DEVELOPING A RURAL COMMUNITY-BASED DISABILITY SERVICE: (I) SERVICE FRAMEWORK AND IMPLEMENTATION STRATEGY

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ABSTRACT: In response to widely recognised dilemmas associated with rehabilitation and disability service provision in remote and rural areas of Australia, a community-based, participatory approach to service development was adapted for a disability service project in central Queensland. The service framework, known as Community Based Rehabilitation (CBR), fosters the involvement of community members in disability service provision. Although this framework has been described previously, few guidelines exist regarding appropriate implementation of such an approach. Consequently, the implementation strategy known as Participatory Rural Appraisal (PRA) was adopted. Participatory Rural Appraisal has been reported to foster the participation and decision-making of community members in community projects. The present article describes the application of this implementation strategy to disability service provision in a relatively under-resourced rural shire. The rationale, framework and process of the pilot are described. A subsequent publication will document the service component, detail evaluation findings and describe the long-term outcomes of this research.

KEY WORDS: Community Based Rehabilitation (CBR), community development, community participation, disability service provision, Participatory Rural Appraisal (PRA).

INTRODUCTION

Rural disadvantage extends beyond economic, social and general health indicators to injury and disability.1,2 People with disabilities in rural areas experience significantly more social problems than their urban counterparts, but have access to fewer resources. Certain distinctive features of Australian rural culture also impact on service uptake, service utilisation and rehabilitation outcome. Unfortunately, many metropolitan-based rehabilitation and disability service frameworks fail to accommodate these demographic and cultural issues. As a result of such factors, rural Australians with disabilities are likely to experience inadequate rehabilitation and disability services; a situation that has been associated with high social, welfare and health costs.3

In response to these concerns, a pilot study was initiated to explore and evaluate an innovative approach to disability service delivery in rural areas, utilising a community-orientated, theoretical framework.4 This approach, based on the World Health Organization’s model of Community Based Rehabilitation (CBR), has been found to be highly beneficial in many small-scale projects in developing countries.5–7 Internationally, CBR has been identified as a key priority by the United Nations Economic and Social Commission for the Asia Pacific Region (UN-ESCAP). Despite a few exceptions, it remains largely untried in Australia. Unfortunately, few practical and effective frameworks exist to guide the implementation of CBR. To this end, the
strategy of Participatory Rural Appraisal (PRA) was adopted and modified to facilitate the implementation of CBR in the current pilot. It is anticipated that the pilot will result in the development of a practical model for the implementation of CBR to respond to the needs of people with disabilities and their families in rural and remote areas of Australia and inform rural disability service development.

THE RURAL CONTEXT

Rural Australians’ attributes and circumstances substantially impact upon their utilisation of rehabilitation and disability services. In general, it may be observed that compared with their urban counterparts, rural people are more likely to experience serious physical or mental health problems but less likely to seek services, often delaying help-seeking until it is socially or economically convenient to do so. They tend to be less financially secure, more socially conservative, more work-oriented, and yet more often unemployed. Specifically, in relation to developing new services, it has been noted that rural people demonstrate a strong commitment to personal independence and self-reliance, deeply committed to local issues, and yet more often unemployed. They have been described as overspecialised, failing to target the more general needs of users and yet offering limited choices. Clearly, the rural context has proven a challenging environment for disability services; for example:

1. Traditional urban models that have been adapted to rural settings have struggled with: (i) the reality of population dispersion and its practical implications; (ii) the inability to achieve a critical mass of service users for a sufficient client base; and (iii) recruitment and retention of staff.

2. Services that require rural clients to travel to urban centres have resulted in considerable expense and disruption for families and community dislocation for people with disabilities.

3. Outreach and visiting services, which are the most common forms of disability service provision in rural Australia, are susceptible to high staff turnover, staff burnout and inadequate rapport between service providers and consumers. They may be perceived poorly by consumers and might result in impersonal, superficial services lacking continuity of care.

4. Satellite services, in which regional bases are established, may be extremely costly and may also lead to the dismantling of existing local supports.

Concerns have been raised that traditional approaches to rural service delivery do not address the crucial interface between the community and disability. It is suggested that this juncture between community and disability is fundamental to ensuring sustainable and appropriate rehabilitation outcomes. Policy-makers have confirmed that alternative models of service provision must be explored and indeed the previous National Rural Health Strategy and the current Healthy Horizons framework affirm the development of appropriate service models as a key priority.

