

CONFERENCE REPORT

Preliminary guidelines for the implementation of Community Based Rehabilitation (CBR) approaches in rural, remote and indigenous communities in Australia

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A B S T R A C T

A forum of health professionals was held in Brisbane, Queensland, Australia, 30-31 August 2003, to discuss the relevance and potential of the Community Based Rehabilitation (CBR) model to rural, remote and Indigenous communities in Australia. The forum identified principles and guidelines for the development of CBR, which are presented here as a focus point for future discussion and action by people with disabilities, rural community members, Indigenous people, policy makers and health professionals. Forum members noted that while considerable strengths were evident in the CBR model, it has yet to make a significant impact on the service system in Australia. While recognising that the Australian context is quite different from many countries in which CBR has traditionally been implemented, they suggested that it may have particular application to remote, rural and Indigenous communities. To facilitate the principles of CBR in these communities, the forum called for recognition of the need for greater community involvement in disability services, the need to develop appropriate training frameworks, and the need to redirect resources to such community models. In keeping with the CBR philosophy, forum members noted that if the model is to be implemented effectively, substantial consumer and community involvement will be instrumental in future steps.

Keywords: allied health, community based rehabilitation, disability, models of service delivery, rehabilitation, training.



In Brisbane, Queensland, Australia, on 30-31 August 2003, 49 health professionals (allied health professionals, medical specialists, nurses, academics and health workers) met to discuss the relevance and potential of the Community Based Rehabilitation (CBR) model to rural, remote and Indigenous communities in Australia.

The forum was sponsored by Services for Australian Rural and Remote Allied Health (SARRAH) and the Centre of National Research on Disability and Rehabilitation Medicine (CONROD; The University of Queensland). Acknowledging the limitations of addressing such issues prior to community and consumer input, the CBR Forum sought to make a first step along this path by:

- Exploring and discussing CBR as practised in other countries (most notably developing countries).
- Considering elements of CBR relevant to rural and remote and Indigenous communities in Australia.
- Identifying the principles and guidelines of an Australian approach to CBR as a prelude for further consultation with Indigenous and non-Indigenous community members in rural and remote areas.
- Advancing the agenda, formation and implementation of an Australian model of CBR, which will have particular relevance to rural, remote and indigenous communities.

Definition of CBR

Governments of over 100 nations have now committed to the CBR model and its recently revised definition, which states that:

CBR 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 services¹.

Forum members noted that, as it is usually implemented, CBR seeks to empower and train local residents and people with disabilities to take on service delivery roles in the provision of independence. The forum recognised that this 'community oriented' perspective of rehabilitation has emerged in response to a variety of issues of concern. These include a questioning of the emphasis on high cost, high technology and institutional-based care, which only meets the needs of some; a recognition that the current rehabilitation infrastructure is inadequate in many contexts and that this is exacerbated by an unequal distribution of resources and staffing; and concerns that negative community attitudes and perceptions towards people with disabilities prevail. At a consumer level, this perspective has emerged parallel with a growing dissatisfaction with the existing hierarchical service system, and an increased awareness that there are many social determinants of health and wellbeing. In light of the relevance of these issues to rural, remote and Indigenous communities in Australia, forum members emphasised that the CBR model should have particular application here, and that efforts towards implementation should be actively progressed.

Relevance to Australia

While the potential of the CBR model has been recognised by a number of Australian workers²⁻¹², forum members noted that the CBR model has yet to make a significant impact on the service system in Australia. Based on this previous experience, forum members recognised that the translation of the CBR model to rural, remote and indigenous settings in Australia will not necessarily be simple or straightforward. For example, at a geographical level, Australian rural and remote communities are in some of the most sparsely populated areas on earth, whereas CBR is usually implemented in areas of considerable population density. At a cultural level, indigenous people in Australia have



experienced a history of marginalisation and oppression. The direct implications and echoes of this profoundly influence the uptake, utilisation and success of any human service initiatives in indigenous communities. Third, at a professional level, firmly established models of rehabilitation service delivery may struggle to accommodate community oriented strategies, and an emphasis on professional roles and boundaries may hinder more generalist service provider models.

Despite such apparent obstacles, there are also very positive signs that the CBR model holds considerable potential in Australia. Locally, two early examples of CBR have been trialed^{7,8} and we are now in a position to evaluate the strengths and weaknesses of these. Further, some innovative approaches have also emerged from more traditional service delivery structures which have clear parallels with CBR (For example North West Queensland Allied Health Service, Mt Isa, Qld.; Katherine Allied Health Project, NT.; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation, NT.). Internationally, recent CBR initiatives increasingly emphasise human rights and capacity building frameworks¹³, concepts which are highly consistent with emerging themes in indigenous and remote health service delivery.

Principles of an Australian model of CBR

The forum emphasised the need for CBR to be understood in two complementary ways. First, CBR can be implemented as a distinct model of service delivery in new services. Second, CBR should also be understood as a philosophy, which can be fostered through supporting existing services to be more aligned with community priorities. Irrespective of the structures, some general principles for implementing CBR include:

- Learning from local people.
- Working with, and building on, what exists.
- Working from the community level up, encouraging community activity.

- Fostering community involvement awareness and action.
- Recognising community change as a fundamental goal.

