Capacity building in community rehabilitation education – a review of the literature

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For the:
Community Rehabilitation Workforce Project, Queensland Health
August 2006
Contents

Context ..................................................................................................................................................3
Community Based Rehabilitation versus Community Rehabilitation .............................3
CR competencies ..............................................................................................................................4
Capacity Building for CR ..............................................................................................................5
Training for CR Professionals .......................................................................................................6
Existing recommendations for CR curricula and delivery .....................................................7
Barriers to uptake of CR education ..............................................................................................9
International and national approaches to CR education and training .............................10
Conclusions ....................................................................................................................................11
Appendices ....................................................................................................................................13
  Appendix A: Literature Review Search Strategy .................................................................13
References .......................................................................................................................................14
Community rehabilitation (CR) is an important component of the spectrum of health service delivery required to meet the current and emerging health needs of the Queensland community. Consequently, there is a concerted focus to optimize the capability of the current and future workforce, to develop, implement and evaluate community rehabilitation programs (Queensland Health, 2006e).

Queensland Health’s Community Rehabilitation Workforce Project (CRWP), funded by the Pathways Home Program, aims to investigate and implement CR training and development initiatives in Queensland. The CRWP commissioned an audit of interdisciplinary CR Competencies in Queensland, in order to establish a foundation upon which to base the development of future CR training and education initiatives (Griffith University, 2006).

With the information provided by the Audit (Griffith University, 2006), the CRWP is now seeking ways in which these CR competencies can be incorporated or enhanced in existing Queensland Tertiary curricula or where opportunity for writing new curricula might exist. Staff from Griffith Health have undertaken this literature review to gather background to inform the process of capacity building in community rehabilitation education.

This literature review discusses the concept of capacity building in relation to CR education and training, curricula and delivery. It also examines the degree to which existing CR relevant education and training courses/programs (at the undergraduate and postgraduate levels) reflect the competencies identified as necessary for effective CR practice (Griffith University, 2006). The search strategy employed for the literature review can be found in Appendix A.

The literature review was also conducted with specific reference to target disciplines namely; physiotherapy, speech pathology, occupational therapy and nursing. This literature review also investigates how CR training is currently delivered, highlighting barriers to access and uptake and identifying the educational processes and training frameworks that the literature suggest are required to effectively impart CR competencies.

Community Based Rehabilitation versus Community Rehabilitation

Historically Community Based Rehabilitation (CBR) and CR evolved from the traditional rehabilitation model to establish a comprehensive multi-sectoral approach to healthcare (Mitchell, 1999). CBR/CR models are influenced by socio-economic,
cultural, geographical and political diversification which makes it difficult to define one model (Doig and Kuipers, 2005).

The difference between the concepts is not easily defined however one clear distinction between CBR and CR is that CBR is largely about community development (more common in developing countries) while CR is about rehabilitation delivered in a community setting. Nonetheless, a lack of consensus and conceptual understanding has ensued as a result of commentators, researchers and practitioners using these concepts interchangeably and perhaps with different objectives in mind (Bailey, 2005; Sui and Chui, 2003). The Audit (Griffith University, 2006) suggests that the "major difference between CR and CBR is the extent to which the process is Consumer-driven and based in grass roots foundations" (p.190). CR then is more consistent with ongoing health reform in Australia and is the reality of contemporary practice (Queensland Health 2006e).

Queensland Health (2006d) defines CR in the following way:

*Community rehabilitation seeks to equip, empower and provide education and training for rehabilitation clients, carers, 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 client outcomes* (p.1).

CR is pivotal in providing rehabilitation services in a Consumer’s environment and is implemented through the development of strong interrelationships between families, communities, people with disabilities and the appropriate health, educational, vocational and social services (Kendall, Buys and Larner 2000; Kuipers and Quinn, 2003; WFOT, 2003).

**CR competencies**

In order to establish the competencies required for effective CR in the Queensland context, the CRWP sponsored an audit process (Griffith University, 2006). The Audit (Griffith University, 2006) adopted comprehensive data collection and methods of analysis to gain comprehensive understanding of CR and the competencies required for CR education and training. The Audit (Griffith University, 2006) identified one hundred and eighty two individual competency statements that were collapsed into 10 competency domains. The specific CR Competency Domains that have been identified from the Audit (Griffith University, 2006) are:

- Frameworks of Understanding
- Networking
- Cultural Awareness
- Consumer Engagement
- Service Continuity
- Reflective Practice
- Community Engagement
• Boundaries and Safety
• Systems Advocacy
• Holistic Practice.