In recognition that services should seek to be responsive to their contexts, the current pilot is based on a model that could be tailored to the unique needs of rural Australians with disabilities. The model recognises that in order to be effective, services must be available, affordable and physically accessible, but they must also be acceptable to their community context. The ‘goodness-of-fit’ between a community service and its clients is crucial to ensuring acceptable, accessible services. To address this issue, authorities in the area have suggested that there is a need to involve rural consumers in the planning and development process. To date, few studies have examined such consumer participation in service planning and delivery. The present study sought to respond to this situation by exploring and piloting an alternative approach to responding to the needs of people with disabilities in rural areas using a participatory implementation strategy.

THE PRELIMINARY STUDY

A preliminary study was conducted prior to the current pilot, first to examine the needs of a sample of rural Queenslanders who had sustained serious disabilities and, second, to identify appropriate methods of delivering rural rehabilitation to these people. In-depth telephone interviews were conducted with a small number of rural people with disabilities who responded to a media campaign (radio stations and newspapers), requesting information about their concerns. As anticipated, commonly reported problems included mobility and access problems, geographical, time and vocational barriers, inadequate services and funding limitations. Interestingly however, respondents in telephone interviews also reported high levels of social assistance from neighbours and considerable support from community members. This study concluded that rural rehabilitation service delivery models should seek to (i) acknowledge the
COMMUNITY-BASED REHABILITATION

Although the term ‘community-based rehabilitation’ is commonly used in a variety of contexts, it is generally accepted that CBR had its beginnings in the World Health Organization initiatives of the 1970s. It has undergone substantial refinement and evolution over the past three decades and CBR is now regarded as the model of choice for disability service delivery in many countries.

Community Based Rehabilitation was defined in a 1994 United Nations joint position paper as a strategy within the realm of community development to facilitate the rehabilitation, equalisation of opportunities and social integration of all people with disabilities. Community Based Rehabilitation is implemented at the grass roots level through the combined efforts of people with disabilities, their families and communities and the appropriate health, education, vocational and social services.

While this definition is broadly inclusive, CBR can be characterised by its emphasis on: (i) developing partnerships and fostering community participation; (ii) supporting and facilitating initiatives taken by people with disabilities, their families and communities; (iii) a focus on local integration; and (iv) the maximisation of formal and informal services. The key principle of CBR has been defined as ‘engagement between people with disabilities and their local communities’. Indeed, CBR may be distinguished from other approaches to disability by its emphasis on the local involvement of community members in reciprocal participation with people with disabilities and their family members.

Typically, CBR projects start with the establishment of a local committee, identification of people with disabilities in a local area and the conducting of a needs analysis. Key community members are identified and approached to act as volunteer workers. Locally relevant disability training materials are usually developed from standard manuals. Training is provided to volunteers in the use of basic rehabilitation techniques and community development strategies. With occasional oversight from professionals, volunteers are assigned to work with a few people with disabilities and their families. In most instances, they conduct basic rehabilitation programmes, monitor progress, train family members and develop an informal referral network.

The CBR approach has been reported to be instrumental in:

1. Demystifying the disability service delivery process, giving responsibility back to the individual, the family and the community.
2. Avoiding unnecessary compartmentalisation of services and subsequent optimisation of health and welfare systems.
3. Raising awareness of the service needs of people with disabilities and enabling people to appreciate how these needs could be met within the community’s own resources.
4. Promoting the visibility, participation, decision-making and social role of people with disabilities.
5. Identifying and reinforcing the resources of families and the local community.
6. Strengthening of the immediate community around the person with a disability and fostering of a greater sense of community responsibility and civic consciousness.
7. Achieving considerable physical, functional and psychological outcomes for people with disabilities, despite the informal, ‘community’ nature of supports.

IMPLEMENTING CBR THROUGH PARTICIPATORY RURAL APPRAISAL

Despite its potential utility, CBR has not been extensively implemented in Western contexts. Consequently, initial planning for the current pilot study involved the search for an appropriate implementation methodology. The methodology that was selected is known as Participatory Rural Appraisal (PRA), an approach that has been found effective for implementing agricultural projects, promoting community development and developing ecological projects within rural communities. The PRA process has also been found to facilitate the
exchange of knowledge and experience between rural communities and researchers and support the auditing and evaluation of projects. The success of PRA may result from the fact that it is seen as an important tool for assisting communities to learn new approaches and take an active role in local development projects.

