Audit of the Training and Education Needs of Staff Working in Community Rehabilitation in Queensland

TENDER NO WPD 1/1/1

Workforce Preparation and Development

WORKFORCE REFORM BRANCH

Queensland Government
Queensland Health

Disability and Rehabilitation Research Unit
February 2006
Executive Summary

The overall objective of the current Education and Training Audit was to define competencies for the CR workforce, identify the barriers to these competencies, the training needs of CR professional and the support roles they require. The specific aims of the Audit are as follows:

- To determine the competencies that are required for CR in Queensland
- To determine the existing competencies in the Queensland CR workforce, gaps, barriers and potential solutions to facilitate competencies
- To determine the education and training needs across disciplines, experience levels, work contexts and organisations
- To develop recommendations for appropriate delivery of education and training for the CR workforce
- To examine the current and potential future roles of support personnel in CR

Methodology

This project utilised multiple methods to gather data that would address the research questions, namely focus groups, expert panels, interviews and surveys. Participants were recruited from a diverse spread of Allied Health, Nursing and support personnel across Queensland who were employed in Community Rehabilitation (CR) services. Participants represented rural/remote and metropolitan areas, Indigenous communities, government and non-government services and all QH districts. The final sample included males and females (although females are more prominent in the CR professional population), a range of professional backgrounds and experience levels and both managers and practitioners.

The final sample consisted of 190 participants who were involved in different components of the method. In addition, six international CR experts were consulted, together with 40 practitioners who were employed in CR programs in the USA.
The competency development process consisted of a sequence of seven steps that involved iterative cycles of data gathering and verification of the findings until consensus was highly probable.

Summary of the Competency Development Process

1. Generate competency areas from Focus Group discussions
2. Expert panel articulate definitions and specific statements/items from quotes and own knowledge
3. Combine across groups (regional, rural, Indigenous, metropolitan) to form major competency domains
4. Researchers clarify competency statements into survey items and check against Interview data
5. Feedback from identified experts in CR regarding gaps, modifications, issues with survey items
6. Expert panels and Focus Group participants to rate importance of items and refine content further
7. Final survey sent to all participants based on all above modifications and addition of training questions

Quantitative survey data were statistically analysed through the SPSS package (version 12.0). For qualitative data, all Interviews, Focus Groups and panel discussions were analyzed using thematic analysis. To ensure the consistency and rigour of the findings in this study all the data was analysed using a thorough thematic coding and categorising process. Although the application of ‘thematic analysis’ is open to a wide range of interpretations, its use in this study followed the systematic process using the method of agreement between two independent coders. The stages included:

(i) Initial coding of each transcript using the paragraph as the primary level of analysis
(ii) Clustering of codes to develop concepts or categories that span across transcripts
(iii) Developing themes from these concepts to explain the phenomenon for the majority of the participants
(iv) Identifying deviations from this explanation and explaining them.
CR Competencies

The results revealed ten key competency domains that were relevant to good CR practice in Queensland. These competencies highlighted the fact that CR was defined as a philosophy based on engagement with consumers and communities, partnerships and collaborations, respect for culture and responsiveness to holistic needs. These core competencies were common across rural/remote, regional, metropolitan and Indigenous practitioners, although there were some key distinctions. Rural and Indigenous practice was intrinsically embedded in communities and boundaries were less easily identified and maintained.

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In practice, however, CR practitioners tended to focus on strategies to reduce hospital stay, minimise hospitalisations and facilitate the transition back to the community following inpatient treatment. In many cases, there were significant discrepancies between their rhetoric and their actual practice. For the majority, CR was confusing and was not based in a well-defined philosophical model of practice. CR practice was
often seen as being inferior to discipline-specific practice and time spent in CR was considered to be potentially damaging to clinical competence.

**CR Training Needs**

Practitioners identified multiple areas of training need. However, one of the most notable needs for training was in the area of frameworks of understanding and models of CR practice. Other areas of high training need included systems advocacy, ways of creating and delivering service continuity and culturally appropriate practice. Training needs were identified in all other competency domains, but specific areas of note that were endorsed by over 75% of the practitioners included:

- Understanding the principles that underpin CR and how they are implemented
- Understand the limitations of different frameworks, approaches or models
- Understanding and monitor the expected outcomes of CR
- Understanding the mental health system and how it interacts with other systems
- Understanding how culture impacts on the individual experience of disability and illness
- Critically analysing existing evidence about CR

**Barriers to CR Training**

Although there were many genuine barriers to training present in their environment, most practitioners focused on five major barriers:

- The need for individual commitment to professional development and learning
- The lack of an organisational culture of staff development within the workplace and the industry
- The need for training to accommodate such a vast range of situational factors and circumstances
- The need for training to respond to a range of levels of knowledge and styles of learning
- The fact that training attendance was often motivated by clinical dilemmas rather than CR practice.

Although these major themes dominated the practitioners’ views about barriers to training, several other themes also emerged as being important. These themes involved the need for CR-relevant supervision, the influence of discipline-specific frameworks on training content, the opportunity to put training into practice, the
lack of CR-specific topics and opportunities for training, knowledge of where to find CR-relevant information and the need for training to fit into a broader career path.

Practitioners also commented on the lack of direct (i.e., travel, accommodation, registration) and indirect funding (i.e., backfill during absences) funding to support training and equitable access to training (especially in relation to support personnel and remote practitioners). A topic that was mentioned many times was easy access to local and state, national and international knowledge bases (e.g., training agendas, databases, eligibility information, service directories, local resource directories, contact lists, local protocols, quick solutions to specific questions etc.).

**Delivery Methods**

Practitioners currently used a variety of methods to gather information, although almost 80% regularly attended local training seminars, team-based learning in their workplaces and expert workshops. There was a preference for the combination of several methods, notably, videos/films with written material and practical workshops with networking opportunities. Learning programs were regarded as being meaningless if they were not accompanied by hands-on instruction or networking opportunities. Training opportunities that facilitated team work, networking and collaborative learning among CR practitioners were preferred. Four delivery modes were mentioned most often, including:

- On the job training with good mentoring
- Team-based learning in the workplace
- Exposure to multiple environments and workplaces
- Networks of experts sharing information

**Support Personnel**

CR practitioners recognised the need for support personnel and acknowledged their important and innovative role in the process of CR. However, few practitioners used support personnel. Those who did use support personnel tended to use them as assistants for the therapist (e.g., equipment, preparation, report typing, appointments). These models clearly required modification to suit the community sector. Support personnel
and consumers identified innovative roles for assistants that involved community-based interventions, liaison, involvement in natural support networks, non-clinical consumer support. This was particularly true for Aboriginal and Torres Strait Islander Health Workers who were critical to the interface between CR practitioners and communities/consumers.

**Conclusions**

This project has clarified the nature of the competencies required for CR in Queensland and has highlighted a gap between rhetoric and practice. Significant training needs were identified, particularly in areas such as principles and practices of CR. Major issues were raised for practitioners in attending training and several methods were recommended for the delivery of accessible training. The significance of this project for Queensland Health is the fact that CR has been introduced in response to the rising costs of healthcare for people with disabilities and chronic conditions. Ironically, however, the potential benefits of CR will not be realised without competent practitioners who can implement its core principles. Thus, investment in the training of the Allied Health and Nursing workforce in CR in Queensland is critical. It is also critical to examine the underlying philosophy of CR and juxtapose this against the environment in which it is currently being operationalised. If CR is to become a meaningful and useful response to our healthcare crisis, then it is imperative to ensure that it is implemented in accordance with the competencies identified in this report, which concur with those reported by CR experts across the world.
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## Abbreviation of Key Terms

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<tr>
<td>CR</td>
<td>Community Rehabilitation</td>
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<td>CBR</td>
<td>Community Based Rehabilitation</td>
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<td>QH</td>
<td>Queensland Health</td>
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<td>WFOT</td>
<td>World Federation of Occupational Therapists</td>
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<td>EBP</td>
<td>Evidence-Based Practice</td>
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<td>TA</td>
<td>Therapy Assistant</td>
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<td>AHA</td>
<td>Allied Health Assistant</td>
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<td>CRep</td>
<td>Community Representative</td>
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<td>CRP-RECP</td>
<td>Community Rehabilitation Provider - Rehabilitation Continuing Education Program</td>
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<tr>
<td>ATSIHW</td>
<td>Aboriginal and Torres Straight Islander Health Worker</td>
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Acknowledgements

The research team would like to acknowledge Dr. Pim Kuipers, Ruth Cox and Dr. Pat Dorsett, Queensland Health for their involvement in the conceptualization, and design of this project, and particularly Dr. Pat Dorsett for her great assistance in the conduct of the project. The opportunity to work in true collaboration with an industry partner is exciting and rare.

The Centre would also like to acknowledge the enormous effort of the reference group and expert panel in analyzing and developing the conceptual framework. This group of people worked extremely hard to support the project and ensure the most reflective use of the data. This panel represents some of the leaders in the Community Rehabilitation (CR) sector. Special thanks to:

Ruth Cox, Delena Amsters, Dr. Pat Dorsett, Areti Kennedy, Judith Milliken, Peter Harre, Janet Struber, Dr. Ans Van Erp, Paul Bew, Margaret Tweeddale and Paula Bowman

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Competencies for Community Rehabilitation in Queensland – February, 2006 – Griffith University
The “Audit of the training and education needs of staff working in community rehabilitation in Queensland” is a key component of Queensland Health’s Community Rehabilitation Workforce Project. The Project is funded through the Pathways Home Program, an Australian Government initiative to facilitate a greater focus on the care and services provided during the transition from hospital to home.

The Pathways Home Program provided for projects aimed at education and training for current and future health care workers across the workforce continuum from support personnel, to students, to experienced practitioners. The overall aim of the Community Rehabilitation Workforce project is to optimise the capability of the current and future workforce to develop, implement and evaluate CR programs to meet the current and emerging health needs of the Queensland community.

The audit of education and training needs was identified as an effective way to inform the development of appropriate strategies to enhance the capacity of the Queensland CR workforce. The purpose of the audit was to describe the competencies required for effective CR, identify the training and education needs of Allied Health and Nursing practitioners currently working in the field and make recommendations to assist with the development and implementation of appropriate initiatives to meet the identified needs. Additionally, the audit will assist in identifying the current and potential future roles of support personnel in CR.

The Community Rehabilitation Workforce Project engaged Griffith University to conduct the audit on behalf of Queensland Health to provide independence and objectivity to the research, to ensure a high quality outcome of the audit and to assist in internal staff participation and skill development.

The audit included both Queensland Health staff and workers from other organisations, which provide rehabilitation in the community. The data from the audit will be used to plan and develop initiatives to meet identified training and education needs and as a baseline to evaluate these initiatives. The data regarding support personnel roles will be used to assist in the development of future roles.
This project was driven by a raft of research questions, which grouped into five major categories:

To determine the competencies required to deliver CR:

What competencies are required for Allied Health, Nursing and support staff to work in CR? Which competencies are specific to CR or common across other clinical areas?

To determine the competencies, gaps, barriers and facilitators in the Queensland CR workforce:

What competencies are currently evident in the workforce in CR in Qld? What are the barriers to utilising competencies in CR? What are the potential solutions to these issues?

To determine education and training needs for the CR workforce in Queensland:

What competencies require further education, training and enhancement? What are the needs across disciplines, experience levels, contexts and organisations?

To develop recommendations for the appropriate delivery of education and training:

What format is appropriate for the delivery of education and training in competencies? What enablers must be incorporated for the workforce to take up education and training? What are perceptions of training issues for managers, practitioners, support staff, Consumers?

To examine the role of support personnel in CR:

What are the current and potential future roles of support personnel in CR?
As Crocker and Heslop (2001) recently concluded, Community Rehabilitation (CR) will not advance successfully in the absence of some key workforce developments:

- A clear career path for CR practitioners both within organisations and across communities;
- Job descriptions and documentation around these positions;
- A database to identify practitioners who are currently employed in CR;
- A functional description of the competencies of CR practitioners;
- The provision of appropriate training opportunities.

It is these observations that have guided the current project.

The overall objective of the current Education and Training Audit was to define competencies for the CR workforce, identify the barriers to these competencies, the training needs of CR professional and the support roles they require. Competencies are aspects of the job that an individual can perform, the set of skills, knowledge and attributes that enable health professionals to work within a particular field. In relation to CR, these competencies have not yet been clearly defined. The specific aims of the Audit are as follows:

To determine the competencies that are required for CR in Queensland

To determine the existing competencies in the Queensland CR workforce, gaps, barriers and potential solutions to facilitate competencies

To determine the education and training needs across disciplines, experience levels, work contexts and organisations

To develop recommendations for appropriate delivery of education and training for the CR workforce

To examine the current and potential future roles of support personnel in CR

The major findings in relation to each research question are summarised below, together with the related recommendations.
Aim 1: To determine the competencies required for CR in Queensland

Research Questions: What competencies are required for allied health, nursing and support staff to work in CR? Which competencies are specific to CR or common across other clinical areas?

Recommendations:

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The interviews with CR practitioners resulted in the development of ten key competency domains and several sub-domains. The domains described a model of practice that necessitated competencies in inclusive and rights-based frameworks of understanding, disability knowledge and cultural awareness, Consumer and community engagement, and holistic practice, including a focus on social and emotional needs, family context and responsiveness to individualised preferences. Importance was attributed to the ability to develop networks and team-based approaches to service delivery, and ensure continuity, coordination and a cohesive continuum of services. The capacity to act locally was also recognised (i.e., a locally-based model of service delivery linked into local organisations and community and drawing on local knowledge bases). Additional competencies that would be required to manage local community environments include reflective practice, creative problem-solving, management of demands and personal/professional boundaries. Finally, it was considered necessary...
for CR practitioners to play a role in policy development, systemic change, and the generation and dissemination of evidence.

Although the competencies were common across rural/remote, Indigenous, regional and metropolitan practitioners, there were some interesting differences. Some issues were less critical to rural practitioners, particularly those associated with the engagement of Consumers and management of personal boundaries and demands. It was surmised that this difference resulted from the fact that the rural practitioners were naturally more enmeshed in their communities and accepted some overlap between work and life. For Indigenous Health Workers, however, they experienced increased pressure as they attempted to operate independently in communities that comprised their extended families and Elders. Competencies associated with service continuity, community engagement and the use of local knowledge were less evident in the metropolitan data, perhaps revealing less need for practitioners to rely on these strategies in this context (i.e., due to the difficulty identifying metropolitan "communities" and local knowledge bases and the fact that services are less able to remain engaged with Consumers for the duration of their time within the service system).

Consumers (including metropolitan Consumers), however, clearly identified a model of CR practice that was based on the engagement of natural supports, recognition of Consumer knowledge as an important source of data and the creation of a coherent package of rehabilitation that responded to their entire being rather than just their functional difficulties. Information, participation and respect were critical to Consumers. They reiterated that their experience was unique to them and very personal – as such, it required sensitive and respectful treatment that was driven by their goals, values and preferences rather than by the demands of a therapist.

CR experts who were consulted to review the competencies identified from practitioners agreed with the Consumers. Comments from CR experts indicated several areas where important CR competencies required further elaboration. For instance, experts observed many statements that contained language reflecting a powerful status for therapists rather than a Consumer-driven process. Experts also noted that there was need for more reference to holistic and contextual issues, such as family. However, in the results from the final survey, practitioners rated their holistic focus as one of the most important competencies. The observations of CR experts are particularly interesting given that practitioners actually rated Consumer engagement and holistic focus as important competencies in CR.
Aim 2: To determine the existing competencies, gaps, barriers and solutions to facilitate competencies

Research Questions:
What competencies are currently evident in the workforce in CR in Qld?
What are the barriers to utilising competencies in CR?
What are the potential solutions to these issues?

Recommendations:

- That practitioners be supported and encouraged to understand that different frameworks of understanding will generate differing manifestations of the competencies in their practice.
- That practitioners be encouraged to understand full implication of particular competencies for practice (i.e., the distinction between hospital-based and community practices, the impact of fostering different networks, the relevance of culture to all practice, and the nature of power in professional interactions.
- That practitioners be encouraged to understand the critical differences between the essence of CR practices and traditional institutional rehabilitation practices.
- That there is clear understanding that CR does not merely represent the translocation of institutional practices into a community setting.
- That the practice of CR be recognised as a legitimate practice in its own right; and therefore is seen to encompass appropriate education; career and mentoring opportunities; and strong consumer participation.
- That the practice shift is driven by facilitative and insightful leadership that both encourages practitioner education and initiates systemic change through adequate and effective resources.
- That available evidence about CR be collated, critiqued, synthesised and disseminated to practitioners.
- That practitioners be encouraged to engage in research and evaluation activities.
- That the role of mentoring in CR be examined and improved/promoted.

This study highlighted the fact that the practice of CR in Queensland tends to focus on reducing hospital stay, minimising hospitalisations and easing the transition back to the community. Although practitioners endorsed competencies such as Consumer engagement, community engagement and holistic practice, their descriptions of their practice presented a model that was driven by demands for throughput and short intensive treatments. Consumer-focused goals and the importance of the home as a basis for rehabilitation featured strongly in their discussions and in their ratings of their own competencies. However, there were significant discrepancies...
between this rhetoric and their actual practice. There was no doubt that many practitioners had embraced the concept of CR in its fullest sense. However, for the majority, CR was a confusing term that was not based in a well-defined philosophical model of practice. There was some evidence that CR terminology created a clash for practitioners who were trying to satisfy multiple and sometimes contradictory demands.

For instance, many practitioners were based in hospitals and found that the more structured demands of hospital rehabilitation overshadowed CR objectives. There was an uneasy feeling among many practitioners that they were claiming to be practicing CR, but could not achieve the CR competencies in their current context. It is important to note that there were also many practitioners who claimed to be delivering CR, but clearly had no conceptual framework that could be considered to emanate from the community paradigm. Indeed, practitioners considered themselves to be most deficient in the area of Frameworks for Understanding CR followed by the ability to engage in Systemic Advocacy. These two competencies dominate most internationally recognised forms of CR, particularly Community Based Rehabilitation (CBR) as defined by the World Health Organisation.