The Audit (Griffith University, 2006) defined competencies as including attitudes, knowledge and skills and delineated ten (10) competency domains determined by CR stakeholder groups as required for effective CR practice. Rehabilitation professionals, according to Crocker et al. (2001) should embody the right values and beliefs such as those that support community inclusion, opportunity for growth and development and citizenship.

According to Farkas and Anthony (2001) and Mertz (2001b) educating such a diverse range of rehabilitation personnel requires a clear curriculum that unites staff, regardless of discipline or background characteristics, around a single mission and philosophy to create a common competency based approach to CR training. Kuipers and Allen (2004) also support the need for all allied health professionals to operate from a “consistent framework of primary healthcare theory” (Griffith University, 2006 p. 29). To this end, CR embraces many core competencies/principles that transcend all allied health disciplines and provide a basis from which the presence or absence of competencies may be determined. As such, CR competencies outlined in the Audit (Griffith University, 2006) provide a competency-based approach to underpin CR training, assessment and supervision of students/practitioners working in CR. Furthermore, competencies are causally related to effective job performance and influence the delivery of care (Young, Chinman, Forguer, Knight and Vogel et al., 2005).

Therefore, clearly defined competencies provided by the Audit (Griffith University, 2006) are critical to the development of the CR profession and professional identity because they underpin and provide for recognition and accreditation processes, standardized and equitable assessment processes, articulated training pathways and career progression (Pearson, Fitzgerald, Walsh and Borbasi, 2002).

**Capacity Building for CR**

While there is no one best way to implement capacity building, the development of a framework that identifies the critical factors to target is an ideal starting point. According to Foster-Fishman et al (2001) and Allen (2001), when ‘capacity’ is emphasized, it channels energy to affect change at four critical levels:
- within members (stakeholders such as educators and students),
- within their relationships (internal and external),
- within their organisational structures (leaders), and
- within the programs they sponsor (partnerships with industry, community and government).
Building member’s capacity can often place unique demands upon them. In order to overcome these demands a wide range of specialised skills is required (Foster-Fishman et al., 2001). For instance, it is important to acknowledge members’ existing competencies and any efforts they have made in order to enhance these competencies. Further, the identification of a foundational base from which to build capacity including for example, understanding diversity, communication and conflict resolution may need to be established (Foster-Fishman et al., 2001).

Creating a relational capacity such as developing multidisciplinary approaches to CR service delivery are required to optimise client outcomes. At this critical level, it is important to create positive internal relationships and external relationships that recognize the interdependence and interrelatedness of all stakeholders and community sectors (Foster-Fishman et al., 2001).

The next critical level is building organisational capacity which encapsulates a strong leadership base that requires leaders to have the necessary skills/competencies and “the vision to transform individual interests into a dynamic collective force that achieves target outcomes” (Foster-Fishman et al., 2001, p. 253). Building organisational capacity can be achieved through empowering others and through efficient and formalized processes and procedures that clarify staff and member roles (Foster-Fishman et al., 2001). A leader that builds organisational capacity for their health professionals for example, is one that fosters a learning culture that supports professional and personal development as an integral component to capacity building.

The final critical level is the design and implementation of programs that provide realistic application within communities. It is therefore important to establish community needs via partnerships and to harness community support when developing and implementing programs in order to mobilize “community support for these efforts” (Foster-Fishman et al., 2001, p. 256). Programs that are developed based on community need complement and maximise existing community strengths and resources.

**Training for CR Professionals**

The final decade of the last century witnessed rapid changes in the tertiary education sector. The implementation of the Dawkin reforms resulted in the creation of a unified national system of tertiary education in Australia and a diversity of courses available. Most universities adopted broad consultation with key stakeholders including employers of their graduates and this influenced a core of “generic graduate qualities/capabilities/attributes” that should be demonstrated by new graduates (McMeekan, Webb, Krause, Grant and Garnett, 2005 p. 14).