Participatory Rural Appraisal may be seen as a research and development ‘style’ (i.e. a learning outsider working with a community to enable them to explore issues at a local level) rather than a formal method in which an expert employs certain development techniques. Participatory Rural Appraisal is characterised by:

1. The use of group processes and community-level interactions (rather than individual interpretation) to share information, collect data, promote analysis of the information and encourage community action.
3. Recognition that community-based action is a multitiered approach.
4. The use of visual representations of concepts at local community meetings (‘maps’ and graphic representations of social and other phenomena). These visual tools, when developed by community members and used appropriately, legitimise local knowledge, promote empowerment and enable creative strategies to be developed by participants.
5. A reliance on qualitative data and triangulation (exploring an issue or question through a number of different methods and from different sources).

In summary, PRA is an approach for sharing learning between local people and outsiders. As a process, it seeks to be flexible rather than rigid, visual rather than verbal and based on group rather than individual analysis. Finally, there are indications that the PRA approach is suited to the area of community disability service development.

THE EIGHT-PHASE PRA MODEL IN THE CURRENT PROJECT

Having identified a service framework (CBR) and an implementation strategy (PRA), the investigators developed a formal research proposal, obtained funding and sought University Ethics Committee approval. Understandably, ethical concerns over the protection of confidentiality, consent, structure of potential interventions and quality control had to be addressed prior to approval. The researchers emphasised that while due processes would be observed and relevant consent would be obtained, in community interventions such as this, traditional constraints were harder to impose. It was agreed that potential risks inherent in the use of participatory and community strategies in disability service research were balanced by the prospective benefits of the framework: responsiveness and community-relevance.

On approval, the researchers returned to the data and experiences derived from the preliminary study to identify a location for the project. Taroom, central Queensland was chosen because a number of the pilot study responses came from the district and, as a result, the researchers established some contact with the shire and its services. As an area with a small population (town population = 700, Shire population = 3000) and limited services, it was seen as a suitable location.

Ongoing review of research and discussions with rural community members resulted in the adaptation and operationalisation of the PRA methodology for the current project. An eight-phase PRA framework was devised (Table 1).

Phase 1: Gaining entry to the local community

Initially, researchers established contact with the community through media, relevant outreach services and local service providers, as well as a visit to the community. After discussion with a number of key people, a community member was identified who was well connected within the community and aware of human service and disability issues. She was approached to participate in the project and was appointed as Community Disability Researcher (CDR). In this part-time paid position, she was provided with informal training in research (trained by researchers in interviewing, data collection, maintaining confidentiality and the research process). She was also provided with basic skills in human service provision and community development.

Phase 2: Conducting interviews on local disability issues and concerns

The CDR slowly took on the major role of obtaining primary information, which involved conducting face-to-face structured interviews with local people with disabilities and their family members. The CDR also conducted structured interviews with relevant community stakeholders (disability service providers, medical and health services, community services and social services). Information from these structured interviews was combined with other locally relevant information on disability. These data provided the basis for the community needs assessment and indicated the level of community commitment to disability issues.

Phase 3: Collecting and analysing secondary information

The researchers conducted a broadly based survey of all health, social, welfare, community, religious, educational,
recreational or other relevant organisations operating within the Shire and neighbouring towns. This survey, in the form of a ‘reply paid’ questionnaire, explored the nature of formal and informal services available, barriers to service provision, the nature of assistance required and the way in which people in the Shire usually obtain assistance.

Simultaneously, secondary information relevant to the community was compiled. Locally relevant sources of information were sought (e.g. community development, health, agricultural development, farm safety, ambulance, police, church, etc.). More general information on social infrastructure, problems and opportunities were extrapolated from relevant secondary data sources (the census, National Health Survey, Federal and State departmental research and databases, studies conducted by non-government organisations, university research, published and unpublished reports).

Phase 4: Devising a preliminary conceptual framework
Information from the first three phases was compiled by all three researchers. These data resulted in the development of a picture of the community’s past experiences with disability services, current realities, local conditions and overriding constraints. This information was compiled into a ‘preliminary conceptual framework’.

Phase 5: Gaining community approval and support for a meeting
Each of the researchers was involved in obtaining approval and support for a community meeting. This was done at an informal level (mostly in follow up after an interview with people with disabilities and family members), at the service level (through formally asking for the support of relevant service and health providers) and at the community level (through formally seeking the support of key community committees).

Phase 6: Conducting a community meeting
A community meeting was then organised to explore community responses to disability issues. Information from the first five phases of the research was presented to meeting participants in diagrammatic and graphic form. This presentation sought to inform participants and use their skills and experience to further refine the information. The resultant information was then summarised with meeting participants into a ‘current reality map’. This map enabled meeting participants to identify and contextualise the needs of people with disabilities in the shire.