Nevertheless, it is important to acknowledge that true CBR was not the dominant model of practice for most practitioners, despite the strong preferences for such a model among the Consumers, CR experts and some practitioners. Models of CR can be conceptualised according to two primary dimensions (the location of the service base (e.g., hospital, outpatient, home-visits, community-placed or community-based) and the extent to which the service is driven by therapists (i.e., therapists as experts, educators, collaborators or resources). Most practitioners appeared to be operating from a model that was driven by the hospital context, focusing on the transition back to the community and engaging in home visits. Some services were “placed” in the community, but the practitioners remained experts. At best, they were educators who were committed to passing on information and knowledge to the Consumer.

Some practitioners differed markedly from the majority, demonstrating practice that reflected a community-driven model and participating in their communities as collaborators and resources for Consumers. However, for the majority, systemic and structural barriers prevented them from moving towards this type of model. Many practitioners were able to articulate the type of CR they would prefer to be delivering (i.e., community based and consumer driven) but reported being unable to accommodate these practices in their current context. The barriers to ideal CR practice identified by practitioners focused on the systemic lack of profile for CR, the
absence of supportive structures such as clear job descriptions, procedural manuals and leadership in CR, and resource issues such as staffing and time. Practitioners noted that there was an important value-base to CR and that some practitioners were not well matched to this type of occupation. However, they also noted that preparation for a community context was minimal and that there was a need to improve understanding about CR at all levels of the system. This understanding of CR was also seen as being essential because it would enable practitioners to “know what they don’t know” about CR, acquire appropriate training, receive leadership support, develop structures and protocols for CR and more effectively manage some of the significant challenges associated with community practice.

The profile of CR was particularly important to practitioners, given the fact that many of them maintained a view that CR practice was inferior to their discipline-specific practice and that time spent in CR was potentially damaging to their clinical competence. There were mixed views among practitioners, with some acknowledging the specialised skill associated with community work, but many viewed it as a generalised and inefficient area of practice that was seen as a luxury. This view was reinforced by their context, which emphasised their ability to consult with large numbers of Consumers and produce measurable outcomes.

Aim 3: To determine education and training needs for the CR workforce

Research Questions: What competencies require further education, training and enhancement?
What are the needs across disciplines, experience levels, contexts and organisations?

Recommendations:

- That it be recognised that practitioners have significant and diverse training needs.
- That practitioner training is congruent with the principles of recognised CR practice.
- That existing training opportunities be catalogued and distributed in an accessible and coherent form so practitioners can plan their developmental activities.
- That a broader range of training is explored (e.g., from sectors other than health).
- That a culture of learning be fostered within organisations and managers.
- That local capacity to deliver training is strengthened.
Areas for Training:

**Consumer Engagement**
- Facilitating consumer-driven rehabilitation processes
- Facilitating and monitoring consumer goal setting and achievement
- Creating opportunities, options and choices for consumers to engage in rehabilitation

**Boundaries and Personal Safety**
- Negotiation and conflict resolution skills to resolve difficult situations
- Legal responsibilities, medico-legal issues and duty of care
- Strategies to manage and review workload and competing demands
- Skills for consumer disengagement and case closure, particularly in small communities

**Networking**
- Understand the service system at all levels
- Up-to-date knowledge of available services and eligibility criteria
- Team functioning, responsiveness and communication between disciplines

**Reflective Practice**
- Innovative use of resources
- Critical analysis of evidence about CR
- Outcome measurement and evaluation in CR services
- Providing supervision, support and/or direction for assistants and formal carers

**Community Engagement**
- Gaining acceptance and trust in communities
- Recognising and applying locally accepted norms for behaviour
- Profiling communities and promoting community capacity

**Holistic Practice**
- Recognising, managing and referring for mental health issues
- Fostering naturally occurring supports, strengthening and supporting families
- Maintaining confidentiality in challenging situations
- Responsive and flexible service provision
- Using technology to support home-based and distance service delivery

**Frameworks of Understanding**
- Definitions of CR, frameworks and models of service delivery
- Principles for CR and how they are implemented in practice
- Consumer experiences of disability
- Cultural influences on the experience of disability

**Service Continuity**
- Encouraging consumers to plan for a healthy future, monitor and manage their own condition
- Screening for risk versus thorough assessment
- Responding to and minimising risk appropriately

**Cultural Awareness**
- Cultural protocols and culturally respected experts (e.g., Indigenous Elders)
- Translating cultural knowledge into practice and behaviour
- Avoiding cultural stereotypes and respecting individual variation
- Challenges associated with rural and/or Indigenous practice

**Systems Advocacy**
- Identify gaps, barriers and issues in the community
- Developing and advocating for opportunities, solutions and policies
- Engaging consumers and community in service planning, development and evaluation
One of the most notable needs for training was in the area of frameworks of understanding and models of practice. CR practitioners identified a need for training in the broad frameworks of CR, and a model of CR practice that was focussed yet flexible. This training need included an orientation to the principles of CR, and how these models may influence everyday CR practice. CR practitioners believed they needed training in how to utilise existing frameworks and models, and to adopt a more critical approach when applying these models to practice. There was a related need for training in how to effectively promote meaningful CR policy, and advocate for Consumer rights within the system. It was also important for CR practitioners to learn how to critically analyse CR literature and document the benefits of CR in a systematic way using structured protocols. Accommodating the knowledge base of new CR practitioners and preparing them for CR practice was also considered important particularly when implementing new models of practice, or operating from locally adapted frameworks of CR.

CR practitioners stressed the importance of home-based CR services, and required assistance to develop efficiencies around this type of service delivery, especially in relation to complicated processes such as enhancing community collaboration. Within this area, particular mention was made of the need for training in cultural awareness, understanding cultural nuances and identifying local protocols. CR practitioners also identified the need for focussed training in how to enhance Consumer relationships, particularly in less than ideal situations and contexts, (i.e., dealing with difficult and complex client issues). Not surprisingly, CR practitioners embraced the idea of further training in issues pertaining to psychological well-being and social health, particularly in relation to understanding the mental health system and facilitating natural supports in Consumers' lives.

Interestingly, CR practitioners indicated a high level of proficiency and few training needs in the area of Consumer engagement. This finding was contradicted by Consumers, who indicated the strong presence of “expert” models of care based in functional frameworks that failed to engage Consumers. In interviews, CR practitioners reported an inability to fully engage in Consumer-driven rehabilitation as they were under pressure to respond to quantitative and time-focused outcome indicators. It is possible that practitioners would indeed be proficient in Consumer engagement strategies in a more favourable context. However, there were also significant examples where the rhetoric of Consumer engagement was juxtaposed against clear examples of expert-driven processes. For the most part, practitioners adopted a centre-based functional model of service delivery that incorporated some home-visits, but did not fully translate into a Consumer and community driven
process. In many cases, even home-visiting was regarded as a “last resort” due to the perceived inefficiencies of this practice. Thus, it is likely that self-reported competence in the area of client engagement reflected limited understanding of the concept.

CR practitioners were aware of the necessity for Consumers to self-manage their own health and well-being as part of the rehabilitation process, but perceived themselves as being in need of training about how to facilitate this outcome. Given the importance of self-management to the current federal health agenda, it would seem important to deliver this type of training in future. Practitioners who cannot promote self-management are inadvertently undermining extensive expenditure that has already been outlaid on self-management interventions.

Finally, there was a need for training in areas that facilitated the everyday delivery of CR. Specifically, resource management (e.g., IT skills), dissemination of knowledge, continuity of care, and intra-service and inter-service communication and teamwork were all highlighted as key training concerns. These skills are often assumed to exist in practitioners, but are rarely taught in their undergraduate and post-graduate training.

Aim 4: To develop recommendations for the appropriate delivery of education and training

Research Questions:
- What format is appropriate for the delivery of education and training in competencies?
- What enablers must be incorporated for the workforce to take up education and training?
- What are perceptions of training issues for managers, clinicians, support staff, consumers?

Recommendations:
- That it be recognised that CR practice provokes a diverse range of training needs for practitioners, and that a focus on clinical education is necessary, but inadequate.
- That multiple modes and media be explored for training.
- That face-to-face networking and application opportunities accompany major training activities.
- That IT capacity be enhanced to enable innovative methods for both CR practice and training.
- That training be developed to foster openness to different frameworks of knowledge representation, such as rurality, cultural ways of knowing and consumer experiences.
- That systemic centralised support and resources be created to acknowledge the complexities of CR practices and the complicated training needs that emerge from that practice.
- That opportunities for consumer consultation and input into training be enhanced.
Although CR practitioners highlighted some key obstacles to training, they gave considerable thought to strategies that would enhance the impact of training in their industry. CR practitioners raised some important philosophical questions about training. For instance, they queried whether training could actually deliver some of the skills required for CR. They noted that person-job match was critical and only life experience or accumulated knowledge gained on the job over many years could generate understanding of the subtle and complex area of CR. However, most practitioners agreed that exposure to training opportunities would facilitate a broader view of rehabilitation as a process that can incorporate and accommodate many different lifestyles, cultures and learning styles different from their own. Although there was a genuine view that training should be delivered by an expert practitioner or academic, a number of CR practitioners highlighted the fact that Consumers were an important source of learning.

Practitioners noted that without a positive attitude to training, and a supportive organisational culture, educational opportunities would be under-utilised, and knowledge was unlikely to be disseminated among team members. Factors such as work-life balance, work structures and rural and remote locations were all mentioned as challenges to actually attending training. CR practitioners clearly identified the need for mentorship and supervision, but were quite adamant that supervision must have a CR focus rather than being discipline-specific or clinical. The lack of priority afforded to training in CR was evident, both in terms of the training that was available and the fact that attendance at training of any kind tended to be motivated by clinical needs. Many practitioners feared losing their clinical skills as a result of their community practice. However, some practitioners indicated that trainers could capitalise on the fact that clinical issues would attract attendance by ensuring that training opportunities contained both elements. CR practitioners also sought training opportunities that were likely to contribute to their own career development process. Unfortunately, career progression was perceived to be associated with a clinical focus rather than a community focus. In terms of training delivery, CR practitioners identified several methods that they believed would enhance their involvement with training courses, and implementation of new learning. Specifically, practitioners respected training opportunities that reflected team-based education (within their actual work environment), collaborative learning and learning through networks. These opportunities were more likely to be utilised than traditional methods such as books, university courses and placements.
Delivery methods that included some form of on-line documentation were also more frequently endorsed. However, the data suggested that any form of on-line learning must be focussed and readily accessible. Many existing web-based methods such as group discussion or on-line tutorials were not frequently used by practitioners due to variable access to the internet. Although methods such as teleconferencing and videoconferencing were less frequently utilised, this may reflect limited proficiency in these areas rather than any inherent lack of interest. Practitioners clearly identified technology as an area of training need.

For CR practitioners, the more training options available to them at any one time, the better. It was clear that in order to maximise learning, CR practitioners preferred a multi-faceted approach. For example, learning programs were regarded as meaningless if they were not accompanied by hands-on instruction, opportunities to apply knowledge and/or networking opportunities. Similarly, audio-visual material was only considered useful if it was combined with written documentation or training manuals that could be used to apply knowledge later in practice.

Clearly, the provision of training was complicated by the complexity of the CR workforce. Nevertheless, practitioners all requested a coherent training framework which they could move into at the most appropriate level. They wanted to be familiar with the knowledge systems being used by other practitioners in CR.

**Aim 5:** To examine the role of support personnel in CR

**Research Question:** What are the current and potential future roles of support personnel in CR?

**Recommendations:**

- That uniformity of language be used to describe job descriptions, roles and titles.
- That clarity be found in relation to the interaction of different sectors (e.g., boundaries of CR compared to ongoing disability lifestyle support? CR throughout consumers' lives?)
- That administrative support is available to ensure practitioner focus on client engagement.
- That recognition be given to the need for both clinical therapy assistants as well as support personnel who act as a conduit between CR activities and the complex stakeholder network.
- That the feasibility of local positions be explored within local government frameworks.
- That equal resources be allocated to the recruitment, retention and training of appropriate support personnel as they are a valued member of CR teams and may have the capacity to facilitate the implementation of CR principles more effectively than other professionals.
The data revealed an extremely complex system with a myriad of support personnel roles that were considered relevant to CR models. There was no single clear-cut support personnel role specifically associated with CR. Rather, there was diversity in the way that support personnel roles were viewed and utilised across CR services and contexts. The data reflected a dichotomy of support personnel functions in that some were predominantly driven by the needs of the practitioner, while others were mainly driven by the needs of the Consumer. The boundaries around support personnel roles appeared to be fluid, and there was a need to develop more concrete parameters. The greatest confusion appeared to be the point at which therapy-based rehabilitation activities ended and lifestyle support for Consumers in the community began. The blurring of boundaries between these related, yet distinct types of support personnel caused some confusion as participants attempted to articulate the roles that were relevant to their CR work. Despite the fact that these support personnel roles appeared to be located across both the health and disability sectors, there was a notable absence of any discourse about cross-sectoral collaboration in the data. The following summary table presents an overview of the project aims, methods utilised and key findings according to each project aim.

### International Comparisons

- The foundation of CR continues to direct its implementation and determines the training that is available – USA base is vocational, Canadian base is human rights, UK and Australian base is medical – this base will have significant implications for ongoing practice.
- Imposing CR training onto an existing profession may not be successful as it is difficult for them to relinquish their pre-CR roles and frameworks.
- Practitioners in CR acknowledge the need for formal training and accreditation, but were desperate for responsive training that was based on the work they were currently doing in the community.
- Practitioners want to have considerable input into designing training opportunities and topics.
- There is a need to avoid the creation of a dissatisfied and underpaid workforce which is viewed as being inferior to professionals.
- CR is a specialisation and must offer career paths and recognition, which is dependent on funding sources.
• Competencies for CR need to be consistent and recognised as valuable skills.
• Implementing a coherent competency and training framework after the implementation of services is difficult – this system should be set up before CR develops too much further in Australia.

Some clear parallels can be found to the Australian system when one examines the Canadian and USA systems. Both systems have been strongly influenced by the foundation of CR (i.e., vocational imperatives, disability and independent living movement, social justice, medical frameworks), an issue that must be considered in the Australian context. In the USA and Canadian contexts, undergraduate and paraprofessionals have been engaged to deliver CR, whereas Masters level qualifications are required for practitioners to be considered specialists. This situation has enhanced the professionalism of the area, but has also created a group of professionals who expect reasonable remuneration. Due to funding constraints, this remuneration may not be available to them. At the other end of the spectrum, those who deliver CR are generally underpaid, dissatisfied and likely to be transient. There is little incentive to undertake Bachelor degree courses, given that they are not regarded as much more qualified than those who are attending certification courses in the community. These are issues that must be considered in Australia as we progress towards the notion of a CR specialisation.
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<tr>
<th>Item</th>
<th>Aims of Project</th>
<th>Research Questions</th>
<th>Approach Utilised Methods</th>
<th>Findings</th>
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<tr>
<td>1</td>
<td>To determine the competencies required for CR in Queensland</td>
<td>What competencies are required for Allied Health, Nursing and support staff to work in CR? Which competencies are specific to CR or common across other clinical areas?</td>
<td>-Stakeholder consultation&lt;br&gt;-Delphi method of item generation&lt;br&gt;-Focus Groups&lt;br&gt;-Interviews</td>
<td>Ten competency domains were identified as important in CR practice:&lt;br&gt;o Frameworks of Understanding&lt;br&gt;o Networks&lt;br&gt;o Cultural Awareness&lt;br&gt;o Holistic Focus&lt;br&gt;o Consumer Engagement&lt;br&gt;o Service Continuity&lt;br&gt;o Reflective Practice&lt;br&gt;o Community Engagement&lt;br&gt;o Boundaries and Safety&lt;br&gt;o Systems Advocacy&lt;br&gt;A total of 173 individual competency items were developed.</td>
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<td>2</td>
<td>To determine the existing competencies, gaps, barriers and solutions to facilitate competencies</td>
<td>What competencies are currently evident in the workforce in CR in Qld? What are the barriers to utilising competencies in CR? What are the potential solutions to these issues?</td>
<td>-Focus Groups&lt;br&gt;-Interviews</td>
<td>Lack of understanding of CR Frameworks was identified as a major barrier in competency application in the CR workforce. Barriers to CR practice as identified by Consumers including&lt;br&gt;o Lack of support to make a positive transition from acute care to community&lt;br&gt;o Confusing and conflicted eligibility criteria across services&lt;br&gt;o Lack of understanding of Consumer perspectives by professionals&lt;br&gt;o Inadequate information transfer from professionals to Consumers&lt;br&gt;o Focus on the medical model where the expert is the professional&lt;br&gt;o Inadequate networking by professionals with community groups&lt;br&gt;o Insufficient attention to the facilitation of Consumer support groups&lt;br&gt;o Exclusion of family, friends, neighbours and other natural supports&lt;br&gt;o Limited attention to emotional and social needs&lt;br&gt;o Lack of understanding of the experience of disability in professional practice&lt;br&gt;o Tendency to limit Consumers’ opportunities to understand their condition&lt;br&gt;Participants indicated three competency areas considered extremely important (Consumer Engagement, Holistic Focus and Reflective Practice). Of less importance were Frameworks of Understanding and Systems Advocacy, although these areas were later identified as training needs. Barriers to implementation of competencies related to systemic issues, resource limitations, inflexible and demanding job structures, assumption of knowledge, vulnerability of Consumers and Consumer perceived as the problem.</td>
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<td>Item</td>
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| 3    | To determine education and training needs for the CR workforce | | -Focus Groups  
-Interviews | Several areas of training need were identified in the data:  
- Understanding how CR fits within the overall rehabilitation and disability system  
- Influencing the system and advocating for Consumer rights  
- Undertaking personal and professional evaluation  
- Engaging in collaborative practice  
- Developing complex Consumer engagement skills  
- Developing complex community engagement skills |
| 4    | To develop recommendations for the appropriate delivery of education and training | | -Interviews  
-Stakeholder consultation | Training issues raised by participants included:  
- The importance of life experience  
- That perhaps all CR skills cannot be trained  
- That the purpose of training was not to become an expert  
- That the Consumer is a source of information  
CR practitioners reported the need for a positive attitude to learning. A learning culture within the organisation was considered necessary.  
Major barriers to CR training included  
- Difficulty maintaining individual commitment to professional development (including supervision)  
- Lack of organisational culture to foster training opportunities (and consider CR training a priority over other learning)  
- Need for training to accommodate a range of levels of knowledge and styles of learning  
- That training was motivated by clinical dilemmas  
A flexible approach to learning was also vital, as many practitioners differed in their availability and capacity to attend training opportunities. |
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<td>Participants considered ‘good training’ to include inbuilt opportunities for implementation or part of a larger program strategically placed to ensure implementation. Further training should be considered in the context of career development. Accessibility of information and physical supports was also identified as a barrier to training.</td>
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<td>Facilitators of training included</td>
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<td>o Supportiveness of the broad policy environment</td>
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<td>o Specific workplace practices</td>
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<td>o The role of Consumers and mentoring</td>
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<td>o Increasing the accessibility of training information and opportunities</td>
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<td>o The funding allocation process</td>
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<td>o A coherent framework for CR training and development</td>
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<td>A variety of training methods was used to gather information when needed.</td>
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<td>o Web-site training, databases and on-line documentation or consultation with experts were among preferred means of learning</td>
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<td>o Other preferred methods of training were those that facilitated network sharing, team-based learning and collaborative information sharing</td>
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<td>o Mentoring and on-the-job training was also thought to be of benefit</td>
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<td>o Utilising a combination of learning approaches was considered a useful strategy by CR practitioners</td>
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<td>o Additionally, multi-site learning were regarded as useful ways of extending the practitioner knowledge base</td>
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<td>5</td>
<td>To examine the role of support personnel in CR</td>
<td>What are the current and potential future roles of support personnel in CR?</td>
<td>-Focus Groups -Interviews</td>
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<td>o CR practitioners had limited access to support personnel</td>
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<td>o Support personnel included Personal Care Attendants, Enrolled Nurses, Therapy Assistants, and Allied Health Assistants, Respite workers, Diversional therapists, Masseurs, Physiotherapy Aides, Assistants In Nursing, unpaid volunteers and ATSI Health Workers</td>
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<td>o The main benefit of support personnel was to assist individual CR practitioners and the health system. Benefits of support personnel to Consumers was less highly regarded.</td>
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<td>o CR practitioners focussed on the support role as a way of facilitating their own practice, (e.g. freeing up time, carrying out mundane tasks), rather than enhancing Consumer needs. The most appropriate training opportunities for support personnel should include a combination of methods (formal, informal, on-the-job training), directed and supervised by CR practitioners</td>
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Introduction