Recently however, concerns have been “expressed at the increasing amount of content required to be included in the curricula and the challenges facing curriculum
developers in preparing students to practice in increasingly complex work environments” (McMeekan et al., 2005 p. 7). Rapid increases in knowledge and treatment approaches in diverse settings has created an overcrowded curriculum and precipitated the need for research to inform curriculum change (McMeekan et al., 2005). Changes in health care delivery with community management of patients with chronic conditions and early discharge into the community exemplifies such need. In addition, the number of stakeholders with different agendas involved in curriculum development (which includes Consumers) coupled with changes in service delivery and the need for practitioners to have the necessary competencies to respond to these changes, has weighed down the curricula in the target disciplines. Consequently there is limited capacity to increase the length of degrees to incorporate additional courses. Doing so could adversely affect the numbers enrolling and graduating, compounding the current skills shortage amongst the target professions.

An increasingly diverse and complex range of roles and responsibilities exist for allied health professionals in order to meet current and future health service delivery demands (Ford and McIntyre, 2004). Despite this, allied health practice continues to be guided predominately by the competency base derived through their discrete core discipline. As a result, those allied health professionals practising in CR have developed non discipline specific competencies largely through on-the-job experience, in-service training and/or postgraduate studies (Griffith University, 2006).

Kendall et al., (2000) discuss the importance of educating workers about the fundamental principles of CR and its essential constructs of empowerment and inclusion, to aid CR implementation within the community, as opposed to socialising students into traditional practices. Kuipers and Allen (2004), Sharma (2005) and The World Federation of Occupational Therapists (WFOT) (2003) concur with Kendall et al (2000) stating that CR principles of equity, justice, community capacity and trust should be more clearly operationalised and that CR is pivotal to transferring knowledge (and therefore power) to the community.

**Existing recommendations for CR curricula and delivery**

Historically, education has been based upon a traditional didactic approach to learning (Higgs and Edwards, 1999). Skill development then occurs along a continuum from readiness to expertise. The stages of the continuum from the lowest to the highest are readiness, awareness, acquisition, application, utilization and finally maintenance (Farkas and Anthony, 2001). While skill development and expertise is increased by traditional didactic approaches to learning, such academic programs often only provide introductory expertise training by helping students to perform skills correctly in a simulated setting. As a result, many training programs expect expertise-level outcomes from exposure-level training (Farkas and Anthony, 1990). Ideally, expertise training requires a combination of intensive supervision, practice, feedback, didactic presentations and exercises. Very few programs
however provide for such practical skill development due to the extent of supervision and the intensity of expertise level training required (Bond and Spurritt, 1999).

Therefore, as much as possible, training delivery should be on site, local and accessible (Crocker and Heslop, 2001). This proposal is supported by research by Reymond et al., (2005) that revealed the need for education delivery to be refocused to facilitate interaction, case studies and be personalised to individual clinicians in particular settings. Other commentators such as Enderby and Wade (2001) advocate for a CR model of service delivery that acknowledges services at a community level. Here people, families and communities can be resources and provide professionals with information, knowledge and skills. This educational framework, also a key recommendation of the Audit (Griffith University, 2006) recognises the consumer as an expert and important source of knowledge. In this way, a balance of the ‘lived experience’ with clinical knowledge in training and practice settings may be provided to potential students.

The Audit (Griffith University, 2006) also highlighted a need for CR training and education to have a consistent approach (inclusive of language and content) across disciplines to facilitate an understanding of the CR domains. Further suggestions are that competency development and career paths should be clearly articulated across industry and community sectors (Crocker and Heslop, 2001). In reconciling these general principles with training and recruitment approaches, Kuipers and Allen (2004) (at an Australian CBR forum) discussed requirements for the implementation of CR training in rural, remote and Indigenous Australia and identified the need to develop entry-level training. Forum members not only proposed, “that broad-based, entry-level training (that recognises prior learning and articulates with other health worker training) [was] required” (Kuipers and Allen, 2004, p. 3), they also stressed the importance of including CR training in the core curriculum for CR health professionals. Forum members suggested that such a CR educational framework would also enable “greater interdisciplinary linkage across allied health professions and, in rural areas, greater linkage with University Departments of Rural Health” (Kuipers and Allen, 2004, p.3).