Based on the current reality map, priorities for action were identified by the meeting participants. Two major questions were then proposed to the participants, namely:
1. Which of these issues can we influence directly within our current local resources? How?
2. What can we influence indirectly through lobbying, advocating for our community, etc. How?

A number of strategies were then identified that were relevant to that community. These were again prioritised and combined with previous information to form the ‘future planning matrix’. Potential strategies for action were noted and the outcomes of the meeting were summarised.

### TABLE 1: Eight-phase PRA framework utilised for implementing a community-based disability service pilot in rural Queensland

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<tr>
<th>Phase</th>
<th>Description</th>
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<tr>
<td>1. GAIN ENTRY</td>
<td>Appoint and train local person as Community Disability Researcher.</td>
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<td>2. INTERVIEW</td>
<td>People with disabilities, others: ascertain level of need, level of community commitment.</td>
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<tr>
<td>3. Collect and analyse SECONDARY INFORMATION.</td>
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<tr>
<td>4. Devise PRELIMINARY CONCEPTUAL FRAMEWORK.</td>
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<td>5. OBTAIN APPROVAL AND SUPPORT for a community meeting on disability issues.</td>
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<tr>
<td>7. Provide FEEDBACK from meeting to all interested parties. Suggest model for action.</td>
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<tr>
<td>8. INSTIGATE processes for action. Identify key local person(s). Develop structures.</td>
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Current reality map:
- a) EXPLORE. Group exploration of disability as a community issue.
- b) MAP NEEDS AND SERVICES. Visual representation of needs and supports.
- c) MATCH. Plot needs against available services: note strengths, weaknesses.
- d) PRIORITISE. Identify key issues for action. Plot on ‘matrix’.
- e) LOCAL ACTION. Identify what can be done within the community.
- f) BROADER ACTION. Identify what requires action beyond the community.
- g) SYNTHESISE. Match areas for action with strategy suggestions from meeting.
- h) SUMMARISE. Provide overview of community meeting. Notify of next step.

Future planning matrix:
- a) EXPLORE. Group exploration of disability as a community issue.
- b) MAP NEEDS AND SERVICES. Visual representation of needs and supports.
- c) MATCH. Plot needs against available services: note strengths, weaknesses.
- d) PRIORITISE. Identify key issues for action. Plot on ‘matrix’.
- e) LOCAL ACTION. Identify what can be done within the community.
- f) BROADER ACTION. Identify what requires action beyond the community.
- g) SYNTHESISE. Match areas for action with strategy suggestions from meeting.
- h) SUMMARISE. Provide overview of community meeting. Notify of next step.
Phase 7: Providing feedback to community members and key stakeholders

Within a few weeks of the meeting, the researchers collated and summarised meeting proceedings and, based on the derived information, proposed a model for action that was consistent with the derived map and matrix. This feedback was sent to all meeting participants and other key stakeholders, requesting comments and further suggestions.

Phase 8: Instigating processes for action and sustainability

The action model was revised to accommodate returned comments and suggestions from the community. Key people were identified who were willing to act in a voluntary capacity to support people with disabilities within the proposed model. Working closely with the Community Disability Researcher, the researchers started implementing the model and developing necessary community structures to ensure that the proposed programme was sustainable.

The eight-phase, adapted PRA process is seen to have resulted in a locally relevant, appropriate response to disability issues. The developed service delivery model has evolved with significant community input. It has strong community support and is focused on issues of concern to local people with disabilities and other community members. This model, its outcomes and evaluation, will be described in a subsequent publication.

CONCLUSION

Disability and rehabilitation services in rural areas have often been designed on the basis of urban models of care and implemented without input from the community. As a result, these models may clash with the rural community culture and fail to embrace the strengths of these communities. In response to these concerns, the current paper has outlined a pilot study that is presently being conducted in Central Queensland. This pilot represents an attempt to utilise and integrate an approach to rehabilitation that has been used in developing countries (CBR) through an adaptation of an appropriate implementation methodology (PRA).

The use of the PRA methodology has facilitated a degree of community ownership of disability issues and is resulting in service responses that are appropriate to the local community. While the results of the implementation and findings of the evaluation will be reported in a subsequent publication, anecdotally, it appears that the combination of a CBR conceptual framework and a PRA implementation strategy is resulting in:

1. A sustainable service model to respond the needs of people with disabilities.
2. Greater community awareness of disability issues.
4. More effective networking and coordination between community members.
5. Greater informal and community supports for people with disabilities.

For the research and rehabilitation community in general, the project will represent a practical demonstration of the utility, limitations and strengths of these approaches.

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