Probably in the history of social services no other framework has become as popular in such a short time as Community Based Rehabilitation (CBR) (Dalal, 1998). CBR gained international momentum with the increasing realisation that institutional based services were expensive and failed to adequately integrate people with disabilities into society (Dalal, 1998). CBR is generally described as a form of community development on to which “different components of rehabilitation are grafted” (Tjandrakusuma, 1998, p.1). Although the initial concept of CBR originated in developing countries, some components of the concept have been implemented in developed countries (Finkenflugel, Wolffers & Huijsman, 2005, p 189). The success of the CBR approach lies in its capacity to encourage people with disabilities, their families and the local community to participate in rehabilitation (Tjandrakusuma, 1998).

The term CBR has been defined by the World Health Organisation (WHO, 2002) as:

...a strategy within general community development for rehabilitation, equalization of opportunities and social inclusion of all children and adults with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families and communities and the appropriate health, education, vocational and social service.

CBR is usually focused on equipping, empowering and educating Consumers, families, carers and communities to promote sustained independence and quality of life. The approach is thought to maximise personal agency, physical and mental outcomes, accessibility to resources and opportunities for participation (WFOT, 2003). In terms of practice, Sharma (2005) described CBR as a conceptual paradigm incorporating five principles:

1) Utilisation of available resources
2) Transfer of knowledge
3) Community involvement
4) Utilization and strengthening of referral services and
5) Utilisation of a co-ordinated, multi-sectoral approach.
Taylor, Braveman & Hammel (2004) distinguished CBR from traditional rehabilitation approaches by the fact that it tends to occur within natural community settings using professionals as well as Allied Health Aides or volunteers, utilising programmes aimed at achieving broader social and systemic changes. Most CBR programs are characterised by services that are predominately delivered in Consumer homes rather than in a hospital environment. Further, CBR programs actively promote independence from therapy services by training significant others in the community to deliver rehabilitation.

In their review of CBR in Australia, Doig and Kuipers (2005) recognised that there was no consensus or universal model of CBR. The World Federation of Occupational Therapists also acknowledged that many “different forms of rehabilitation exist, all being called CBR” (WFOT, 2003, p. 4). Indeed, CBR can represent very different services that respond to community pressures and whims without any underpinning of evidence (Enderby & Wade, 2001). Ambiguity and confusion has also emerged because researchers use terms such as CBR and CR or rehabilitation in the community interchangeably (e.g., Bailey, 2005; Sui & Chui, 2003). This diffusion of terms (i.e., particularly between CR and CBR) is complicated by the fact that programs all tend to embrace some aspect of the CBR principles or frameworks for implementation.

Indeed, the operationalisation of CBR is extremely diverse. For instance, Enderby and Wade (2001) identified four CR models in the United Kingdom (UK). These models all involved the use of structured teams of professionals working with a broad range of Consumers with disabilities, but varied considerably in their way of working. Similarly, Geddes and Chamberlain (2001) identified significant variation in stroke home-based rehabilitation teams in the UK, ranging from those engaged in post-discharge CR to long-term support and rehabilitation. They also identified a community approach to rehabilitation that centred around General Practitioners. In discussing CR, Barnes and Radermacher (2001) focused on hospital discharge schemes, hospital-at-home schemes and care/case management approaches. Kneafsy, Long, Reid & Hulme (2004) acknowledged that care/case management is an essential aspect of a community approach as it provides a match between Consumer need and available community skills and resources together with seamless service delivery. It can also deliver increased collaboration between social, health, educational and vocational professionals within a supportive framework of resource allocation and governmental structures.
Clearly, the delivery of rehabilitation in the community can be defined in many and diverse ways, leading to confusion for practitioners. However, irrespective of how it is operationalised, there are several defining characteristics of all CR programs, namely:

- The environment in which services are delivered
- The use of networks to create a complete response to Consumer needs
- The engagement of Consumers in their own rehabilitation.

In CR, components of treatment that have traditionally been provided within a hospital or outpatient environment are provided in the home or community setting with a focus on increasing Consumer independence and health status (Griffiths, Austin & Luker, 2004). As Barnes and Radermacher (2001) noted, rehabilitation has generally been viewed as a hospital-based sub-speciality of medicine or an Allied Health intervention focusing on physical functioning. However, there is now an increased focus on the benefit of providing rehabilitation services in a Consumer’s environment to promote community integration and holistic assessment (Doig & Kuipers, 2005).

It is also generally agreed that CR is implemented through the development of strong interrelationships between families, communities, people with disabilities and the appropriate health, education, vocational and social services (Kendall, Buys & Larner, 2000; Kuipers & Quinn, 2003; WFOT, 2003). This networking can manifest in opportunities for continuous family training, education and involvement, improved accessibility to services for caregivers and enhanced co-operation between family members and service providers (Doig & Kuipers, 2005). Similarly, Crocker and Heslop (2001) concluded that all CR programs should promote the full inclusion of Consumers into their communities and engage all stakeholders to take an active role in that process in a way that respects people with disabilities.

Despite these commonalities, a consistent approach to CR programs and understanding of CR continues to be elusive. In the UK, CR has “grown like Topsy” even though there is no commonly used phrase, definition or common meaning (Enderby & Wade, 2001, p. 580). Indeed, CR is seen as pivotal in the reformation and modernisation of health care in the UK. However, researchers have emphasised the need to identify the correct
philosophies, guidelines and competencies that can support its appropriate implementation. By defining clear parameters for CR practitioners, services can be delivered efficiently and effectively while meeting the needs of the community.

The Looming Crisis and the CR Response

“It is widely recognised across Australia that the health system is struggling to maintain and respond to the health and well-being of our communities” (Telfer, 2004, p.1).

This situation has largely arisen as a result of workforce shortages, geographical dispersion, changing demographics, technological innovation and an increasingly market-driven health system. Queensland Health (QH) (2002) is also facing significant challenges created by current health trends, such as increased life expectancies, a shift from acute to chronic conditions, higher levels of anxiety and depression, obesity and drug use. In the USA, Mertz (2001) has suggested that there is also “a national crisis looming” (p.1) in the delivery of adequate health to communities. Similarly, Enderby and Wade (2001) noted that growing demand for hospital beds, especially for the elderly and people with disabilities has created significant concerns in the UK. According to Barnes and Radermacher, (2001), health systems are facing pressure to provide more resources in the community to counterbalance the cost of hospital services. Systems are increasingly questioning the emphasis that has been placed on high-cost, technologically-based treatment that is delivered in institutions, particularly as these models of care only meet the needs of a proportion of Consumers (Hoge et al., 2005). These forces have, therefore, increased the popularity of approaches such as CR, because they have the potential to address many of these challenges by promoting efficient use of community resources.

The Australian health workforce must be able to address the demands of a changing society and respond to the health and well-being needs of our communities. However, the system is currently struggling to maintain a workforce and there is little doubt that we are facing impending shortages in the health system (Lowe & O’Kane, 2003; Telfer, 2004). Globally, considerable demand is being placed on the Allied Health and Nursing workforce. Many countries, including Australia, are rethinking service configurations and redesigning work roles to accommodate these demands (Enderby & Wade, 2001; Mertz, 2001; Telfer, 2004).
Geographically, Australia is experiencing a rapid spread of its cities, leading to densely populated outlying areas that are not well serviced in terms of the health system (Lowe & O’Kane, 2003). The sustainability and capacity of current health services to meet the needs of these communities has been questioned (Lowe & O’Kane, 2003; Vindigni, Parkinson, Walker, Rivett, Blunden & Perkins, 2005). Further, it has been widely acknowledged that we must look to new models of service delivery and workforce structures that can be responsive to the health needs of our communities (Battye & McTaggart, 2003; Tefler, 2004).

The shortage of a health workforce is most apparent in rural and remote areas of Australia. In addition, it has been recognised that Australia’s Indigenous health system is under enormous pressure, with Indigenous health professionals representing only 0.9% of the health workforce (Productivity Commission, 2005). This figure is disproportionate to the significant representation of Indigenous people with disabilities in the population (Kendall & Marshall, 2004). In Queensland, rural and remote regions accommodate 48% of the population, but only 34% of the Allied Health professional workforce (Lowe & O’Kane, 2003). Other research in Australia’s rural and remote communities has revealed shortages in most health professions. According to a survey of health units in country South Australia, vacancy rates for Physiotherapists were (28%) and (19%) for Occupational Therapists (Tefler, 2004). This has lead to lobbying for an increase in the number of University places in South Australia, however, was unsuccessful.

Innovative solutions are required to ensure that our Allied Health and Nursing workforce can respond appropriately to disability and rehabilitation needs in the future. To address this concern and ensure the provision of a sustainable health service, the Australian and State Governments are investing significantly in attracting a health workforce (Ford & McIntyre, 2004; Tefler, 2004). Some Australian States have undertaken initiatives to improve the rural and remote Allied Health and Nursing workforce situation, such as providing support programs, professional development packages, undergraduate bonded scholarships and innovative training and educational pathways (Lowe & O’Kane, 2003; Tefler, 2004). However, innovative use of models such as CR may also be a feasible solution to this shortage.
Other influences on CR are the significant advances that have occurred in communication technology, internet communication and web-based learning. These technologies have enabled new models of service delivery to be considered (Mertz, 2001; Murtaugh, Pezzin, McDonald, Feldman & Peng, 2005). Telerehabilitation is gaining momentum as a method of service delivery that is convenient and cost effective (Cox, Amsters & Pershouse, 2001). Technology-driven changes in biomedical science continue to promise reduced healthcare costs. They also continue to provide the means by which rehabilitation can shift from institutional to ambulatory settings (Mertz, 2001).

Not only does technology benefit service delivery in the community, but Consumers themselves have become increasingly “technology-savvy” (McMeeken, Webb, Krause, 2005; Queensland Government, 2002), which raises expectations about the way in which information and support might be gathered. This shift has occurred as a result of greater emphasis on Consumer empowerment and self-management (Doig & Kuipers, 2005). For advocates of the social model of disability and the independent living movement (Oliver, 1996), CR is now acknowledged as an approach that may bring about a shift in the philosophy that underpins rehabilitation service provision. CR may offer a strategy for equalisation of opportunities and social integration of people with disabilities.

Enderby and Wade (2001) argued that the conceptual confusion associated with CR has meant that limited evidence is available to demonstrate its effectiveness. Nevertheless, a few empirical studies have shown that a community-based approach to rehabilitation can reduce length of hospital stay without any detrimental impact on functional and social outcomes. In fact, some studies (see Doig & Kuipers, 2005 for a review) have shown that participants in community programs reported higher levels of social activity and independence than those in traditional programs, resulting in psychological benefits for Consumers and cost savings for the system. Although scant, this type of evidence suggests that CR models may enhance the effectiveness of our strained health systems and reduce long-term cost.

Thus, there is evidence that the current health workforce cannot meet the demands of our increasing, diverse and ageing population, a population that is expecting greater control over their own healthcare and is being encouraged to adopt the principles of self-management. Technology in communication and mobility is allowing
new models of service delivery to be explored at a time when health systems, in particular in rural and Indigenous areas, have been found to be inadequate. Together, these trends have created a favourable situation for CR, enabling it to be recognised as a way of accommodating the changing patterns of health and social care needs in Australia (Kneafsey, Long & Ryan, 2003).

**Can CR Respond to the Crisis?**

Given its relatively new status in Australia, and many other countries, there are no identifiable CR practitioners. Instead, practitioners from a range of disciplines have tended to adopt different components of CR as dictated by their values, preferences or working arrangements. As a result, the implementation of CR has depended heavily on individual practitioners within the rehabilitation system, usually those who value Consumer-centred practice and are able to overcome any barriers in their working environment. CR has, therefore, been applied in Queensland without consistent guidelines based on a cohesive model of CR practice. As a result, it has faced ongoing barriers to implementation, including lack of resources and training.

An important question about the implementation of CR in this context concerns the diversity of skills, knowledge and frameworks that are currently guiding CR practices. If CR is to be implemented as a consistent model that can address the difficulties in the current approach to rehabilitation, it is necessary to understand the competencies that are present in the workforce and adopt a coherent approach to this issue. The current demand for performance, accountability and quality in service delivery provides the impetus for standards, polices and guidelines for Allied Health and Nursing practitioners who engage in CR (Hoge et al., 2005). More than ever before, there is greater emphasis on the capacity of health systems to improve the competencies of their workforce.
What are competencies and why are they important?

Health professions have their origins in the Middle Ages and represent the earliest examples of regulation of an occupational group (Pearson, Fitzgerald, Walsh & Borbasi, 2002). Professionals in most Western countries are now regulated by the State through legislation (Pearson et al., 2002). Regulatory authorities have been established in most disciplines and are responsible for setting standards for admission to the profession (Pearson et al., 2002) and ensuring that professional members maintain an approved level of competence in particular areas. In this context, competency standards provide a “clear statement of what is considered to be important in competent performance in that profession” (Heywood, Gonczi, & Hager, 1992 cited in Pearson et al., 2002, p.359). It is in the interests of the profession to promote competency standards as competent practitioners are likely to facilitate high-quality care that improves Consumer outcomes (Young, Forquer, Tran, Starzynski, & Shatkin, 2000).

As Bradshaw (1998) noted, competencies and competence, represent distinct concepts that are often confused. Competencies are job-related, referring to a person’s capacity to meet the requirements of a job. In contrast, competence is person–related, meaning the underlying ability of individuals to deliver effective performance in a job. Therefore, competencies can be understood as aspects of the job that an individual can perform and competence can be understood as an individual’s behaviour underpinning competent performance. “Competence is not only acquired through training, but also requires personal characteristics such as flexibility, common sense, problem-solving ability and compassion” (Hoge et al., 2005, p. 607).

Competencies are critical to the development of a profession because they provide consistent recognition, accreditation, and equitable assessment processes, articulated training and career progression within occupations across Australian States and Territories (Pearson et al., 2002). Competencies also define how practitioners are expected to assess, treat, and interact with Consumers. They offer the potential to improve performance and outcomes by providing a platform for training and supervision of practitioners as well as providing structure for recruitment and profiling of workforces.
Further, competencies provide a frame of reference about the expectations that are “reasonable in community settings and have mutual agreement from healthcare organisations, clinicians, and Consumers” (Young et al., 2000, p.322). Therefore, competencies should reflect performances in typical community settings as well as representing the diversity that exists among practitioners (Young et al., 2000).

However, the most important feature of competencies is that they can influence the design of programs by promoting or preventing critical reflection about practice. The presence or absence of particular key competencies can impact on the development of practitioner networks that, in turn, propagate models of practice. Over time, the nature of the entire workforce can be altered through the impact of competencies on recruitment methods and preferences. Consequently, the development of appropriate CR in Queensland depends critically on the existence of relevant competency standards.

Competencies are generally described as attitudes, knowledge and skills that are causally related to effective job performance and influence the delivery of care (Young, 2005). In this project, QH have adopted the World Health Organisation definition of competencies, namely “the skills, abilities, knowledge, behaviours and attitudes that are instrumental in the delivery of desired results and/or consequently of job performance”. Competencies incorporate specific practical skills and knowledge, but also include general professional abilities and culturally or contextually-specific components. Some of the competencies associated with any profession will be core and common across professionals, whereas others will be unique, specialist or specific to that discipline. Each identified competency should be linked to indicators by which its presence or absence can be determined.