To highlight training needs from the allied health professional’s perspective, Crocker and Heslop (2001) conducted a focus group that identified the need for training that is linked to the job profile/function and to the clients they serve. Focus group participants suggested the development of individualised training plans as well as a passport system to document the completion of relevant competencies/courses (Crocker and Heslop, 2001). Participants also suggested a balance of training that is delivered locally and away from the community/worksite as a way to foster networks and reduce isolation (Crocker and Heslop, 2001). To this end, Crocker and Heslop (2001) propose training that can be delivered by E-learning, distance education, weekend programs and on site education. Other recommendations generated at the focus group included the establishment of a CR Careers Project to consolidate alliances and partnerships across systems and sectors such as universities,
community colleges, mental health systems, disability organizations and in house training programs.

The Audit (Griffith University, 2006 p.5) identified the most frequently used training methods as on line documents and articles, training seminars at the workplace, workshops with experts, team-based learning networks with other practitioners, conferences, input from consumers and training development plans. However, the most preferred methods for training were videos and written material within a network session, hands on training combined with group networking, on the job training with good mentoring, team-based learning in local workplaces, exposure to multiple environments and workplaces and finally networks of experts sharing information. A combination of networking, experiential hands on learning and team practicum that exposes students to multiple workplaces in an interactive team environment then appears to be the most conducive delivery of CR education and training.

**Barriers to uptake of CR education**

Lack of knowledge and experience in CR, lack of core competencies within and across disciplines and limited opportunities for CR training and professional development have the potential to result in an ineffective CR workforce and subsequently, poor and unsustainable client outcomes. Practitioner’s personal values and behaviours are also affected when inadequate consideration is given to career opportunities and training, alongside low pay (Mertz, 1999). The repercussions of these factors not only affect training uptake and workforce competence but also retention of the health workforce. For CR, these affects are compounded by a low profile, compared to other discipline specific therapy in the health workforce (Griffith University, 2006).

The Audit (Griffith University, 2006 p. 7) presented the findings in regard to barriers to training in five (5) major categories:

- lack of an individual commitment to professional development and learning amongst some practitioners,
- lack of an organisational culture to foster staff development,
- need for training to accommodate a range of situational factors and circumstances,
- need for training to accommodate a range of levels of knowledge and styles of learning,
- motivation to attend training based on clinical dilemmas rather than CR practice.

Allied health professionals also commented that training should fit into a broader career path and that it should be part of a career structure that would enable them to progress or achieve desired positions and recognition (Griffith University, 2006). Other commentators including Crocker and Heslop (2001) have documented similar barriers.
According to the World Health Organisation Report (2000) in order to provide support and maintain a competent health workforce, it is imperative to acknowledge that “knowledge does not deteriorate with use, but old skills however do become obsolete with the advent of new technologies and continuing education” (p. 76). Communication technology, Internet communication and web-based learning for example, have enabled innovative and exciting new models of training service delivery to be considered (Mertz, 2001; Murtaugh, Pezzin, McDonald, Feldman and Peng, 2005).

The literature revealed that the factors affecting training uptake were diverse, individual, organizational, geographical and economic. Cost, time and mobility of those receiving the training, the expertise of the trainers and educators and their availability and advances in educational technologies represent some of the barriers to the establishment of effective training programs (Braun, Cheang, and Shigeta, 2005; Brittain and Norris, 2000). Other barriers identified were the duration of training (Russell and Bradley, 1997), reluctance to accept change and failure to adapt to new methods (Abbas, 2003) and organizational culture, job satisfaction and level of commitment (Griffith University, 2006).

**International and national approaches to CR education and training**

Philosophies that may drive CR education are vocational imperatives, human rights and social and medical frameworks. These differences are reflected in the training programs each country provides for their health professionals. Capacity building for CR education and training in the USA is strongly correlated with eligibility to participate in vocational rehabilitation (Leung, Holloway, Reed and Menz, 2004). Conversely, academics and commentators for CR education and training in Canada such as Marlett (2001) and Neufeldt (2003) state that capacity building for the Canadian CR curricula is entrenched in the principle of entitlement and based on client-determined social outcomes for rehabilitation that are not dominated by vocational outcomes. To illustrate these contrasting agendas for CR, the Audit (Griffith University, 2006) compares the Canadian and US perspectives as socialist rather than capitalistic respectively.

For Australia, Bottroff, Grantley, and Brown (2000) highlight the importance of anchoring CR education and training to need. In this scenario, CR education and training curricula is informed by consultation with industry, community and government. The consultative process with industry and community for the development of CR education and training at Flinders University has provided for professional development opportunities and ensures that graduates are well prepared to meet the realities of CR practice.
These differing perspectives and subsequent approaches to CR education and training have implications for the nature of CR and the training required within Australia (Griffith University, 2006). Investigation has shown, that there is no single Bachelor of CR currently available nationally though many state and national universities offer courses and programs (including the target disciplines) whose content reflect varying degrees of CR competency domains.

