturally appropriate service provision (Peat, 1997)

8.7 Transferability of successful models

While CBR has central themes and elements it ultimately lends itself to flexible models of implementation, which allows services to be developed around the dynamics and particular need of the community. This flexibility is central to the success of CBR program frameworks, ensuring a responsiveness and relevance to the community and local participation (UNESCAP). This given, the development of a CBR framework for wide implementation in the context of remote Aboriginal communities is potentially problematic. Each Aboriginal community potentially represents a distinct cultural group; this variability of cultural systems will influence the nature of
a successful CBR in that community. In short, what works in one area may not necessarily work in another.

8.8 **Barriers for Community Based Workers**

Several barriers or ‘unseen stressors’ (Glynn et al., 1999) that may influence the practice of the Community Based Worker are identified in the literature and case study materials. These are best summarised in Curry’s article 'Barriers to Practice for Indigenous Remote Area Community Based Health and Social Service Workers - A discussion paper' (Curry, 2003), and include:

- **Workplace barriers**: Uncertainty about role; workplace isolation; high turnover of professional staff; lack of planning orientation; lack of cooperation from others in the broad workplace; limited on-site support from relevant visiting health professionals; lack of access to vehicles and transport; limited office and communication infrastructure

- **Education Barriers**: limited formal education; low level post school qualifications; few facilities at home or in the community for personal study; low community expectations; lack of quality training

- **Health Barriers**: responsibilities of care of sick family members; personal illness; death of relatives

- **Social Barriers**: disruptive home environments; local targeting of worker for numerous external roles; pressures from non-working peers

- **Economic barriers**: poor salaries and uncertain tenure; different cultural economic motivations

- **Historical and cultural barriers**: lack of familiarity with modern workplace; health, education and housing deficiencies; family vs. workplace priorities; inability to heal directly with sections of the community (Curry, 2003).

While it is not expected that all of these barriers will act on the experience of all Community Based Workers they are worthy of consideration.
9. Conclusion

In summary, the literature in this research area is very limited. Few articles have been published, and while several project reports are available, they tend to have a limited circulation and are difficult to access. This literature review has drawn on the limited body of literature around the delivery of allied health services to Aboriginal communities and health service delivery models to Aboriginal communities, with particular reference to the application of Community Based Rehabilitation in Australia. It has outlined: the key barriers to the delivery of allied health services in rural and remote Aboriginal communities; CBR as a framework; CBR and Community Based Workers in rural and remote Aboriginal communities; case studies of CBR and Community Based Workers in Australia; and Key issues in the employment of Community Based Workers. Each of these areas highlight the key considerations in the development of an appropriate service delivery model of the provision of allied health services to rural and remote Aboriginal communities.
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