The competencies of the CR workforce are pivotal to the realization of full inclusion, empowerment and self-management for Consumers within the community. Telfer (2004) recently emphasised the importance of supporting and maintaining a competent CR workforce in an environment of increasing demands and changing models of service delivery. Given that the health environment fosters a diversity of practices, Travis (2002) stressed the importance of structures that support consistent, reliable and optimum service delivery.
In this regard, Kuipers and Allen (2004) highlighted the need for all Allied Health practitioners to operate from a consistent framework of primary healthcare theory. Allied Health and Nursing practitioners currently operate from the competency base derived through their core discipline (e.g., Physiotherapy, Speech Pathology, Occupational Therapy, Nursing). For those involved in CR, however, some important competencies are likely to emerge only from experience and post-qualification training. To some extent, Allied Health and Nursing professions identify competencies that align with CR principles, namely promotion of community integration, collaborative partnerships, care delivery models based on Consumer needs, cultural competence and adoption of technology (Mertz, 2001). For instance, the stated goal of Rehabilitation Nursing professionals is to provide, in collaboration with an interdisciplinary healthcare team that includes the Consumer, a holistic approach to Nursing care that maximizes the Consumer’s independence and mastery of self-care activities (Association of Rehabilitation Nurses, 2005). The National Competency Standards for Registered Nurses (2002) reflect the contemporary role Nurses currently play in the health system and the complex nature of Nursing activities within different environments (Australian Nursing and Midwifery Council, 2002).

In relation to Speech Pathology, the Scope of Practice describes the skills, knowledge, attitudes and ethical behaviour expected of its members (Speech Pathology Australia, 2002). The guidelines identify competencies in collaboration, assessment, goal setting, Consumer/family education and support and advocacy, delivered in a variety of contexts (including community and home settings) and service approaches that include multidisciplinary, inter-disciplinary, trans-disciplinary, holistic and collaborative frameworks (Speech Pathology Australia, 2002).

Occupational Therapy aligns most closely with the principles of CR. For instance, the World Federation of Occupational Therapy (WFOT, 2003) contains reference to the competencies required to facilitate CBR programmes that address human rights issues and promotes inclusive communities. According to WFOT, Occupational Therapists foster empowerment and use their practice to satisfy the personal needs and full citizenship of their Consumers. WFOT (2003) also urges its members to act as social change agents to encourage enablement, advocacy and social reform for their Consumers. However, these competencies are not necessarily reflected in the entry-level standards.
The Australian Physiotherapy Association (APA) Code of Conduct in their preamble, describe Physiotherapy as “a holistic approach to the prevention, diagnosis of disorders of human movement to enhance the health and welfare of the community” (2001, p.1). All APA Members are guided to work towards justice in the community, planning and implementation of services designed to provide optimum health care for the community. The APA has stated that the practice of Physiotherapy is so extensive that competency standards are prepared for entry-level only (Australian Physiotherapy Association, 1994). However, McMeeken, Webb and Krause (2005) have acknowledged that changes in health care delivery have encouraged Physiotherapists to give greater emphasis to community processes. For the most part, however, training for Physiotherapists focuses on their ability to diagnose and treat specific physical conditions.

To address the inconsistency of the competencies across the disciplines that are involved in CR, a set of core competencies must be established specifically for CR practice. These competencies must transcend all professional fields and reflect the uniqueness of CR service delivery. Although competency standards are unable to identify all facets of a profession, they present a clear statement of the level of functioning that is considered to be competent performance in that area (Heywood, Gonczi & Hager, 1992). Most importantly, clear statements about the competencies that are expected within a specific area will facilitate competence-based assessment of current CR practices (Pearson et al., 2002).
Training Issues in Professional Education

The performance of health care systems depends ultimately on the skills, behaviours, knowledge and motivation of the people responsible for delivering services (WHO, 2000). Many experts see lack of investment in the human resources as one of the most significant problems facing health systems in future (Eldis, 2005, p.2). To provide and maintain a health workforce, is it important to realise that “knowledge does not deteriorate with use, but old skills do become obsolete...” (WHO, 2000, p. 76).

Several researchers have indicated the need for changes to educational curriculum to accommodate and facilitate CR. For instance, Kendall, et al. (2000) discussed the importance of educating workers about CR and its central constructs of empowerment and inclusion to facilitate its appropriate implementation within the community. This type of education was seen as being essential and more constructive than continuing to socialise students into traditional practices (Kendall et al., 2000). Kuipers and Allen (2004) stated that the core principles of equity, justice, community capacity and trust should be more clearly operationalised for training purposes. Similarly, the WFOT (2003) acknowledged the importance of educating their professional members to provide CR, thus recognising that CR necessitates specific competencies that may not be delivered by current professional training curricula. However, at the same time, concerns are being expressed in many disciplines about the increasing amount of content required to be included in curricula and the challenges of preparing students to practice in increasingly complex work environments (McMeekan et al., 2005).

Although many of the core competencies and principles of CR are present in the major Allied Health and Nursing curricula, there are few undergraduate or post-graduate training programmes internationally that are specific to CR. At a post-graduate level, Farkas and Anthony (2001) noted that educating such a diverse range of rehabilitation personnel to deliver CR requires an extremely clear curriculum that unites students, regardless of their discipline or background characteristics, around a single mission and philosophy.

Similarly, Mertz (2001) advocated for a shared scope of practice among Allied Health and Nursing to create a common competency based approach to CR training. However, Crocker and Heslop (2001) also noted the importance of selecting rehabilitation professionals who have the necessary values and beliefs to support
community inclusion, opportunity for growth and development and citizenship. “There is a recognition that people with disabilities are best served by competent staff who not only have the right values but have the right competencies” (Crocker & Heslop, 2001, p. 17). In this regard, they commented on the fact that we should not “push people out of the system who have the ‘right stuff’ [for CR] but may not have formal training” (2001, p. 18).

Irrespective of the level of qualification of the practitioner, professional development is an approach to learning that involves the planned and continual development of an individual throughout their career. It requires commitment and adequate resources from the individual, the employer and professional institutions (Young, 1995). Broomfield and Humphris, (2001), who researched continuing education frameworks for General Practitioners (GP), found that they failed to meet the current educational needs of practising GPs. It was found that GPs benefited from adopting a problem-based learning approach that promoted self-directed study on optional subjects in a learning environment of curiosity and critical evaluation. Current research has also suggested that attendance at many postgraduate education accreditation courses is relatively poor, even though most practitioners regard knowledge and skill updating as being an important activity (Broomfield & Humphris, 2001).

Principles of Adult Learning

Historically, education has been based upon a traditional didactic approach to learning (Broomfield & Humphris, 2001). Academic programs can easily provide introductory expertise through this didactic teaching of skills and demonstrating them in a role-play or simulated setting. However, fifty years ago, Lorge (1947) first voiced the fact that adults required different educational strategies to children. He stated that adults have “wants” in four major areas that drive their learning experience, namely, to gain something, to be something, to do something or to save something. It is important to acknowledge that adults vary enormously in how they acquire knowledge. Consequently, “no one theory of adult learning can adequately address the diverse needs, experience and cultures that adults bring to the learning environment” (Elias & Marriam, 1995; cited in Stroot et al., 1998, p. 1).
Learning can be divided into three domains: cognitive, psychomotor and affective. The cognitive domain is based on knowledge, including fact, understanding and application. Delivery of training in this domain is typically based on lectures and presentations. The psychomotor domain is skill-based and includes the processes of imitation, practice, and habit. Finally, the affective domain is based on behaviour and beliefs. This domain involves processes such as awareness, distinction, and integration (De Fink, 1999). All learning experiences should draw on each of these domains and all the processes that underlie them.

Stroot et al. (1998) also identified that adults prefer flexible training schedules that respond to their own time constraints. They generally learn better when learning is individualised but cooperative and interactive, practical, and based on problem-solving. Adults also prefer learning that allows them to process their experience through reflection, analysis and critical examination. They seem to benefit from active participation in the learning process and teaching methods that increase their autonomy.

According to Kolb’s (1984) experiential learning model, individuals exhibit a preference for particular learning behaviours that can be categorised into four distinct styles: convergers, divergers, assimilators and accommodators. Convergers acquire knowledge by thinking and analysing; divergers acquire knowledge through intuition; assimilators have the ability to create theoretical models and reason inductively; and accommodators will discard theory if the facts do not seem to fit (Stroot et al., 1998). Linares (1999) found no significant differences in learning style among students and staff in Nursing and Allied Health, but noted that the convergent style of learning was most prevalent. Convergers were more self-directed in their learning than those who adopted other learning styles (Linares, 1999, p. 407).

Given the presence of convergent and analytical approaches to learning among the health professions, it is not surprising that the concept of evidence-based practice (EBP) has been widely accepted as a guide for interventions (Stevenson, Lewis & Hay, 2004). However, in a recent study, Physiotherapists reported that they primarily relied on courses and in-service training for information about their clinical practice. Most agreed that their practice should be guided by EBP, but ascribed low priority to literature, journals and research as a learning tool. The study revealed that even though Physiotherapists were supportive of EBP they remained reluctant to change their practice in accordance with research literature. Turner and Whitfield (2001) confirmed that “research literature ranked least in importance as a basis for choosing techniques” (p. 17) among a range
of health professionals. Gosling and Westbrook (2004) showed that health professionals will make use of an online evidence system if it is provided, but usage patterns varied across the professional groups.

**Professional Development Issues in CR**

In relation to CR, Mertz (2001) discussed the need for training and education that promoted competencies such as community integration, collaborative partnerships, delivery models based on Consumer needs and service delivery preferences, new professional and practice models, cultural competency and technology adoption. In another study, practitioners in CR requested training that was linked to their job profile and function, and to the needs of the Consumers they served. These practitioners suggested that individualised training plans be developed, together with a passport system that identified the competencies and training that was required by each practitioner (Crocker & Heslop, 2001). There was also strong support for the inclusion of people with disabilities and their families as facilitators or instructors in specific areas.

Telfer (2004) noted that training programs must also be designed to respond to the innovative service delivery models required by CR practitioners and support personnel in rural, remote and Indigenous communities. In particular, training frameworks need to accommodate students who may not be interested in traditional university pathways that require them to leave their family and community. Alternative learning pathways that offer local career development and training opportunities through schools, TAFE, tertiary health studies and specific professional degrees could be considered.

**Summary**

The 21st century brings new challenges to training providers and universities who are responsible for the preparation of a health professional workforce for the future. Training institutions need to respond more effectively to the demands of the changing health environment and keep pace with new models of service delivery. Health care reforms and policy changes have significantly influenced health care delivery over the last decade, and one result has been a growing acknowledgment of CR as a model of choice. Implementation of CR will require major changes to existing health professional competencies and educational frameworks. In particular, it has been noted that there will be “transformation of the specialized Allied Health professional into a
multi-skilled, multi-layered health care provider” (Blasini-Caceres & Cook, 1997, p. 67). Universities, training providers and practitioners can no longer rely on their “skills of old” to practice in today’s market place. Significant consultation is required among practitioners, policy makers, unions, Consumers, training and educational institutions and professional associations to support this transformation. Significant issues to be addressed will include industrial ramifications, community backlash and professional territorialism. However, as Telfer (2001) noted, the risk of failure can be minimised with early involvement of all parties in the development of a solution and close collaboration throughout the implementation process. As Mertz (2001) suggested, it is time to re-evaluate the fundamental properties of work, education and professional development in light of the trend towards CR. If we are flexible and adventurous with our thinking, the new models that develop will support the implementation of CR.

The current health and community care landscape emphasises the need for an effective workforce that is able to maximise Consumer outcomes. If CR is to respond appropriately to the future needs of Consumers and health professionals, it is necessary to review the competencies CR practitioners will require in order to do their work, and evaluate the competencies that are present in the current workforce. Training must be informed by these competencies and reflect preferred styles and methods of learning. The current Education and Training Audit seeks to address these issues, using a collaborative and recursive approach to data collection.
Methodology

This project utilised multiple methods to gather data that would address the research questions, namely Focus Groups, expert panels, Interviews and a survey. Although the methodology was largely determined by the project brief, there was scope to work collaboratively with the reference committee to ensure that the research questions could be answered adequately. This section of the report describes the method that was developed to examine these questions.

Definition of Competencies used in this Project

For this project, competencies have been defined as including three component parts, namely knowledge, skills and attributes, as suggested by Watson, Stimpson, Topping and Porock (2002). The specific definitions provided by Aubry, Flynn, Gerber and Dostaler, (2005) were adopted as follows: Knowledge can comprise general knowledge, specific knowledge about CR and/or knowledge about injury and illness. Skills can include work practices such as relationship and communication skills, individual assessment and planning skills and advocacy skills. Personal attributes relate to values and attitudes in addition to personal characteristics.

Overview of Recruitment Processes

This project included participants from a diverse spread of Allied Health, Nursing and support personnel across Queensland. First, an extensive list of key professionals and organisations within CR was generated by the Project Officer and QH Project team. To ensure representativeness and appropriateness of the list, it was checked by all members of the reference committee. Participants for the Focus Groups and Interviews were selected from this list of potential participants. The survey was sent to the entire participant list, together with instructions to forward the survey to any other relevant CR practitioners of whom they were aware. In sample selection, several principles were maintained. First, recruitment was designed to ensure adequate representation from each QH Zone, namely Northern, Southern and Central. Within these Zones attention was given to the inclusion of organisations from rural/remote and metropolitan areas, Indigenous communities, government and non-government services, QH districts and different types of CR services. At the individual participant level, attention was given to gender, professional background, managers and practitioners and experience levels.
For the purpose of this project, the Rural, Remote and Metropolitan Area (RRMA) classification system was used and participants were recruited to represent all areas as shown below.

**Table 1: Rural, Remote and Metropolitan Area (RRMA) classification system**

<table>
<thead>
<tr>
<th>Metropolitan Zone</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Capital cities e.g., Brisbane</td>
<td></td>
</tr>
<tr>
<td>2 - Other metropolitan centres e.g., Gold Coast</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rural/Regional Zone</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3 - Large regional centre / urban centre population of 25 000 to 99 999 e.g., Cairns</td>
<td></td>
</tr>
<tr>
<td>4 - Small rural centre / urban centre population 10 000 to 24 999 e.g., Roma</td>
<td></td>
</tr>
<tr>
<td>5 - Other rural area / urban centre population &lt; 10 000 e.g., Dalby</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Remote Zone</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - Remote centre / urban centre population &gt; 5000 e.g., Goondiwindi</td>
<td></td>
</tr>
<tr>
<td>7 - Other remote centre / urban centre population &lt; 5000 e.g., Injune</td>
<td></td>
</tr>
</tbody>
</table>

Initial contact was conducted either by ‘cold calling’ key personnel identified in these organisations (or the organisation’s central telephone number) or by emailing the project information pack to prospective participants (letter of introduction and two project information sheets) (see Appendix A). Participants were first requested to participate in a Focus Group discussion, but if they were unable to do so, were invited to participate in an Interview or survey at a later stage in the project.

Participants who expressed interest and agreed to participate in the project in any way were sent additional information in the form of preparatory reading, outlining the specific aims, working definitions, and prompt sheets to facilitate consideration of their case study experience. Details of each of the participant groups are shown in Table 2.
### Reference Committee

**AIM: To foster collaborative decision making among stakeholders**

The Reference Committee comprised key QH personnel employed on the Competency Audit (e.g., Project Officer, Advisors and Managers), significant executive staff members of QH in critical areas such as Allied Health and Indigenous health workforce, and a Consumer Advisor. This committee was central to the competency development process, and were consulted at key decision points over the course of the project on matters pertaining to recruitment, survey design, analysis, and reporting.

### Focus Groups

**AIM: To develop competencies for CR**

The Focus Groups were intended to inform the development of an Interview protocol and survey. They were aimed at determining the prevalent conceptualisations of CR and producing first-level agreement about the competencies required to deliver CR across a range of contexts. Five Focus Groups were conducted, metropolitan (RRMA Zones 1 and 2 – see below) Indigenous and non-Indigenous regional (RRMA Zone 3), Indigenous and non-Indigenous rural/remote (RRMA Zones 4 to 7). The regional Focus Group also consisted of some participants who provided outreach to RRMA Zones 4 to 7, but the majority were focused on RRMA Zone 3 service delivery). For analysis, the two Indigenous groups were collapsed, leaving four major groups (metropolitan, regional, rural and Indigenous).

A total of 50 participants took part in the Focus Groups. Seven contacts refused any participation in the project (one organisation, six individuals (three females, three males). A further seven participants who agreed to

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**Table 2: Summary of Participants in Each Component of the Project**

<table>
<thead>
<tr>
<th>Community Audit Participants</th>
<th>(n=190)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference Committee</td>
<td></td>
</tr>
<tr>
<td>QH Project Officers</td>
<td>4</td>
</tr>
<tr>
<td>Significant QH Executives</td>
<td></td>
</tr>
<tr>
<td>and GU Researchers</td>
<td></td>
</tr>
<tr>
<td>Focus Groups</td>
<td>50</td>
</tr>
<tr>
<td>Interviews</td>
<td>58</td>
</tr>
<tr>
<td>Consumer Panel</td>
<td>9</td>
</tr>
<tr>
<td>Expert Panels</td>
<td>19</td>
</tr>
<tr>
<td>Survey Round 1</td>
<td>10</td>
</tr>
<tr>
<td>Survey Round 2</td>
<td>40</td>
</tr>
</tbody>
</table>

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**QH Project Officers**

Reference Committee

AIM: To foster collaborative decision making among stakeholders

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**Focus Groups**

AIM: To develop competencies for CR

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A total of 50 participants took part in the Focus Groups. Seven contacts refused any participation in the project (one organisation, six individuals (three females, three males). A further seven participants who agreed to
participate in Focus Group discussions failed to attend for unknown reasons (two metropolitan, one regional, and four Indigenous). The inclusion of a selection of community Elders in the Indigenous Focus Groups was also an important factor in gaining depth of understanding of Indigenous issues and support for the project. The Focus Group participants discussed their conceptualisation of CR, the types of competencies required to deliver CR in their region and any issues or challenges they faced (see Table 3 for Focus Group Protocol). Discussions each lasted approximately two hours and the discussion was transcribed verbatim for later analysis. (See Table 4 for Focus Group Participants).