**Conclusions**

This literature review was undertaken to inform capacity building of community rehabilitation in the Queensland context. Having clear definitions and nomenclature to describe CR is clearly an important part of CR education, particularly in relation to its relationship with CBR. CR competencies as defined by the Audit (Griffith University, 2006) underpin CR training and education which should flow through to effective job performance. The CR competencies can also potentially provide a force for unity between different disciplines, through creating a common competencies base in training and practice.

The review has highlighted that capacity building requires educators and students to forge strong links with industry, community and government. This ensures that the direction education takes is in keeping with community need.

It is suggested that currently allied health professionals practicing CR in Queensland have primarily honed their non-discipline specific competencies through experience, in-service training or postgraduate studies. A need for CR competencies to be included/highlighted within core curriculum of undergraduate programs was mooted. However, undergraduate curricula for the target professions is becoming increasingly crowded as educators attempt to adapt to a rapidly changing health care delivery environment. Therefore it is likely that CR material can only be incorporated and/or highlighted within programs if there is no net effect upon the length of programs.

It was recognized that to acquire expertise in CR competencies, training must include practical components which might require intense supervision. This is in addition to didactic presentations and simulated exercises. The consumer, families and communities are also important sources of knowledge for students.

Accessibility of training (particularly for practicing professionals) is of vital importance. Training needs to be linked to job profile and function with as much individualization as possible. Networking, experiential hands on and team based learning were identified as most conducive to delivery of CR training.

The need for a link between CR competencies, education and training and potential career paths was identified. Some form of entry level CR training was suggested as a way to possibly meet the particular needs of rural, remote and indigenous clients.

Substantial barriers to uptake of CR education were identified including limited opportunity, lack of accommodation of training to individual needs and lack of organizational support. The absence of a clearly defined career path within CR was
also a disincentive to training. Communication technology should drive innovation in training models and provide a reduction of some barriers.

CR education and training in Canada and the USA very much reflect medical, social and vocational frameworks within those jurisdictions. Similarly Flinders University in South Australia, has tailored its approach to CR education and training in response to Australian perspectives.
Appendices

Appendix A: Literature Review Search Strategy

The search strategy involved a review of the literature collated by the Audit (Griffith University, 2006) and following up on specific leads relevant to the current project such as issues pertaining to community rehabilitation (CR) education and training and barriers to uptake. Also, the literature search was conducted based on knowledge of key commentators in the field, knowledge of a number of current initiatives and a systematic search of the following databases:

Table A1: Types of Databases Searched

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<thead>
<tr>
<th>Peer-Reviewed Databases</th>
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<tbody>
<tr>
<td>Cinahl via Ovid</td>
<td>Proquest (ALL)</td>
<td>Medline via Ovid</td>
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<tr>
<td>Blackwell Synergy</td>
<td>NARIC (National Rehabilitation Information Centre)</td>
<td>Ingenta</td>
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<tr>
<td>Cochrane Library</td>
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<th>Non-peer reviewed databases</th>
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<td>Google</td>
<td>Google Scholar</td>
<td>Hobson’s Guides (provides information on every course, every campus and every higher education institution in Australia)</td>
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### Table A2: Key Search Terms

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<tr>
<th>CONCEPT: KEYWORDS</th>
<th>KEYWORD SUBGROUP</th>
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<tbody>
<tr>
<td>Community Rehabilitation (CR) OR Community-based Rehabilitation (CBR) OR</td>
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<tr>
<td>CR Capacity Building OR</td>
<td>Rehabilitation</td>
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<td>AND</td>
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<tr>
<td><strong>KEYWORD SUBGROUP</strong></td>
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<td>Allied Health OR</td>
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<td>Nationally OR</td>
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<tr>
<td>Internationally</td>
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### References


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University of Calgary. (2005). Community Rehabilitation. Department of Community Rehabilitation and Disability Studies Faculty of Education, retrieved 06/12/05 from [http://www.ucalgary.ca/programinfo/Education/CommunityRehabilitation.html](http://www.ucalgary.ca/programinfo/Education/CommunityRehabilitation.html)


