Royal Australasian College of Physicians

Australasian Faculty of Rehabilitation Medicine

Submission to Parliamentary Inquiry

Needs of urban dwelling Aboriginal and Torres Strait Islander peoples.

1. ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

The Royal Australasian College of Physicians (RACP) comprises a Fellowship of medical specialists who are committed to providing the highest quality of care in internal medicine, paediatrics and their sub-specialties for the people of Australia and New Zealand.

The RACP represents over 7,000 Fellows who are made up of Fellows of the College of Physicians and the three Faculties of Rehabilitation, Public Health and Occupational Medicine, and the Chapter of Palliative Medicine. In addition, the RACP encompasses a range of associated Special Societies representing the spectrum of specialist practice in Internal Medicine. Core functions of the RACP include training, accreditation, maintenance of professional standards, research and policy in areas such as workforce, public health, health financing and systems development.

2. AUSTRALASIAN FACULTY OF REHABILITATION MEDICINE (AFRM)

The AFRM is made up of Fellows with considerable experience in all aspects of rehabilitation medicine including service provision in Aboriginal and Torres Strait Islander communities and rural and regional settings. The Faculty's direct relationship with its Fellows allows the College and the Faculty to draw upon considerable clinical management and health service delivery expertise.

3. DISABILITY IN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

It is clear that Aboriginal and Torres Strait Islander people have a significantly higher rate of circulatory disease including cerebrovascular disease, endocrine disease especially diabetes mellitus, infections and trauma. These diseases, if not fatal, have a strong capacity to lead to significant disability and handicap, although there is limited data to quantify this in Aboriginal communities.

From the limited data available there appears to be a significant higher rate of disability amongst Aboriginal people as compared to non-Aboriginal people. Perhaps one reason for this limited data set is the difference in understanding of "disability" within Aboriginal and Torres Strait Islander cultures. Being disabled in an Indigenous culture has a different meaning and perception from non-Indigenous cultures. Health and disability service provision must take this into account.

It appears that most Aboriginal health services are focused on prevention and treatment of disease, with little in the way of services for disability. Disability services are different from acute care services. Special training is required in disability service provision in order to ascertain the needs of the individual and determine the type of service which would be both culturally appropriate and useful.

4. COMMUNITY BASED REHABILITATION

The Australasian Faculty of Rehabilitation Medicine supports and promotes the development of Community Based Rehabilitation (CBR) as a way to improve the access to rehabilitation services for Aboriginal and Torres Strait Islander people.

Community Based Rehabilitation is a World Health Organisation (WHO) endorsed program which provides a mechanism for specialised rehabilitation knowledge transfer into areas with limited resources and/or cultural unfamiliarity with the concept of rehabilitation. Much of the success of CBR lies in empowering the community in dictating its needs. A summary of CBR is attached. (Attachment 1.)

Whilst the CBR model has been primarily used in the third world setting, the people who have been integrally involved with the development and implementation CBR have stated that it is a model which could equally be applied in the urban setting.

The Northern Territory Government has utilised Community Based Rehabilitation as one of its strategies for disability management.

5. A WAY FORWARD

Many Aboriginal people feel more comfortable accessing services designed and delivered by and for Aboriginals. By delivering services in the community, workers can build trust with the community and enhance participation. Providing workers with access to employer and profession sponsored professional development will ensure the skills required to deliver an effective service.

Developing and implementing CBR requires people with commitment to the ideas and commitments of CBR and more importantly, to the people in the community and their way of life. In turn, linking with larger metropolitan based rehabilitation centres ensures access to state of the art research and development in rehabilitation practice and service delivery.

Aboriginal health workers show this commitment and dedication to professional development and service delivery to their communities. It is with these workers that an effective and appropriate community based rehabilitation service delivery model will be implemented and maintained.

6. CONCLUSION

Meeting the disability needs of Aboriginal and Torres Strait Islander communities requires more than moving clinicians out into the community. Clinicians are trained to deliver disability services in a clinical setting rather than the community setting. Development of CBR requires an independent group not involved with service delivery but who are involved with:

- Developing training packages for knowledge and skill transfer
- Accessing and entering communities
- Negotiating and developing mechanisms for community access to services
- Advocating for CBR in communities and the health care system
- Developing and maintaining monitoring and feedback systems and creating change based on information.

Fellows of The Australasian Faculty of Rehabilitation Medicine offer consultative services in the development, implementation and monitoring of Community Based Rehabilitation services. These services are available to urban indigenous communities, their health services and other agencies involved with community development within Aboriginal and Torres Strait Islander people.

Attachment 1.

Community Based Rehabilitation (CBR): Summary

1. Aims & Objectives

Like other, institution-based rehabilitation programs, CBR aims to optimise the functional status of people with disabilities to secure their independent, active participation in their community.

Unlike other programs, CBR has three distinct aspirations:

- reprovision of basic rehabilitation services in – or as close as possible to – the person's own home, building on existing infrastructure within the community;
- incorporation of everything necessary to improve the quality of life for a person with disabilities, eg. access to nutrition, water, sanitation, housing, education, child care, transport; attitudinal change within the community to disability issues;
- prevention of disability within the community.

This therefore requires:

- a fundamental change in philosophy as much as a translocation of services, eg. training for clinicians in working with communities, within community settings, with cross-cultural issues; transferring knowledge and skills to a community, inspiring and advising rather than providing services to an individual; offering a single access point for services; incorporating local definitions of quality in monitoring and evaluation arrangements;
- a much broader, more ambitious intersectoral policy approach, with recognition that 'full participation' includes participation in the social, economic and political life of the community. Activities directed at overcoming societal discrimination and at equalising opportunities are therefore as central to CBR as the development of rehabilitation services;
- full involvement in the development and implementation of CBR by people with disabilities and their families (as primary care givers, advocates and representatives), health and social care professionals, community members, government (local, regional etc.) and NGOs.

2. Applicability of CBR to Aboriginal Health

The CBR approach was developed for communities with a high level of need and with a low level of resources and/or culturally unfamiliar with traditional concepts of rehabilitation. In 1982 the WHO assessed CBR as being an 'appropriate, feasible and economically viable approach for Third World countries'. It does not negate institution-based rehabilitation but does recognise its cultural and geographical limitations. It can also provide an 'intermediate' tier of service provision and a bridge between a community and institution-based services.

Although Aboriginal communities are resource rich *comparatively*, there are parallels in terms of health status, attitude to disability, and in the priority given to disability issues within the community. Previous approaches within the Aboriginal community have encompassed aspects of CBR, but have never been presented as such and have never encompassed the full range of CBR activities.

3. Key Lessons from Other CBR Programs

There appears to have been relatively little research and evaluation into CBR. With limited resources it has largely taken second place to program implementation. What there has been has tended to focus on inputs rather then outputs (eg. transfer of technology/skills, community involvement) and – in its broadest sense – health outcomes (eg. empowerment of people with disabilities).

It has also been suggested that once committed to CBR, governments have not wanted to have evaluations which question that commitment or the efficacy of the approach.

Key lessons:

- appropriately developed and implemented, and building on firm foundations (ie. starting on a small scale), CBR can be effective, eg. in reducing hospital utilisation, increasing uptake of voluntary services, increasing empowerment and improving quality of life;

- the demands of CBR on community coordinators should not be underestimated; expectations should be realistic and considerable ongoing support – including financial support – is required;

- the needs of people with disabilities will not always be a community's primary health concern, and definitions of and cultural approaches to disability will vary; how will this impact of an approach that seeks to empower and be guided by the community?

- not all families will have the capacity to act as primary care givers.

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