Table 3: Summary of Focus Group Protocol

<table>
<thead>
<tr>
<th>Question</th>
<th>Additional Prompts if Necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you describe CR?</td>
<td>Consider how you would describe CR if you were to explain it to others who had no knowledge of CR</td>
</tr>
<tr>
<td>What is the purpose of CR? What makes CR different to other contexts?</td>
<td>The following definition may be used as a prompt for discussion, ‘CR seeks to equip, empower and provide education and training for rehabilitation Consumers, family, community members and the community sector to take on appropriate roles in the delivery of health and rehabilitation services to achieve enhanced and sustainable Consumer outcomes’. What does this mean for you in your practice?</td>
</tr>
<tr>
<td>Describe the types of support roles you have come across in your CR work?</td>
<td>How was this support role beneficial to your work and to the Consumer? What other support role would you like to see in CR? Why? How would these potential roles address current gaps in service delivery?</td>
</tr>
<tr>
<td>Think about your best and worst Consumer outcomes in your role as an Allied Health or Nursing practitioner in CR. List the knowledge, skills or attributes that helped you, or would have helped, you manage.</td>
<td>What factors do you feel helped / hindered you carrying out your role? Factors might be specific to your role in CR or more general to Allied Health and Nursing. Think about practitioners you know who are not competent in CR – what would help them to do a better job in CR?</td>
</tr>
</tbody>
</table>

Table 4: Focus Group Participants (Health Practitioners)

<table>
<thead>
<tr>
<th>ID</th>
<th>Location</th>
<th>M/F</th>
<th>Position</th>
<th>Service District</th>
<th>Hospital or Community Based</th>
<th>Public or Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Metropolitan</td>
<td>F</td>
<td>Community Health Nurse</td>
<td>Central</td>
<td>Community Ngo</td>
<td>Public</td>
</tr>
<tr>
<td>2</td>
<td>Metropolitan</td>
<td>F</td>
<td>Nurse</td>
<td>Central</td>
<td>Community Ngo</td>
<td>Public</td>
</tr>
<tr>
<td>3</td>
<td>Metropolitan</td>
<td>F</td>
<td>Occupational Therapist</td>
<td>Southern</td>
<td>Community Ngo</td>
<td>Public</td>
</tr>
<tr>
<td>4</td>
<td>Metropolitan</td>
<td>F</td>
<td>Physiotherapist</td>
<td>Southern</td>
<td>Community Ngo</td>
<td>Public</td>
</tr>
<tr>
<td>5</td>
<td>Metropolitan</td>
<td>F</td>
<td>Senior Occupational Therapist</td>
<td>Southern</td>
<td>Hospital Ngo</td>
<td>Public</td>
</tr>
<tr>
<td>6</td>
<td>Metropolitan</td>
<td>M</td>
<td>Management/Allied Health</td>
<td>Central</td>
<td>Hospital Ngo</td>
<td>Public</td>
</tr>
<tr>
<td>7</td>
<td>Metropolitan</td>
<td>F</td>
<td>Senior Physiotherapist</td>
<td>Southern</td>
<td>Community Ngo</td>
<td>Public</td>
</tr>
<tr>
<td>8</td>
<td>Metropolitan</td>
<td>F</td>
<td>Occupational Therapist Team Leader</td>
<td>Southern</td>
<td>Hospital/ Community Ngo</td>
<td>Public</td>
</tr>
<tr>
<td>No.</td>
<td>Region</td>
<td>Gender</td>
<td>Position</td>
<td>Location</td>
<td>Position Type</td>
<td>Employment Type</td>
</tr>
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<td>-----</td>
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<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>9</td>
<td>Metropolitan</td>
<td>F</td>
<td>Occupational Therapist</td>
<td>Central Community</td>
<td>Public</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Metropolitan</td>
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Interviews

AIM: To understand the application of competencies, training needs and role of support personnel

The Interviews focussed on competencies and their application to practice. In addition, the Interviews explored practitioners’ education and training needs, issues associated with training and the role of support personnel in CR. Participants were randomly selected from among those who had not participated in the Focus Groups and the same principles for sampling were used (i.e., representativeness). Participants responded to the structured questions shown in Table 5. Fifty-eight Interviews were conducted with CR practitioners, managers and support personnel across Queensland (see Table 6).

Table 5: Summary of Interview Protocol

<table>
<thead>
<tr>
<th>Question Domain</th>
<th>Example Question</th>
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<td>Defining CR</td>
<td>What is the purpose of CR from your perspective? What makes CR different to other forms of rehabilitation? Here is the definition of CR that is being used at present is provided by WHO (present WHO definition). Do you think it is useful? Does it accurately describe the field of CR?</td>
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<td>Understanding of Competencies</td>
<td>What do you think makes you competent in CR? Anything else? Can you think about someone you know who is NOT competent in CR – what are they lacking? What would help them to be better at CR? Are there times when you have felt incompetent or ineffective in your practice as a CR practitioner? What did you wish you had then to help?</td>
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<tr>
<td>CR in Practice</td>
<td>Think about your best and most positive example of CR from your recent work in your role as an Allied Health or Nursing professional practicing in CR. Briefly describe how you worked with this person.</td>
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<td>Training Issues</td>
<td>Think about the range of competencies you have just described - what are the education and training needs for CR practitioners to acquire these competencies? How do you think each of these needs is best learned? Can they all be learned in the same way?</td>
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<tr>
<td>Support Personnel</td>
<td>Are there other support personnel you work with to bring about CR outcomes (comment on specific mention of support roles if made earlier)? Describe the types of support roles you have come across in your CR work. How were these support roles beneficial to your work? and to the Consumer? What is the role of support staff in CR? What should they do? How should they be trained?</td>
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Table 6: Interview Participants

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AIM: To understand Consumer conceptualisations of CR

To ensure that the findings of the study were related to the experiences and perceptions of Consumers, an expert panel of Consumers was gathered. One Indigenous Consumer and two consumers with spinal injuries were unable to attend the group. The Consumers were identified by peak organisations with relevance to CR populations, including rural and remote, Indigenous, acquired injuries such as spinal, brain and visual injury, and chronic diseases such as stroke and arthritis, as well as general aged care services. Each organisation was requested to select a Consumer who would be comfortable discussing CR in a group format. Nine Consumer representatives (7 females, 2 males) participated in the discussion, consisting of Consumers and Carers. One participant was a Consumer Advocate for aged services who did not personally have a disability. See Table 7 for a full description of the sample.

Table 7: Participants in the Consumer Panel

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<td>F</td>
<td>Consumer</td>
<td>Rural and remote health</td>
</tr>
<tr>
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<td>M</td>
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<td>F</td>
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<td>Stroke group</td>
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<td>F</td>
<td>Consumer</td>
<td>Aged and Community Service</td>
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<td>F</td>
<td>Consumer</td>
<td>Stroke group</td>
</tr>
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<td>Carer and Consumer</td>
<td>Indigenous community</td>
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<td>M</td>
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<td>Metro</td>
<td>F</td>
<td>Consumer</td>
<td>Not relevant</td>
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</table>
The Consumer group discussion was initially intended to focus on specific competencies and elicit experiences of Consumers with that competency. However, it quickly became apparent that the competency structure was meaningless to Consumers. Accordingly, the discussion was modified to allow Consumers to discuss CR in an unstructured way (see Table 8 for Consumer Group Protocol). The discussion was audio-recorded and scribed for analysis.

### Table 8: Consumer Group Discussion Protocol

<table>
<thead>
<tr>
<th>Question Domain</th>
<th>Example Question</th>
</tr>
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<tbody>
<tr>
<td>Defining CR</td>
<td>What does CR mean to you? What are the principles of CR?</td>
</tr>
<tr>
<td>Understanding of Competencies</td>
<td>What does/did your rehabilitation team look like? (Who makes up your rehabilitation team)? Do/did these people work together (sharing information, etc...) on your behalf?</td>
</tr>
<tr>
<td>Competency Barriers and Gaps</td>
<td>In an ideal world, what type of support would you have liked to assist you when you left hospital and returned to the community? There are many ways of thinking about disability that have implications for the way rehabilitation providers work with you and/or treat you. In an ideal world, how would you have liked your rehabilitation providers to think about disability?</td>
</tr>
</tbody>
</table>

### Expert Panels

**AIM: To develop specific competency statements and refine conclusions**

A purposively selected group of recognised CR experts representing key government, non-government and academic interests were invited to participate in the development and review of the competency items. In accordance with the iterative data collection method stipulated by the Delphi technique, it was important to include this input from independent experts regarding the format and grouping of the final competency statements. Experts were required to develop statements of competencies from the Focus Group data, to check and validate each competency item prior to final survey dissemination, consider the appropriateness of the item wording, and the adequacy of representation of key CR concepts.

The expert panel consisted of the QH CR project team and the Griffith University research team. Participants were also invited to join the expert panel if they had national or international recognition as an expert in CR (i.e., peer-reviewed publications in this area), extensive experience as a CR practitioner or educator, recent experience of the CR process as a Consumer/Carer and advocate. Sub-panels were constructed to represent
the specific interests of relevance to the project (e.g., rural/remote, Indigenous, metropolitan, conceptual). The composition of the expert panels is shown in Table 9 below.

Table 9: Membership of the Expert Panels

<table>
<thead>
<tr>
<th>Metropolitan</th>
<th>Rural/Remote</th>
<th>Indigenous</th>
<th>Regional</th>
<th>Conceptual</th>
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<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The Metropolitan expert panel comprised Senior Rehabilitation Consultants currently working in CR, and a Consumer advocate. The Rural/Remote panel was represented by senior CR practitioners, one of whom was employed in CR education. The Indigenous panel included key Indigenous QH workers with extensive experience in CR, and an Indigenous Community Health researcher. The Regional panel consisted of health professionals largely working in CR coordination roles within regional areas of Queensland. A Conceptual panel comprising leading independent Health and Community scholars was vital in cross-checking the data and in developing overall themes.

International Key Informants

AIM: To explore issues experienced in USA and Canada in the development of CR

Five key USA stakeholders and one Canadian stakeholder were interviewed, representing both ACRE and the CRP-RCEP network, to provide an international comparison of CR training efforts. In addition, a key Canadian stakeholder provided written material on the topic of the CR Interview questions. Finally, the conclusions were tested at a workshop of 40 CR practitioners in the USA. The key Interviews accounted for 23/50 (46%) of the States who engage in the network and included 4/10 (40%) of the Federal Regions.

These Interviews also represented the most populated States (California and Texas, respectively) in the USA, and as discussed earlier, targeted regions with a number of rural and Indigenous areas, including the entire Southeastern Region, which contains some of the most poverty-stricken areas in the USA. In addition, the work in the USA was contrasted with work in Canada, where one of the most internationally recognized courses in CR is conducted. In Canada, the informants represented two of the major universities involved in the delivery of CR training.
Participants were asked to comment on the following questions:

- What is the background and history of CR in the USA and Canada.
- How is CR defined in the USA and Canada?
- What is the content of training systems/major course work?
- Describe the accreditation system, core skills and competency criteria.
- What are the strengths and weaknesses of the system?
- What are the linkages between the educational system, professional bodies and practice?
- To what extent does CR in USA/Canada involve Allied Health personnel?

**Survey Participants**

**AIM: To understand competency profiles in CR workforce and identify training needs**

The development of the survey was an integral component of the project as its content represents the competencies identified by the CR practitioners. The final Survey participants comprised Allied Health and Nursing practitioners working within CR either in the public or private sector in Queensland. The total number of surveys distributed was 164, though participants were encouraged to forward the survey to colleagues who may not have been included (see Table 10 for summary demographics, and Table 11 for description of survey participants). QH Project Officer distributed the survey (with a cover note) via email to ensure maximum representation from health practitioners in the public sector. Participants were invited to rate the relative importance of competency domains developed, identify training needs and specific training methods and strategies for future competency enhancement. A total of 40 surveys were returned. Although the number of participants in the final round was limited, CR practitioners had made a concerted effort to complete all sections of the survey. This feedback provided detailed information particularly relating to current sources of training and preferred training requirements. Analysis of the competency survey indicated trends relating to importance of competency domains within CR, areas of greatest training need, and preferred methods of training.
Table 10: Demographic Details for the Survey sample

<table>
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<th>No. of Respondents</th>
<th>% (n=40)</th>
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</tr>
<tr>
<td>Female</td>
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<td>90</td>
</tr>
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<td>25</td>
</tr>
<tr>
<td>Years working in CR</td>
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<td></td>
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<td>20</td>
</tr>
<tr>
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<td>2-5 years</td>
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<td>&gt; 10 years</td>
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<td>Nursing</td>
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<td></td>
</tr>
<tr>
<td>Administrative – CR</td>
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<td>6</td>
</tr>
</tbody>
</table>

NOTE: Not all values total 100%.
Many participants were relatively new to the field of CR compared to their discipline specific work experience, with approximately half having worked in CR for five years or less. The length of time working in CR (Mean=5.60 years, SD=5.9 years; Range 1 month – 12 years) was almost half that spent in discipline specific practice (Mean=12.05 years, SD=8.03 years, Range 1 year – 27 years). Of those who had attained postgraduate qualifications in community health related disciplines (e.g., Physiotherapy, Public Health) (33%), almost all of these had a business/administration focus and had limited experience in CR practice overall (five years or less). The average age of participants was 37 years (Range 24 years – 61 years). The majority of participants were female (90%), though this is likely to be reflective of the gender bias in the health and community service workforce. Indigenous, Islander and Non-English speaking backgrounds were also represented to a small degree. The majority of participants were located in the Southern Health Zone, which incorporated metropolitan Brisbane and surrounding suburbs.

The survey consisted of three parts. Part A related to demographic information. Part B required participants to rate the importance and proficiency of the competency domains. Participants were required to indicate their response to this part of the survey using a four item Likert scale (1=Extremely important, to 4=Not at all Important, and 1=I very much have this competency to 4=I do not have this competency). Part C required participants to consider their training needs in relation to the specific CR competency items within each domain. It also asked participants to nominate their preferred methods of training and to identify some solutions to the training barriers identified by CR practitioners in the Interviews.
Table 11: Summary details of Survey Participants (n=40)

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<th>ID</th>
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<th>ATSI/TSI / NESB</th>
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<th>JOB POSITION</th>
<th>DISCIPLINE BACKGROUND</th>
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<th>ORG TYPE</th>
<th>AV TIME IN DISCIPLINE (years)</th>
<th>AV TIME IN CR (years)</th>
<th>YEARS DIFFERENCE in CR</th>
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<td>PHYSIO</td>
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NOTE: - = missing data; OT=Occupational Therapy, PHYSIO=Physiotherapy, SPEECH=Speech Therapy; CNC=Clinical Nurse Consultant
An Overview of the Competency Development Process

Competencies for the CR workforce are not well developed, and generally derive from either unsystematic sources or a knowledge base that is not contextually relevant to Allied Health and Nursing practitioners in Queensland (e.g., international CBR frameworks or in relation to specific diagnostic populations such as mental health). It is therefore crucial to develop competencies that can be applied in the Queensland context using rigorous methodology that is meaningful to stakeholders.

Competencies can be developed on the basis of empirical research, existing standards of care or clinical guidelines. It has been recognised, however, that competency development is a complex process, fraught with difficulties (Ballantyne, Cheek, O’Brian & Pincombe, 1998). A major issue with the development of competencies is that the data that underpins these competencies is usually provided by practitioners. There is an implicit assumption in this method that practices are currently being performed in a competent manner that is acceptable to Consumers. Ballantyne and her associates also noted that competency determination takes place in an ever-changing health system that impacts significantly on practice. To some extent, this structural context predicates the way in which practitioners operate, and therefore, directs the competencies that are developed.

A possible starting point in avoiding complications is to identify competency areas around common values and vision that typify CR and good practice (Hewitt, Larson, Lakin, Sauer, O’Neil & Sedlezky, 2004). For this reason, the current study is based on a qualitative examination of the values and principles of CR, how it is defined in different environments and how it is actually implemented by practitioners when they describe incidents in their practice. However, to derive competencies that are based on true CR practice, it is critical to engage publicly recognised experts and Consumers in the process of identifying the competencies that underlie the values of CR. It is also necessary to incorporate the views of multiple stakeholders (e.g., managers, practitioners, graduates, Consumers and policy-makers).

As noted by van der Link and Boon (2002), it is necessary to adopt multiple data collection techniques and methods of analysis to ensure that competency development is not an artefact of a particular method. Thus, to gain an in-depth and comprehensive understanding of CR and the competencies involved, the current study
employed multiple methods (Focus Groups, expert panels, a survey of practitioners, semi-structured Interviews and case studies of practice).

To ensure that the findings represented a collective view of current competencies for CR, there was a need to collect and analyse data systematically, from a range of practitioners and with a view to reaching consensus. A Delphi Technique was utilised as a systematic and efficient process of gathering broad views about CR from a variety of stakeholders in order to reach a common understanding of the competency areas that underlie practice. The Dephi Technique is typically recommended as a methodology where the research problem requires agreement about subjective statements, and when more individuals are involved in the data collection phase than can effectively interact in a face-to-face exchange for the time required to reach consensus (Crouch, Dale & Crow, 2002; Goodman, 1987; Linstone & Turoff, 1975).

Summary of the Competency Development Process

8. Generate competency areas from Focus Group discussions
9. Expert panel articulate definitions and specific statements/items from quotes and own knowledge
10. Combine across groups (regional, rural, Indigenous, metropolitan) to form major competency domains
11. Researchers clarify competency statements into survey items and check against Interview data
12. Feedback from identified experts in CR regarding gaps, modifications, issues with survey items
13. Expert panels and Focus Group participants to rate importance of items and refine content further
14. Final survey sent to all participants based on all above modifications and addition of training questions

Using an adaptation of the Delphi technique, several stages were used to generate competencies for CR. First, the Focus Group data was analysed to create several major categories, which could be referred to as competency areas for each group (metropolitan, rural/remote, regional, Indigenous). For each competency area, a parsimonious list of competency statements was generated by the expert panels on the basis of the Focus Group data. Similarities were identified across groups to create competency domains (which incorporated areas from each of the groups). The domains, areas and statements were examined by expert panels, confirmed against Interview data and validated by initial Focus Group participants. A final survey was
sent to all CR practitioners to identify the importance of competencies and their training needs. Finally, the competency domains were discussed by the Consumer panel.