Principle 1. CBR is a distinct service provision model that should be adopted by organisations, governments and researchers in Australia

Forum members identified a pressing need for the establishment of distinct CBR service initiatives in rural, remote and indigenous communities in Australia. To this end they suggested four guidelines:

1. **The implementation of CBR in rural, remote and Indigenous Australia will require the development of entry-level training and recruitment of community disability workers:** Forum members proposed that broad-based, entry-level training (that recognises prior learning and articulates with other health worker training) is required. Training and accreditation should be credible to the local community, should accommodate cultural differences and low literacy, and should be based on a strong community development foundation. Trained community disability workers should be provided with ongoing skill development and networks to ensure ongoing support.
2. **The implementation of CBR in rural remote and Indigenous Australia will require a realignment of professional training:** Participants in the forum emphasised that university training of allied health and other health professionals should include CBR training in the core curriculum, emphasising community development and primary healthcare theory and skills. They suggested that a CBR educational framework could provide the basis for greater interdisciplinary linkage across allied health professions and, in rural areas, greater linkage with University Departments of Rural Health.



Forum members emphasised that the roles of all workers involved in rural and indigenous CBR should be based on: (i) a clear understanding of the views of the relevant community; (ii) a willingness to integrate social and cultural knowledge with scientific health-professional skills and perspectives; and (iii) a commitment to supporting vulnerable people (eg women, community workers).

- 3. The implementation of CBR in rural, remote and indigenous Australia will require the transfer of knowledge and skills to community members:** The CBR model advocates for adequate and appropriate rehabilitation services to be available to a greater proportion of the population. This is to be achieved through a meaningful transfer of knowledge about disabilities and rehabilitation to people with disabilities themselves, their families, and members of their community. Consequently, people with these skills and information (rehabilitation and health professionals) must take on community training roles on an 'as-needs' basis.

Forum members recognised that the transfer of rehabilitation knowledge and skills can be performed by experienced practitioners and can occur under a variety of modalities (in the process of care, through web-based materials, under formal training etc). However, professionals must be skilled in passing on their knowledge and facilitating the role of community-level workers to do the same.

- 4. The implementation of CBR in rural, remote and indigenous Australia will require a reprioritisation and redirection of resources:** In describing CBR as an attempt to democratise disability information, skills and resources, forum members noted that this may be greatly facilitated by a community-specific model for the allocation of resources. They suggested that while CBR has been

viewed as an economical alternative to existing disability and health services, the emphasis in implementation should be the provision of appropriate rehabilitation services to a greater proportion of the population. As such, substantial government and organisational support will be required for the effective and sustainable implementation of CBR in rural, remote and indigenous communities.

As a localised approach, CBR should seek to more meaningfully link with local industry, relevant community groups and local leaders (elders, council leaders etc) than is currently the case under the traditional model. Such linkages may positively influence community attitudes, develop community capacity, promote vocational and other opportunities for people with disabilities and support local socio-economic development.

Principle 2. CBR is a process and orientation to service delivery that should be further fostered and built on in rural, remote and Indigenous communities in Australia

The forum emphasised that in addition to the implementation of distinctive projects, CBR in Australia should also be expressed as efforts to enhance, shift or reorient existing services. CBR can be viewed as a set of philosophies and principles that can improve current approaches to rehabilitation and disability service delivery in rural, remote and Indigenous communities. Consequently, they suggested two guidelines:

- 1. Identify and endorse examples or aspects of specific health and rehabilitation services, which are consistent with a CBR model:** Examples include some Indigenous and community controlled health initiatives, attempts to employ community development strategies in health service delivery, and consumer self-management type initiatives. Such initiatives and trends should be supported.



2. **Use CBR principles to initiate engagement with communities:** In an effort to overcome the fragmentation of services, workers should utilise family and community skills, resources and support in disability service provision. This can be enhanced by providing mechanisms for community consultation and control, and by building local community capacity.

Issues for attention

While each of the items identified invite a number of questions, the forum identified the following areas as requiring further consideration to facilitate the implementation of CBR in rural remote and Indigenous Australia:

- The potential use of tele-health and current technologies within a community based approach is unclear (being largely inaccessible to many) but one that holds considerable potential.
- As a social movement, CBR lacks a coherent core of research, experimental studies or systematic reviews. The relationship of CBR to the evidence-based practice movement requires greater clarification and a rethinking of the nature and value of 'evidence' in such settings.
- Core CBR principles of equity, justice, community capacity and trust should be more clearly operationalised within rural, remote and Indigenous CBR practice in Australia.
- The possible application of the CBR model to ethnic communities in Australia deserves attention.

Conclusion

Participants recognised that these guidelines (arising from health professionals) are only a limited and partial step towards the implementation of CBR; however, they may provide a starting point for the more crucial community and consumer input into the process. The forum emphasised that

there will be a need for consumers, local communities, service providers and other stakeholders in rural, remote and Indigenous communities in Australia to influence this agenda, through local systems of implementation based on broad consultation. This can be supported by: (i) a multidimensional development approach, that includes change at systems and organisational levels; (ii) appropriate intermediate level and professional training on community working; and (iii) conceptual, policy and financial support from Commonwealth and state governments.

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