By employing multiple researchers, involving participants in the analysis and development process, accessing a diverse range of participants and using iterative analysis techniques, the risk of bias is minimised. This multi-layered method also increases the likelihood that the competencies identified in this project will resonate with the majority of CR practitioners in Queensland.

**Method of Analysis**

Quantitative survey data were statistically analysed through the SPSS package (version 12.0). For statistical analysis, a series of ANOVAs with post-hoc testing (Tukey’s HSD) was conducted. For qualitative data, all Interviews, Focus Groups and panel discussions were analyzed using thematic analysis. To ensure the consistency and rigour of the findings in this study all the data was analysed using a thorough thematic coding and categorising process. Thematic analysis involves the ability to recognize important messages in the data. In this analysis, it is the ‘idea in the narrative’ that is important, rather than considerations such as frequency (Daly, Kellenear & Gliksman, 1997). Thus, the purpose of thematic analysis is to identify important concepts or categories and examine them in relation to the rest of the data and context. From these categories, themes are developed that provide explanation of the phenomenon under study. Thematic analysis was selected in preference to other approaches (i.e., content analysis) because it allows greater consideration of the process and meaning.

Although the application of ‘thematic analysis’ is open to a wide range of interpretations, its use in this study followed the systematic process outlined by Coffey and Atkinson (1996), namely:

(i) Initial coding of each transcript using the paragraph as the primary level of analysis
(ii) Clustering of codes to develop concepts or categories that span across transcripts
(iii) Developing themes from these concepts to explain the phenomenon for the majority of the participants
(iv) Identifying deviations from this explanation and explaining them.

This analysis focused predominantly on the method of agreement. However, it was also important to use the method of difference to determine why the data may not have adequately accounted for “negative” cases or
cases that differ from the norm (as described in (iv) above). This method can validate the findings (i.e., can different points of view be explained with reference to a similar construct or relationship?). It can also highlight areas where the results are inadequate or require revision.

To guarantee the consistency and integrity of the findings, all data were analysed separately and independently by two members of the research team. Any discrepancies in consensus of the findings were resolved through discussion. The use of two analysts ensures the independent interpretation of the data, codes and themes and a high level of agreement of their representativeness.

Prior to making final conclusions, much of the data was presented to experts in the field, who participated in the analysis of themes. Mishler (1990) argued that the trustworthiness of interpretations in a qualitative study could be enhanced by “making available substantial sections of … text available to other researchers” (p. 36). Atkinson, Heath & Chenail (1991) also suggested that knowledge is legitimized when external peers agree that the interpretations and conclusions are accurate reflections of the phenomena under study.
The results for this study are organised according to the five major research areas and the specific research questions within each area.

Both qualitative and quantitative data have been used in this study, and data from multiple sources has been combined to address each question. Each type of data has a different purpose. Quantitative data can provide generalisable data about the frequency of occurrence and relationships between constructs. The purpose of qualitative data is not to draw conclusions regarding numbers, frequency, or measurements that can be generalised beyond this sample. The purpose of qualitative data is to describe experiences and perceptions in depth and learn from the prevailing opinions within the target group of interest. Qualitative data can be used to determine trends and patterns.

Important issues that arose during the study, but do not easily fit into this structure have been presented separately at the end of the report.
What competencies are required for Allied Health, Nursing and support staff to work in CR?

Which competencies are specific to CR and which are common across clinical areas?

This section of the report focuses on the development of a framework to describe the competencies required by practitioners in Queensland to deliver CR.

The development of competencies comprised a multi-stage method, including Focus Groups, expert panels and survey. The process of reaching consensus and developing the competencies is equally important as the final results. Accordingly, this process and the basic outcomes of each stage are also described in this section of the report. Consumer data is also examined to describe the important elements of CR from this perspective. Important observations and indications that arose during this process (e.g., areas where gaps were present, differences between groups and so forth) are presented together with the final analysis of the survey ratings of importance.
Major Outcomes from each Step of the Competency Development Process

Summary of the Competency Development Process

1. Generate competency areas from Focus Group discussions
2. Expert panel articulate definitions and specific statements/items from quotes and own knowledge
3. Combine across groups (regional, rural, Indigenous, metropolitan) to form major competency domains
4. Researchers clarify competency statements into survey items and check against Interview data
5. Feedback from identified experts in CR regarding gaps, modifications, issues with survey items
6. Expert panels and Focus Group participants to rate importance of items and refine content further
7. Final survey sent to all participants based on all above modifications and addition of training questions

The main findings from each stage of the competency development process are shown below.

Step 1: Initial clustering of the Focus Group data generated over 80 competency areas across four groups (metropolitan, regional, rural and Indigenous). Each area was presented as a thematic cluster table, which included a brief description, and the related quotes (see Appendix B for example).

Step 2: The four expert panels examined the relevant cluster tables to articulate a full description of each competency area and generate specific competency statements that represented the quotes that formed the cluster. If necessary, the panel modified, combined or reduced competency areas based on their expert opinion. Following modification by the expert panel, a total of 64 areas of competency remained across the groups (see Appendix C for the competency areas generated for each group).

Step 3: In order to reduce duplication and arrive at a common set of competencies applicable to all CR practitioners, the competency areas were compared and contrasted across the four groups. The comparison revealed some patterns across the groups. Common competency areas were evident across the groups. These areas included:
• A holistic approach that was grounded in the context
• The development of strong partnerships and networks
• The acquisition and use of local knowledge
• Systems advocacy

Areas where minor differences emerged were intuitively reasonable. For instance, rural practitioners focused more on the importance of local knowledge and rural understanding than recognised CR frameworks. This finding is not surprising, as many rural professional practitioners such as rural Nurses tend to have “skills and knowledge beyond that acquired in basic nursing training” and “greater flexibility in traditional roles and responsibilities has been a long standing feature of rural practice” (Asthana & Halliday, 2004, p. 461). Demand management was a common issue across the groups, but was not distinct for rural practitioners, possibly due to work-life overlap in rural towns. Similarly, the ability to maintain professional boundaries was common, but for rural practitioners, it was acknowledged that boundaries were likely to be less clear and not always possible to maintain in small towns. Further, Consumer engagement was not a distinct area for rural practitioners, possibly due to the fact that personal relationships may already exist with many local families. For Indigenous practitioners, the issue of professional boundaries was magnified as a result of the pressures they experienced both in their practice as health workers and as active members of their communities, many of which contained their extended families.

In contrast, service continuity, community engagement and the use of local knowledge were distinct issues for rural, regional and Indigenous practitioners but not for metropolitan practitioners. The operating context of rural, regional and Indigenous practice dictates their need to promote community engagement and the use of local knowledge. Further, they work with Consumers at the end of a service continuum that often involves discharge from metropolitan hospitals or service systems. The fragmented nature of the service continuum and its impact on Consumers and families is, therefore, readily apparent to these practitioners.

Training and supervision only emerged as an issue for regional practitioners, possibly associated with the fact that these practitioners were most likely to be working with assistants. For rural practitioners, it was expected that their operational model would involve the supervision and training of family, community organisations,
volunteers and assistants in remote areas. For these practitioners, any other form of operating was inefficient. However, for regional practitioners, particularly those who were working in relatively large towns, training and supervision of assistants involved increased responsibility. The sense of responsibility seemed to be magnified by the relatively isolated context that was limited in terms of alternative training or supervisory arrangements. In metropolitan areas, assistants were usually accommodated within a larger organisation and, therefore, may not have been the responsibility of individual practitioners. In relation to the Indigenous practitioners, the majority were in support personnel roles (e.g., Aboriginal and Torres Strait Islander Health Workers). Although there was much discussion about the extent to which this role should be viewed as a support role or an expert role, the issue of supervision and training did not arise.

From this comparison, a smaller set of 13 competency domains was identified (see Table 12). The competency items associated with these domains were refined by the research team to ensure they were clear and useful. After refinement, the 13 competency domains represented a total of 182 individual competency statements as generated by the Focus Groups remained. Following minor reworking, the competency statements were developed into final competency items for each competency domain.

**Step 4:** The 13 competency domains were then checked against the Interview data to ensure that no additional competencies could be identified from non-Focus Group participants. Although the Interviews provided elaboration of some competency areas, no new areas were evident.

**Step 5:** Expert advice was sought from a panel of five conceptual experts in the field of CR. These experts were selected due to their experience in the field, international publications on the topic, involvement in policy-making and education in the area and their familiarity with the literature on the topic of CR models. The experts were asked to examine the items and make any changes, additions or deletions that would improve the items with specific reference to CR philosophy. Eight items were considered to be duplications of other items and were removed, resulting in the merging of three competency domains into pre-existing domains (Competency Mentoring; Knowledge Acquisition; Professional Boundaries). This modification created a total of 10 competency domains (see Table 12).
Other than removal of duplication, the modifications made by the experts fell into six major categories. These categories reflected important philosophical issues that appeared to be missing from practitioners' understanding of CR. The major issues that arose as gaps or areas in need of modification according to experts included:

- Important frameworks and principles promoting human rights and the rights of individuals with disabilities to make choices and participate in society (e.g., protecting rights and advocating for Consumers, understanding principles based on human rights and the dignity of risk, ethics, social justice and full participation).

- The active role of Consumers contributing to the development of services and policies – acknowledging the role of Consumers in such planning and change activities (e.g., engaging Consumers and communities in planning and development for services, contributing to policy-making in the area of CR).

- A commitment to enabling Consumers to drive the rehabilitation process as a fundamental principle of practice (e.g., facilitating self-determination and self-management, using enablement as a paradigm for practice in CR).

- The important role of the family and the natural supports that exist in the community context (e.g., fostering natural supports, acknowledging and responding to the needs of the family, understanding the role of the family).

- Commitment to an individualised process of rehabilitation and recognition that one model of practice will not meet the needs of all Consumers (e.g., flexible processes that respond to the context of each Consumer, individualised responses based on Consumer needs).

- Modification of language throughout the items to de-emphasise the hierarchical nature of the health system and enhance the position and voice of Consumers in the rehabilitation process (e.g., use of language that gives power to Consumers – e.g., changing words such as ‘care’ to ‘support’, avoiding language that implied control by practitioners, using language that was positive and respectful).

**Step 6:** The final set of items (173) for the 10 domains were sent to the original Focus Group participants for endorsement of importance and modification if necessary. Response rate from this group was low, with only 10
of the 39 (25%) health practitioners responding to the survey. However, the feedback provided by those who did respond indicated agreement that the items were important to CR and only minor modifications regarding scoring were suggested. As a result, the survey format and item response categories were simplified.

Table 12: Summary of the Competency Development Process

<table>
<thead>
<tr>
<th>Number</th>
<th>Competency Domain – Original Format</th>
<th>Competency Domain – Final Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CR Frameworks: This competency domain concerned the acknowledgement, understanding and critiquing of one's practice against recognised CR frameworks (e.g., WHO, ICF, case management and case coordination) to develop a theoretically underpinned approach to practice.</td>
<td>Frameworks of Understanding: Understanding and implementing recognised models and frameworks that underpin CR</td>
</tr>
<tr>
<td>2</td>
<td>Consumer Engagement: This competency domain focuses on the Consumer as central to every process – services are based on Consumer needs, the Consumers’ direct service provision according to their preferences. Consumers have choice and options that are communicated clearly and understood. At all times, Consumers are supported to engage in self-determined health behaviour.</td>
<td>Consumer Engagement: Interacting in a way that promotes Consumer understanding, choice, control and engagement in their own health and wellbeing</td>
</tr>
<tr>
<td>3</td>
<td>Holistic Approach: This competency domain involves using an inclusive approach to assessment and interactions with Consumers that recognise situational, environmental, family, Carer and community influences on Consumers and their preferences or needs. All aspects of service provision extend beyond health needs to incorporate biopsychosocial needs and are delivered to suit the specific context, environment or situation.</td>
<td>Holistic Focus: Recognition that the needs of individuals extend beyond immediate physical health issues and that incorporate social and emotional health</td>
</tr>
<tr>
<td>4</td>
<td>Service Continuity: This competency domain is about providing continuity of services by supporting Consumers through transitions, screening for risk and intervening early to optimise long-term outcomes, following-up and monitoring Consumer progress over the long term and identifying gaps in the continuum.</td>
<td>Service continuity: Coordination of transition points, particularly when movement is from metropolitan treatment back to rural community and ability to identify risks that could be prevented</td>
</tr>
<tr>
<td>5</td>
<td>Partnership Building: This competency domain acknowledges the need to work in multi-disciplinary teams, but also to practice in inter-disciplinary ways that capitalise on the strengths of other disciplines and recognise the limitations of one’s own capacity. It involves the establishment of networks and</td>
<td>Networks: Ability to engage and work in a team, share information, and collaborate with other services to ensure that gaps in the service system are addressed</td>
</tr>
</tbody>
</table>
teams to build on existing services, share knowledge, develop partnerships and coordinate whole packages of service delivery.

6 Appreciation of Local Knowledge and Lifestyle: This competency domain involves using, respecting and actively seeking out local and culturally relevant knowledge, adapting and accommodating to different knowledge-bases or perspectives and understanding different ways of knowing. It also involves accepting and valuing different styles of living.

Cultural Awareness: Demonstrating an awareness of cultural differences and practicing in ways that accommodate culture

7 Community Engagement: This competency domain incorporates all aspects of being in a community, engaging with local communities in a respectful and trusting way, involvement in local activities, recognising how individuals live and function within a community, appreciating a collective way of operating and investing in the community.

Community Engagement: Understand and invest in the local community to become a trusted partner

8 Professional Boundaries: This competency domain is associated with maintaining professional boundaries and keeping a “separateness of self” within one’s practice of CR, despite the need for intense community involvement, Consumer focus and appreciation of context.

Boundaries and Safety: Ability to care for one’s own well-being in complex environments and maintain professional boundaries

9 Personal Safety Awareness: This competency domain represents the ability to work safely and prevent injury or illness arising from work by applying good workplace health and safety principles. However, it also focuses on being aware of threats to personal safety that are specific to working in the community or travelling long distances and managing oneself in a way that avoids or prevents those threats.

Personal Safety Awareness: This competency domain represents the ability to work safely and prevent injury or illness arising from work by applying good workplace health and safety principles. However, it also focuses on being aware of threats to personal safety that are specific to working in the community or travelling long distances and managing oneself in a way that avoids or prevents those threats.

10 Demand Management: This competency domain is about managing competing demands on one’s time, recognising constraints and limitations, monitoring and prioritising workload while maintaining the principles of CR. It also involves responding in a way that minimises unreasonable demands over time.

Demand Management: This competency domain is about managing competing demands on one’s time, recognising constraints and limitations, monitoring and prioritising workload while maintaining the principles of CR. It also involves responding in a way that minimises unreasonable demands over time.

11 Training and Supervision: This competency domain focuses on the ability to manage complicated tasks such as supervising and training family members, Carers or support personnel and taking responsibility for the issues associated with having an instrumental role in someone else’s life or career.

Training and Supervision: This competency domain focuses on the ability to manage complicated tasks such as supervising and training family members, Carers or support personnel and taking responsibility for the issues associated with having an instrumental role in someone else’s life or career.

Reflective Practice: Think creatively to solve problems, prioritise, and plan through difficult and diverse tasks by using local solutions, a creative use of resources and a flexible approach to problems
### Knowledge Acquisition

**This competency domain is about acquiring knowledge to support good practice, and disseminating knowledge meaningfully in the community, applying knowledge learned by experience and being open to new learning at all times.**

<table>
<thead>
<tr>
<th>Systems Advocacy:</th>
<th>Systems Advocacy: Advocating to make changes that improve services for Consumer</th>
</tr>
</thead>
<tbody>
<tr>
<td>This competency domain recognises the fact that CR requires advocates who can lobby systems for recognition, resources and respect. It also focuses on the ability to promote CR through the collection, use and dissemination of evidence, influencing policy and attracting resources, as well as improving services for Consumers and upholding rights.</td>
<td></td>
</tr>
</tbody>
</table>

## Final Competency Domains and Statements derived from Practitioners

### FRAMEWORKS OF UNDERSTANDING

#### Endorsing and applying recognised frameworks

- Understand the principles of human rights (e.g., ethical practice, social justice, participation, equity)
- Adopt a clear definition of CR
- Recognise the practice implications of working in communities (rather than in institutions, private practice or other discipline based service delivery)
- Understand models of service delivery that may be used in CR and how to implement them
- Maintain a Consumer-focus regardless of the context in which practice occurs
- Understand and monitor the expected outcomes of CR
- Know the capacity of the service to respond according to the philosophy of CR
- Understand the principles that underpin CR and how they are implemented in practice
- Understand the limitations of different frameworks, approaches or models
- Draw on multiple frameworks to develop an appropriate response

#### Understanding Disability

- Recognise that disability is understood from different theoretical and philosophical models
- Recognise the presence of disability and chronic illness in the community
- Understand how disability is experienced in the community
- Understanding how cultural issues influence the experience of disability in general
- Understand the challenges associated with rural and/or Indigenous practice
- Understand the concept of ‘rurality’ and how it influences behaviour, beliefs and interactions
- Understand how culture impacts on the individual experience of disability and illness
- Understand the practice of Consumer choice and dignity of risk
Understand the benefits and limitations of medical frameworks

Respecting and Using Local Knowledge

- Be willing to seek out and acquire local knowledge through local networks and stories
- Acknowledge the existence of local ways of knowing and knowledge bases
- Use language that is locally relevant and understood
- Modify practices according to local knowledge
- Respect the values, beliefs and ideas of the local people
- Seek out unwritten ‘ground rules’ and use them in planning and service delivery

NETWORKS

Networking

- Identify key people from other relevant services with whom to liaise
- Understand the inclusion and exclusion criteria of major services
- Network with service providers from other disciplines or organisations
- Facilitate networks and linkages within the community
- Understand how services operate and potential influences on each service
- Acknowledge and accept the input of other professionals and community organisations
- Understand the levels of government and how they interact and impact on Consumer services
- Keep up to date regarding available services
- Utilise case management and coordination skills

Leadership and Teamwork

- Encourage support among colleagues within the organisation
- Identify an appropriate team to meet Consumer needs
- Recognise the limitations of skill sets within teams and rectify or accommodate these gaps
- Engage in information sharing among team members
- Respect privacy and confidentiality of Consumers within team discussion
- Conduct ongoing review of team functioning
- Negotiate roles within a team to ensure an appropriate mix of skills
- Monitor and regulate team responsiveness to Consumer focussed goals
- Communicate with non-Allied Health practitioners and facilitate their understanding of CR
- Accept leadership roles and take action when leadership is required
- Recognise and respect the competencies of other professionals in relation to one’s own

CULTURAL AWARENESS

- Respect different cultural ways of doing, thinking and being
- Understand the impact of historical events on particular cultural groups
- Facilitate the use of language that is culturally sensitive
- Use listening and observational skill to identify cultural protocols
- Understand and respect the role of culturally respected experts (e.g., Indigenous Elders)
- Determine how cultural knowledge translates into practice and behaviour
- Seek advice and guidance from people about their own culture
- Acknowledge your lack of cultural knowledge
- Recognise individual and group variation within cultural norms
- Avoid assumptions based on cultural stereotypes
- Understand the implications of culturally diverse communities and the implications of this composition

**HOLISTIC FOCUS**

**Social and Emotional Focus**

- Support and respect Consumer rights to self-determined decision-making
- Support and respect family decision making styles
- Develop and apply basic social and emotional helping skills
- Build relationships with Consumers that ensure a thorough understanding of their holistic needs
- Understand the mental health system and how it interacts with other systems
- Recognise mental health issues or illness and make appropriate referrals

**Context Focus**

- Understand the impact of contextual factors on the person (e.g., environment, economic and vocational status, community, family, personal and cultural history)
- Understand the implications of disability and rehabilitation on all family members and the household
- Foster naturally occurring supports such as neighbours and community members
- Address contextual factors in all assessment and planning using an individualised approach
- Respect kinship and relationship structures
- Use of strategies designed to strengthen families and communities
- Recognise the functional implications of the disability for particular contexts
- Be aware of additional challenges to confidentiality that arise from holistic practice
- Be sensitive to issues relating to age and gender in service delivery
- Understand the role of family and significant others in the Consumer's life
- Acknowledge the distinction between family and caring roles
- Provide support to family members, and voluntary Carers so that they can facilitate Consumer outcomes
- Assist family members and voluntary Carers to adjust to their roles and responsibilities

**Flexible and Responsive Service**

- Implement strategies to ensure that the service is responsive and flexible
- Recognise Consumer preferences for location of services
- Identify and accommodate Consumer preferences regarding the nature of service delivery
- Identify technology that can support home-based service delivery
- Acknowledge travel restrictions experienced by Consumers
• Recognise and manage challenges to maintaining confidentiality
• Implement strategies to maintain relationships with Consumers when direct contact is limited

CONSUMER ENGAGEMENT

• Use a communication style that is understood by Consumers
• Take time to listen to Consumer needs
• Assess Consumers’ existing knowledge base, and address gaps in knowledge
• Describe medical and rehabilitation procedures clearly and avoid jargon
• Respect different ways of Consumer learning and absorbing information
• Check Consumer level of understanding when information or education has been delivered
• Align the expectations of Consumers, practitioners and services
• Encourage Consumers to direct their rehabilitation process
• Align services to meet the individual needs of Consumers
• Understand the nature of power in professional relationships
• Facilitate Consumers to identify and achieve their own goals
• Respect different lifestyles, opinions, decisions and preferences non-judgementally
• Understand Consumer expectations of the service and its outcomes
• Encourage Consumers to engage in the rehabilitation process
• Understand the impact of positive and respectful language
• Provide Consumers with options and ensure equal understanding of all options

SERVICE CONTINUITY

Secondary prevention and risk management

• Assist people to learn how they are going to manage their lifestyle
• Encourage Consumers in planning for a healthy future
• Understand the difference between screening for risk and thorough assessment
• Recognising and responding appropriately to potential risks to health, both acute and chronic
• Support Consumers to monitor their own condition and to take necessary action

Continuity across settings

• Understand Consumer dis-engagement and create opportunities for engagement over time
• Provide options and consider alternatives to allow Consumers choice relative to life phase
• Facilitate networks of service providers to support Consumers
• Monitor and assess outcomes relevant to the individual’s context and goals
• Reassess Consumer needs and engage in progressive goal setting
• Follow up with Consumers regarding service access to ensure satisfaction of outcomes
• Find a balance between service continuity and Consumer self-determination
• Educate relevant professionals about the continuum of service provision and the role of CR
• Foster a team approach that is inclusive of the Consumer, family and community services
REFLECTIVE PRACTICE

- Acquaint yourself with the roles and responsibilities of your position
- Seek guidance from within or outside your own team as needed
- Locate new information, sift through information and use it appropriately
- Engage in self-directed learning and problem solving to address complex situations
- Monitor the cultural appropriateness of your practice
- Participate in professional development activities to maintain professional competence
- Be able to work in unstructured environments
- Utilise reasoning skills and critical analysis to solve complex problems
- Recognise the limitations of local solutions
- Engage in innovative use of existing resources
- Update knowledge of health/disability issues regularly
- Collect and collate meaningful information regarding outcomes of the CR service
- Evaluate your own practice in an ongoing way
- Build activities that support reflective practice into workloads
- Critically analyse existing evidence about CR
- Be familiar with issues of outcome measurement
- Monitor the well-being of Therapy Assistants who work under your direction
- Take responsibility to mentor, educate and train new practitioners in CR
- Understand adult learning principles

COMMUNITY ENGAGEMENT

- Understand the ‘community sector’
- Understand and appreciate how different types of communities operate
- Understand the process of gaining acceptance and trust in the community
- Recognise locally accepted norms for behaviour
- Find the ‘common ground’ before acting
- Build relationships with the community based shared visions and goals
- Understand the role of health practitioners in communities
- Profile the community from multiple angles (e.g., businesses, social networks, processes, and geography)
- Be aware of the implications of personal and professional relationships, especially in small communities
- Maintain engagement with communities between visits (for visiting practitioners)
- Participate in local community activities
- Interact in honest, transparent and open ways with the community
- Develop services that are relevant to the community and its needs
- Promote community capacity
- Support other professionals, community groups, services and individuals in the community
BOUNDARIES AND PERSONAL SAFETY

Personal Wellbeing

- Be aware of professional boundaries
- Develop and sustain professional networks for advice and support on CR
- Adopt strategies for personal well-being
- Respect the boundaries of health worker support personnel, including Indigenous Health Workers
- Acknowledge power imbalances and be confident about one’s role
- Use negotiation and conflict resolution skills to resolve difficult situations
- Understand the legal responsibilities that impact on practice
- Adhere to professional codes of conduct
- Be prepared to travel, and operate effectively in many different locations
- Understand medico-legal and duty of care issues when delegating tasks

Demand Management

- Develop strategies to manage competing demands
- Conduct structured and regular review of workload, case load and outcomes
- Develop skills of Consumer disengagement and case closure, particularly in small communities
- Utilise time management and planning skills
- Balance community needs with personal and service demands
- Acknowledge service, professional and personal capacity limitations and refer as appropriate

Injury prevention

- Recognise workplace health and safety challenges that arise in the community context
- Engage in risk identification and risk assessment
- Develop a system of workplace safety within the organisation/service
- Observe personal safety during CR work in the community

SYSTEMS ADVOCACY

- Identify areas where Consumer needs are not being met in the community
- Participate in the development of local opportunities for Consumers
- Contribute to strategies to address gaps, barriers and inadequacies in the community
- Allocate time to non-clinical activities, such as education of other professionals, reporting and development of services
- Engage Consumers and community in service planning, development and evaluation
- Contribute to policy making activities whenever possible
- Advocate and articulate the issues associates with Consumer and community rights
Step 7: The final survey (see Appendix D) was sent to all participants on the recruitment list (n=164). This step enabled the competencies to be rated by practitioners according to importance.

Importance of the Competencies to CR Practitioners

Findings from the final survey are presented below, with particular reference to the competencies that were considered important to CR practice by the current CR workforce and experts in the area. Participants considered all ten competency domains to be important to CR practice, which was not surprising given the consensus that was reached during the development process. This consensus is critical to the future implementation of any competency framework. However, some competencies were rated as relatively more important than others.

Participants rated the following competency domains as being the most important to their CR practice:

- **Consumer Engagement** – understanding Consumer service preferences, Consumer control over their rehabilitation, and Consumer engagement with the process.
- **Reflective Practice** – the role of the CR practitioner in the rehabilitation process, highlighting the need to be creative in the use of resources, plan and prioritise using local solutions and adopt a flexible approach to problem solving.
- **Holistic Focus** – recognising Consumer needs that extend beyond immediate physical health issues, and incorporate social and emotional health.

There was less agreement among the participants regarding the relative value of Frameworks of Understanding (Mean=2.05, SD=.71). Some participants rated Frameworks of Understanding as being less crucial to their CR practice than other competencies, while others considered it to be relatively important. This mixed finding may confirm that CR practitioners are currently operating in the absence of any coherent framework and with limited understanding of the relevance of frameworks. As a result, they have assigned a lower priority to this domain. Alternatively, their current frameworks may be irrelevant to their CR practice and to their understanding of CR, thus prompting them to rate frameworks as less important than other competencies.
Although cultural awareness was rated as being less important than other competencies, there was a trend for this to increase in importance with increasing time in practice. CR practitioners who had been in CR greater than 10 years rated Cultural Awareness as being more important than all other domains (F(4.23)=3.07, p<.05) when compared to CR practitioners who had been working in CR for less than one year. However, it is important to note that CR practitioners had generally not been working in CR for lengthy periods of time, particularly in comparison to their duration of discipline-specific practice.

A Comparison to the Existing CR Competency Framework

In July 2005, the QH Workforce Innovation and Reform Directorate prepared a statement about the competencies that were considered important to CR. These competencies were drawn from knowledge of the literature and expert opinion. Eight major areas were identified as shown in Table 14 below. In contrast, the current project established 10 competency domains as shown above. A comparison between these two frameworks reveals considerable overlap, but also areas of divergence. Both frameworks include reference to the philosophical underpinnings of CR and the models for operationalising interventions. The practitioner-driven framework included reference to disability knowledge and the use of local knowledge as well as the more universally recognised models. In terms of operating models, the QH framework focused on primary health care models (e.g., health promotion, self-management). In contrast, the practitioners included multiple models (e.g., prevention and risk management, case management, education, motivational Interviewing, social models etc.) and noted that combinations of different approaches were required in different situations.

Recognition of contextual issues, such as holistic assessment, family needs and natural supports, also featured in both frameworks. However, the practitioner-driven framework included a focus on social and emotional skills. Community engagement was a significant feature of the practitioner-driven framework. Although community understanding was represented in the QH competencies, the practitioners articulated this issue as a more proactive task. Similarly, Consumer engagement was represented in the QH framework (e.g., collaborative goals setting, practitioners as resources for Consumers). However, in the practitioner-driven framework, the description of Consumer engagement was more detailed, including communicating in ways to promote understanding, respecting different ways of absorbing information, encouraging Consumers to direct rehabilitation, tailoring services to individuals, understanding the nature of power relationships, use positive and
respectful language and providing true choice. Cultural awareness also featured more prominently in the practitioner-driven framework, possibly due to the large input of rural and Indigenous practitioners. Interestingly, cultural issues emerged as a major concern for practitioners and an area in need of training.

Networking in the community was a strong feature of both frameworks. Similarly, both frameworks contained references to higher level activities, such as planning, research, quality monitoring, policy, and ethical practice. However, these issues were expressed as a single factor in the QH framework (Management and Research Issues in CR). For practitioners, there was a distinction between being reflective about their own practice (e.g., collecting data and feedback, developing their own knowledge about CR) and acting at a systemic level (e.g., contributing to change in the community, engaging in research, education, service planning and development etc.). Interestingly, systems advocacy was an area where practitioners identified gaps in their knowledge that required training.

Finally, the QH framework (see below) included an item about managing risks in uncontrolled community settings. This topic was a major concern for practitioners, leading to the development of an entire factor titled Boundaries and Personal Safety. The sub-themes within this factor were personal well-being, demand management and injury prevention. Although similar issues are present in any occupation, these topics related to the particular challenges created by the community context.

Thus, the current framework has validated similar competencies to those initially identified by the QH workforce team, but has highlighted areas that are more prominent in practitioners’ experiences (e.g., processes of Consumer and community engagement, systemic advocacy and reflective practice, risks associated with community work, cultural competence, local relevance and disability knowledge).

**Competencies Identified by QH Workforce Innovation and Reform Directorate**

1. An overview of the background of CR
   - Historical and philosophical development of community approaches
   - Overview of individual, medical, social and community approaches
   - Community approaches and traditional Allied Health and Nursing (AH & N) practice
• Community based approaches and the continuum of care
• Rehabilitation within the health continuum (through a framework such as the International Classification of Functioning, Disability and Health (ICF))
• ICF dimensions of activities, participation and environment as they relate to the community life and rehabilitation of people with disabilities

2. Awareness of associated frameworks for intervention

• Health promotion
• Primary health care
• Chronic Disease Self-Management

3. Awareness of rehabilitation Consumer issues in the community context

• Needs, resources, supports and barriers pertaining to the disabled person in the family and home context
• Needs, resources, supports and barriers pertaining to the disabled person in the community and social context
• Population trends and changes in the Consumer population
• Cultural issues
• Changing needs across the lifespan and community service delivery

4. Recognition of factors that impact on CR

• Range of services available in the community – GPs, non-profit organisations, private practitioners, alternative therapies
• Funding arrangements in the community
• Accessibility of services – coordination, availability and awareness
• The diversity of “community” - geographical, cultural, socioeconomic, generational variables

5. Awareness of place of assessment and goal setting in CR

• Holistic assessment and evaluation of individual CR programmes
• Importance of Carers, the family & community context in rehabilitation assessment and goal setting
• Appropriate assessments and outcome measures for the community
• Collaborative processes in needs assessment, goal setting, attaining goals, monitoring and evaluation
• Sustainability of individual CR programmes

6. Understanding of key intervention issues in CR

• Importance of Carers, the family and community context in rehabilitation intervention
• Strategies for initiating CR at the individual level
• Strategies for initiating CR at the family level
• Strategies for initiating CR at the community level
• Factors/practices that optimise outcomes for Consumers in a community setting
Factors/practices that lead to the sustainability of outcomes for Consumers in a community setting - and how these might be evaluated
Factors/practices that influence outcomes – practitioner attitudes and values, community, employer and co-worker attitudes
Importance of supporting Carers’ health and well-being

7. Key skills in CR practice

- Practitioners as “resources” for people with disabilities, Carers, family members and community members
- Practitioners as educators/trainers for Consumers, family, Carers and community
- Developing CR materials and resources
- Information technology in CR – including telehealth
- Group skills including facilitation
- Working with and supervising support workers
- Promoting education and learning with intermediate level workers
- Working in a multi-disciplinary team – including role overlaps and blurred boundaries
- Inter-professional collaboration in the community setting
- Inter-agency collaboration in the community setting
- Participatory techniques including planning, implementation and evaluation of CR with other service providers
- Ethical issues, accountability and shared decision making
- Risk management in the uncontrolled community environment
- Linkages between vocational and CR

8. Awareness of management and research issues in CR

- Management and planning of CR
- Community support, funding and sustainability
- Evidence and CR
- Community-based research methods
- Research for policy and development
- Ethics, rigour and quality in community based research

A Consumer Perspective of CR

A Consumer Focus Group (as described on page 27) was conducted to clarify CR Competencies valued by Consumers. The issues raised by Consumers provided some important comments on professional competencies in CR. Importantly, Consumers perceived that they had received very limited access to CR and reported that services had been minimal following their hospital discharge. Even Consumers who had accessed CR services viewed these as a minimal event (i.e., a phone call or an assessment) rather than a service. They
also perceived these instances to be hospital-based events and did not classify them as CR. The Consumers identified gaps and barriers that required attention to facilitate the implementation of CR. These issues included:

- Lack of support to make a positive transition from acute care to community
- Confusing and conflicted eligibility criteria across services
- Lack of understanding of Consumer perspectives by practitioners
- Inadequate information transfer from practitioners to Consumers
- Focus on the medical model where the expert is the professional
- Inadequate networking by practitioners with community groups
- Insufficient attention to the facilitation of Consumer support groups
- Exclusion of family, friends, neighbours and other natural supports
- Limited attention to emotional and social needs as well as physical needs
- Lack of sensitivity to the experience of disability in professional practice
- Tendency to limit Consumers’ opportunities to understand their condition and treatment

It was difficult for Consumers to capture the concept of CR using the terminology as contained in the competency descriptions, as derived from professional data. However, Consumers clearly identified several important values that could be related to the competencies. In particular, they identified the need for a consumer-driven process that engaged consumers and family in the CR team. The approach of CR was expected to be holistic and seamless. Further, CR was seen as an intervention that should address systemic and community barriers rather than focussing only on the person with the disability. These areas are discussed in the following sections according to four major themes:

- A Holistic Framework
- A Consumer-Driven Focus
- An Advocacy Role
- A Seamless Process

A Holistic Framework

- *Holistic Frameworks that Promote a Valuable and Productive Life and Self-Management*

According to Consumers, their understanding of CR was that it should facilitate their return to independence, “not being dependent on others”; “improving their quality of life”; developing “self-management skills”; becoming
“a valuable member of the planet”, a “productive” member of society, and accessing and utilizing community support to “get back to where you were” in your life. Ideally, CR should support a changed “state of mind” from “victim to person” and facilitate the process of becoming an “interactive person in the community again”.

Consumers agreed that CR should value the emotional, social, and physical aspects of their lives and that this was crucial to the implementation and success of rehabilitation. They described how many practitioners viewed Consumers as “a back or a condition” and how this perspective “fails to address the important issues...the context is different...[What] you need is a holistic approach...They [practitioners] don’t take the blinkers off”.

- Critical Role of Natural and Informal Supports

Most Consumers described a lack of formal support from health practitioners, but spoke emphatically about the critical role of naturally occurring and informal supports such as family, friends, neighbours, and community groups. The natural and informal networks emerged as pivotal components in supporting Consumers in their community, which was not surprising. Family, friends, and neighbours provided important practical support that enabled participants to remain in their own homes -- “…my mum comes religiously every Saturday...she’s 78...she does my ironing, she cooks meals up...when I get home I just grab one out of the fridge and stick it in the microwave...”.

In the absence of family support, neighbours were an important resource,”...when my wife and son were at home, we virtually had nothing to do with [neighbours]...but since my wife left, they’ve been the greatest help to me...”. Sometimes the support of neighbours made life just that little bit easier for participants -- “…she’ll [neighbour] help me with watering the garden and that sort of thing”. In other instances, neighbours provided critical help in the event of an emergency -- “…I cut all my hands up and was bleeding...I yelled out to the guy next door...he was over in two minutes...”.

However, an important message for CR practitioners was the fact that Consumers were uncomfortable when they were forced to “rely solely on family and friends”. Although they clearly valued and appreciated the support of their social network, they also needed formal CR services. The Carers in the group confirmed that they wanted to continue to provide support to their relatives, but desperately required formal CR services to assist,
“...when I asked for help...they say, ‘oh, we don’t do that’...[it’s a] full on Nursing role [for me] when he [son] gets really sick...”.

Community support groups offered valuable support to several participants and appeared to fill some of the gaps that they experienced in accessing the community health sector -- “...don’t have an established rehabilitation team so the Support Group was a placebo”. For participants, membership in a support group enabled them to meet their social and emotional needs, gain a greater understanding of their condition and access information through the exchange of ideas and strategies.

Consumers did not consider the roles of formal and informal supports to be mutually exclusive; rather, a combination of the two was essential. Further, it was important to Consumers that the two types of support complemented and facilitated each other. They did not want either form of support to exclude the other. The significant messages for practitioners in this discussion were to identify and support natural processes, to work with natural supports to strengthen their capacity, facilitate and sponsor support groups where possible, to encourage the involvement of natural networks in rehabilitation, and to respect Consumer decisions about the extent of involvement by family, friends, neighbours and community organisations.

A Consumer-Driven Process

- An Individual and Unique Journey: Professional Terminology Should Reflect Consumer Experiences

They confirmed that feeling validated and “important as an individual” was essential to their rehabilitation. Consumers stated that “we are the Consumers”, and there should be more emphasis placed on their unique needs, adapting rehabilitation to suit their environment and providing support to facilitate their own journey.

Although each experience of disability and rehabilitation was singular, they all needed significant levels of support and clinical understanding of their condition, “we need more information”. Participants often spoke about their constant striving and aspiration for “independence”, yet they all expressed simultaneous needs for varying levels of interdependence (e.g., support groups, home help, natural supports, etc).
There were strong comments from Consumers that reinforced the need for more emotional support to adjust to their disability, “I was left in a black hole” to cope. “I wasn’t given any support or understanding regarding how my condition would affect me and my family…”. The need for support to help meet the emotional challenges faced by Consumers was one of the most common themes throughout the discussion.

**Teamwork Among Practitioners**

Consumers described how there was a need to bring “a lot of different people into your life” for support in a range of areas and that there was a need for these practitioners to work together. There were, however, mixed responses regarding teamwork among practitioners. Some Consumers believed that “communication is not necessarily good” among team members. In contrast, other Consumers complimented their rehabilitation teams by referring to them as “well oiled”. Teamwork in rural locations was considered to be excellent, but specifically within a hospital environment. Physiotherapists and Occupational Therapists were viewed as the most important members of the team at this stage. There was limited reference to Nurses delivering community services, whereas Social Workers and GPs were mentioned repeatedly as being an essential part of a team.

Few Consumers had experienced a full CR service. Instead, Consumers spoke about isolated practitioners with whom they had short-term interactions, usually focused on a particular issue or need at the time. However, even those Consumers who had definitely accessed a CR organisation did not present that experience as a holistic package and referred to hospital as the point of delivery.

**We, the Consumers, Are the Most Important Members of the Rehabilitation Team**

When discussing rehabilitation teams, a strong theme in the discussion was the importance of including Consumers as members of the CR team. “Teamwork is excellent between practitioners, but it fails to engage or communicate with the Consumer”, “…they [practitioners] don’t include the Consumer…They don’t communicate with their patient”. Consumers emphasised the fact that the “person must be integral to the team”, but in reality, they often were not included and were unable to make an informed decision about their care. Consumers described how this lack of involvement in the rehabilitation process compromised their level of understanding of their condition – as one Consumer noted, “I don’t even know what I need”. Their ability to interact with
practitioners in a way that promoted understanding, choice and engagement in their own health was valued by Consumers.

Participants expressed a great deal of frustration at being left out of the information loop as they did not want to be sheltered from difficult information - they wanted to be involved. “[Practitioners should]…assume you’re a ‘right-thinking’ adult person and can get information and be told things rather than being sheltered and cocooned like a newborn baby….lack of information…is soul destroying and that I think has the biggest impact”.

Consumers described how lack of information transfer from practitioners often resulted in feelings of being devalued, disempowered, and excluded from the rehabilitation process. The accessibility of information was a recurring topic throughout the discussion. There was a need to improve the transfer of information from practitioners to Consumers, government to community groups, between the hospital and community and among rehabilitation providers. Community groups were identified as an important conduit of information and Consumers suggested that these networks should be informed of changes and initiatives that might impact on Consumers – “… a lack of information really cripples the system…and that doesn’t require extra funding, that can be fixed now”.

- **The CR Team Must Include Family, Significant Others, Community Members, Groups and Services**

Consumers also stated that the rehabilitation team should include family/significant others and relevant community members. Their family members were often excluded from the rehabilitation process and knew little about how to help them appropriately. However, family members often assumed a significant role in caring and supporting the individual. Other strong statements that related to family involvement demonstrated the fact that important “family dynamics were not acknowledged” in the rehabilitation process. Consumers indicated that family members required skills and guidance to balance the provision of practical help with facilitating independence. Educating family members was seen as a critical rehabilitation task in order to assist the person to manage in their home environment.

The fine balance between practitioners and family was also evident. As one Consumer described, sometimes a professional needs to step in and educate the family because they are respected and can engage the family in
the process. This communication between family and practitioners legitimises the experiences of the Consumer and establishes a framework for operating within a household:

...your community worker is going to...sit down with your family and say, 'look, your mum or your dad has a slight problem, you're going to have to not leave things in the middle of the room...doors ajar...put chairs back'...and they need to be told [by a professional], you can tell them yourself until you're blue in the face and they don't listen. But they get told by a professional [and they listen]...- ‘help do the cooking but don’t take away her independence’.

- **Relationships Need to be Revisited: Consumer Centred Approach**

The lack of a ‘Consumer Centred Approach’ to rehabilitation delivery emerged as an underlying frustration for Consumers. These statements tended to be generic to the entire injury and rehabilitation process and applied to members of the entire medical profession [including doctors/specialists]. Consumers did not differentiate between medical professionals and CR practitioners. However, their view of all health professionals appeared to be based on these stereotypes, irrespective of any positive experiences in the community. The Consumers’ view of health practitioners was dominated by experiences of poor communication and lack of engagement.

This lack of Consumer engagement and the disrespect in the relationship was encapsulated in many statements made during the discussion.

- You felt isolated
- There was lack of identification of your needs
- Insensitive to your emotions, privacy, way of living
- You are treated 'like a piece of meat'

- **Valuing What is Important to the Consumer – the Small Things**

Acknowledgment of their achievements in the rehabilitation process was important to Consumers, even in relation to small goals that they perceived to be important to their progress, “...little things that don’t mean a lot to anyone else...”. Consumers gave a variety of examples of achievements that they referred to as “the small things” or “the little things” and noted that practitioners often failed to understand the magnitude of these
milestones. Valuing what was important to the Consumer was seen as critical to supporting their rehabilitation in the community. Group members believed that practitioners needed to develop sensitivity to the Consumer’s perspective and experience in order to fully appreciate their values.

…I suggest that just about all of them [practitioners] need some degree of training in sensitivity…I don’t know if you’ve ever thought about this, but if you’re under the shower, you’ve shampooed your hair and you bend over to try to get the soap out of your crack and you can’t because you’ve only got one hand…one day you reach the point where you can…and you really feel like you’re made!…Then you speak to the lass [OT] and you tell her the story, and she says, ‘well thank you for sharing’…to me it was like conquering Mt Everest [but she didn’t understand].

- **Training Practitioners through Consumer Experiences: A Consumer-Driven Education Framework**

The group discussion emphasised that the majority of practitioners only ever glimpsed a snapshot of the complexity of Consumers’ lives and rarely gained exposure to, or understanding of, their day-to-day reality. According to Consumers, practitioners needed to spend time learning about the experience of disability and how this experience impacts on rehabilitation rather than just implementing “text book” strategies to assist with independent living. For practitioners to fully understand the implications of disablement, Consumers recommended that students and practicing CR practitioners could learn more from observing and listening to people in their real life environments (e.g., community groups and home) than in the classroom -- “Learning from a text book you just don’t get the understanding”.

It was clear from the discussion that Consumers’ lives were marked by unpredictability and changeability that created a complex trajectory, both for the individual and their social network -- “…today my son would be fine …and some days he’s not so good…”; “for someone to understand your disability they have to spend at least …a couple of days [in my home]”. Consumers spoke of the need for practitioners to spend extended periods of time with them in their own environment so they could truly understand their reality and provide appropriate and relevant support -- “…they [practitioners] need to sit down and just let you do things the way you normally do them and then take notes and then say, ‘you could probably do this chore or this task better if you did it this way’.”
According to Consumers, it was critical that practitioners genuinely made an effort to understand their disability and the implications for their life — "...professional people don’t fully understand the implications [of disablement for the individual or family]", as each individual’s experience is so unique — "no two strokes are the same". Consumers found that people tended to focus on their physical loss rather than trying to comprehend the full emotional and social impact of disability, which was noted as the most debilitating experience for them. The process of attempting to understand their disability was simple according to Consumers – practitioners must learn from the Consumer by listening, talking, observing in real environments (e.g., home, support groups, etc) and trying to appreciate the complexity of daily lives -- “they [practitioners] need to talk to you [to understand your disability]". Consumers believed that practitioners should facilitate effective communication, including attentive listening, in order to hear each unique story and respond appropriately.

Innovative strategies for educating practitioners emerged during the discussion. For instance, support groups such as the Stroke Association regularly invite practitioners to “Come and spend some time with us, at our support meetings, even it’s the ‘tea and biscuits’ morning”. One Consumer explained the benefits of such exposure:

I’m part of...[a] stroke support group, we quite often have student doctors, student Physios and student OTs, come and sit in with our group...just to see what we do...they all go away with a lot more knowledge than they had before...so different from what they expect when they’re learning from a text book...they will learn more from speaking to stroke survivors than they ever will from sitting in a classroom.

This discussion highlighted the model of learning that was valued by Consumers. Consumers were operating from stereotypical views of practitioners as “book learners” who acquired information to become experts. Consumers, in contrast, wanted to be valued as the experts themselves and as an important source of learning. Practitioners were seen to value evidence and structured learning that often fails to reflect the lived experience of disablement. Unlike practitioners, Consumers did not highly value formal education as a way of learning about the process of living with and managing disability. Thus, it would seem that Consumers and practitioners might approach the learning context and the purpose of knowledge from different perspectives, creating a challenge for the establishment of genuine partnerships.
A Seamless Process

- **The Transition from Acute Treatment to Community Influences Ongoing Perceptions of Rehabilitation**

Many of the beliefs and attitudes of Consumers towards rehabilitation were still based firmly in their experiences at the time of making the transition from hospital to home. Participants expressed extreme frustration at not being able to access help and support once they had left the acute care setting. For all Consumers, there was little linkage between hospital rehabilitation teams and community practitioners. Further, Consumers described the personal impact of hospitalisation and the need for a gradual transition back to the community. “You become institutionalised… I knew as soon as I would put my foot out the door I would not get any help”.

Inpatient rehabilitation was characterised by a sense of being cocooned, loss of control, and being told what to do -- “…when you’re in [inpatient] rehabilitation, you’re cocooned. Nobody asks you… you’re told…[what to do and when]. You lose control of your life”. Although this was not a pleasant experience, Consumers felt a sense of abandonment when they left the hospital environment. Consumers emphasised how important it was for all health practitioners (both hospital and community-based) to pay adequate attention to the social and psychological consequences of their disability after discharge.

Actually making connections with community-based practitioners was a significant issue for Consumers. Some discussions revolved around the need for information.

...when you get discharged...you feel you’re abandoned. So you really need more [liaison with healthcare practitioners], especially in the first few weeks - to help you kick-start your life again - you move from one place [hospital] to another which should be a familiar place, your own home, but it’s not familiar [anymore] because a lot of what’s there is useless to you now and you can’t manage…quite often you’ve got a Carer who knows less about what’s wrong with you than you do, and you don’t know very much…there was nothing [information or education] about the emotional side, nothing about the physical side, we had to do trial and error...information is the key.

This discussion highlighted the need for seamless service delivery, information sharing across contexts and Consumer engagement to enhance relationships and create an environment that fosters a sense of control for
Consumers. Inadequate support and understanding at this pivotal transitional point can increase frustrations and create an atmosphere that is negative.

- **Eligibility is a Barrier to the Implementation of CR**

There were strong comments regarding the relative lack of CR services and the difficulties created by eligibility criteria. Many Consumers described how they were unable to access any community services, both now and when they were making the transition from hospital to community. Some were accessing private sector health services as a result of their health insurance, but were unable to access public government services due to means testing restrictions. Private sector services rarely offered integrated systems that focused on community interventions. Instead, private services were usually therapeutic, clinical and short-term. Thus, their ongoing physical therapy, community, emotional and social needs were overlooked.

...we fall between the cracks...even though we are financially better off...The government services are for those who are in need, but we are 'in need' and we get turned away

I would have had a lot more help if I was on a pension

...it was impossible to get help...I was turned away from a Community Centre

Eligibility criteria provided considerable concern to some Consumers. One Consumer talked about the notion of there being a “template for CR” and if Consumers did not “fit” the template, then they were refused services. The experiences of Consumers suggested that the health and rehabilitation system is complex and difficult to negotiate.

Other barriers to accessing CR services expressed by participants were long waiting periods, complacent staff, lack of consideration for people’s resources when planning interventions (e.g., cost), and lack of knowledge about necessary services.

...I belong to the mob [service] down the road and sometimes I could go and punch them because you ask for help and they say 'oh we don’t do that’ or ‘I'll get you somebody that will do it’, but you’ll wait a week’. Or you’ll wait a fortnight and maybe they’ll come back to you and say 'yes’, but if you push them – ‘oh, I forgot to do that’.
...what they came up with, the idiots, is that I could buy one of those things that you wear around your neck and they press it if they fall over.... It costs a fortune.

An Advocacy Role

- **Community Understanding of Disability, Engagement and Support is Pivotal to CR**

CR was considered to be about much more than an Allied Health practitioner implementing therapeutic interventions. For Consumers, CR was also about the community being aware of disability and how it influences their ability to regain independence. Consumers explained that their needs were broader than physical functioning and health – as such, rehabilitation was about the “whole of life and how you are going to function and live within the community”. Rehabilitation was also about the need for health practitioners and the community to be educated about disability from the perspective of the Consumers. The discussion strongly supported the need for environmental and physical adaptations within the community to facilitate access for people with disabilities. This need was not separated from rehabilitation and was generally viewed as part of the total package that should be provided by CR.

- **Environmental and Attitudinal Barriers**

In a related topic, environmental and attitudinal barriers were identified as further contributing to participants' marginalisation, preventing them from participating fully in their community -- “you could walk in...to become a member of a library...and you’re standing there with your white cane and they ask you for your driver’s licence. For crying out loud”. Consumers also described structural barriers that impeded their access and participation – “architects design buildings that only have handrails on one side of the stairwell. Now that’s fine for one way, but the other way you’re stuffed”; “It’s very difficult when your legs don’t work...I went to go see my Grandson play piano...there was no way in the world I could get down those steps [in the auditorium]...so I stayed up top by myself”. Throughout these examples was a common thread – Consumers felt overlooked, invisible and as though their humanity was discounted as a result of their disablement, “if you’ve ever been in a wheelchair, people talk to the person pushing the wheelchair, it could be pushed by an orangutan and they’d rather talk to the monkey”.

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Consumers were adamant that the community would benefit from education and awareness raising, and saw this as an important role for the health sector — “...the health department, if they're working with people with multiple conditions...there needs to be some sort of public education system...”. To genuinely facilitate CR, it was seen as necessary to facilitate supportive structures and strategies within the community. A true CR model seeks to view the community itself as the ‘Consumer’ and involves identifying the needs of the community, community collaboration and community ownership of programs.

The Elements of CR From a Consumer Perspective

Based on the discussions among Consumers, a number of factors emerged which should be integrated into a Consumer focussed CR Competency Framework.

A Holistic Framework

- Pay attention to my holistic needs, including my emotional and social state
- Work with other practitioners and with my natural support systems

Consumer-Driven Process

- Recognise me as an expert and an important source of knowledge
- Be “in-my-life” not just “in-my-home”
- Understand my unique experience of disability in my daily life
- Nothing about me without me
- Appreciate my individual journey and the impact of this on rehabilitation

Promote Disability Awareness

- Promote disability awareness in the community
- Be proactive to reduce barriers in the environment and society

A Seamless Process

- Do not compartmentalise rehabilitation – it should be one package
- Begin early to prevent losses and crises
- Share information to devolve control to me and my family
- Respond to my values, what is important to me over time, and my changing needs
- Ensure equitable access to services for all of us