Community-based rehabilitation

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Introduction

In a global sense, community-based rehabilitation (CBR) is the primary means by which disabled people in most countries of the world have any access to rehabilitation or disability services (Evans, Zinkin, Harpham, & Chaudury, 2001). CBR exists in an array of styles and approaches across developing and economically developed country contexts, with notable differences as well as similarities between those contexts. Community Based Rehabilitation was first promoted by the World Health Organisation in the mid-1970s to address the limited nature of the rehabilitation workforce in developing countries, through the provision of basic services at a community level, incorporating principles of primary health care, relevant rehabilitation practices, and seeking to use local resources and build local skills (Hartley, Finkenflugel, Kuipers, & Thomas, 2009).

The most broadly used definition of CBR, has noted that CBR is "a strategy within general community development for rehabilitation, equalization of opportunities, and social inclusion of all people with disabilities...implemented through the combined efforts of people with disabilities themselves, their families and communities, and the appropriate health, education, vocational, and social services" (ILO, UNESCO, & WHO, 2004). The emphasis in this statement on community development, poverty reduction, equalisation of opportunities, and social integration are in keeping with the developing country context from which CBR emerged, but key aspects of CBR are also highly relevant to economically developed countries.

Characteristics and objectives of CBR programs

CBR is usually conducted or provided in natural community settings, such as clients' homes rather than formal service delivery settings (hospital or centre-based environments). The active engagement of clients, family and even community members in service delivery is core to CBR. Clients are viewed as partners in, if not active directors of, the process. As a strategy, CBR seeks to equip, empower and educate people with disabilities and all stakeholders towards an end goal of greater independence, community participation and quality of life. The CBR approach typically seeks to maximize personal agency, accessibility to resources, and opportunities for participation, leading to the same physical, psychosocial

and other outcomes as other disability service models. In CBR, skill transfer to the community and systemic change is essential. CBR programs are likely to be aimed at achieving broader social and systemic changes as well as maximizing social inclusion and improvements in individuals' functional capacity.

The objectives of CBR are not only to maximise physical and mental ability but also to support access to regular services and opportunities, to assist people with disabilities to actively contribute to their own communities, and to encourage community members to promote and respect human rights. The breadth of scope of CBR is consistent with the conceptual base of the International Classification of Functioning, Disability, and Health (ICF) (WHO, 2001), which defines disability within a complex interaction of causal, contributing, and consequential factors. Indeed the emphasis in the ICF on personal and environmental factors as key barriers or facilitators to a person's functioning, further reinforces the relevance of a community contextualised approach. In a similar way, CBR also represents a shift in focus from the individual's disabling condition (at the acute care end of the healthcare spectrum) towards a more holistic focus on the person within their social and family context (at the community end of the spectrum).

Regardless of country context, CBR is typically oriented towards achieving optimal functioning, quality of life, and community integration. As would be expected, CBR does not typically address early impairment or disability in the acute stages of injury or illness, but assists people whose impairments and disabilities require long term rehabilitation and care. The exact nature of CBR services will depend on the needs of the particular client or client group within their context, the presence of disability supports, environmental resources including availability of generic services in the community (i.e., home care support, community nursing), the availability of skills and expertise, practical feasibility, and the availability of funding.

Factors driving the shift towards CBR

In economically developed countries, the emergence of CBR has largely been the result of shifts in philosophical perspective, practical considerations, financial constraints, and client preference. In these countries, where the health and disability service sectors are usually well established, community based approaches (such as outreach, home therapy, home care, community support and vocational support) often exist across service sectors and complement inpatient and traditional rehabilitation services (hospitals, medical clinics or institutions).

Multiple factors continue to reinforce the shift toward CBR, including changes in demographic factors (e.g., ageing population), service delivery factors (e.g., reduction of hospital lengths of stay), illness trajectory factors (e.g. enhanced survival after serious injury), as well as a recognition that outcomes from community-based services compare favourably with rehabilitation alternatives (Barnes & Radermacher, 2001; Doig, Fleming, Kuipers, & Cornwell, 2010; Langhorne et al., 2005). Alongside this shift has been an increase in the availability and the use of a range of services in the broader community context. For example, for people who are ageing, services are increasingly available in local communities, such as meal delivery, community nursing and respite services, as well as domestic assistance services such as home help. Central philosophies of community-based service delivery are gathering prominence and are applicable in a broader community context to cater for the needs of many people living in the community, including those affected by the consequences of ageing, chronic disease or other disabling conditions.

In developing countries, key influences that have shaped the development of CBR over recent decades have included increased attention to the concerns of disabled people at the community level, and by disabled people's organisations at national and international levels. These concerns have resulted in increased recognition of discrimination and exclusion, and the need to address social and political aspects of disability, including power dynamics in rehabilitation service relationships (Lang, 2011).

Effectiveness of CBR

Because CBR cannot be described as a discrete intervention, and the expected outcomes are not standardised, its effectiveness is difficult to establish. However, from CBR studies in developing countries, reported outcomes have included: increased independence, enhanced mobility, and greater communication skills for people with disabilities (WHO, UNESCO, ILO, & IDDC, 2010). Studies have found that CBR projects in developing countries are linked to positive social outcomes, enhanced social inclusion, and greater adjustment of people with disabilities. Where livelihood interventions have been integrated into CBR, this has resulted in increased income for people with disabilities and their families, and consequently increased self-esteem and greater social inclusion. In educational settings, CBR has assisted in the adjustment and integration of children and adults with disabilities (Hartley, et al., 2009).

There is a limited amount of research to date to establish the effectiveness of CBR in economically developed countries. Reviews of outcome studies in community settings have primarily been in the area of stroke rehabilitation and indicate that, on the whole, teams working in the community delivering rehabilitation services achieve at least equivalent outcomes compared with traditional hospital-based rehabilitation (Barnes & Radermacher, 2001; Doig, et al., 2010; Langhorne, et al., 2005). Studies in Sweden, the UK, and the US have demonstrated that home-based rehabilitation for people with stroke enables early discharge from hospital and a reduction in hospitalisation costs (Holmqvist et al., 1998; Mayo et al., 2000; Rodgers et al., 1997; Rudd, Wolfe, Tilling, & Beech, 1997). Similarly, a systematic review and economic analysis of published randomised controlled trials comparing early hospital discharge and home-based rehabilitation with usual care for patients after stroke concluded that a policy of early hospital discharge and home-based rehabilitation for patients with stroke may reduce the use of hospital beds without compromising clinical outcomes (Anderson, 2002).

However, there are also several critiques of CBR, mainly related to the dearth of robust research procedures and the paucity of systematic outcomes (Finkenflugel, Wolffers, & Huijsman, 2005). Practice-related critiques include the unmet need for medical rehabilitation (Evans, et al., 2001), the failure to maximise the participation of people with disabilities (Turmusani, Vreede, & Wirz, 2002), and neglect of the psychosocial dimensions of disability (Kassah, 1998). The community-orientated model has also been criticised for relegating people with disabilities to the place where they experience most stigma and discrimination, and increasing the burden for women with the expectation that they will provide care for people with disabilities.

Staff and training

In developing countries, CBR relies largely on family members and community volunteers, who operate with very basic training, often within a community committee structure. In

some cases these volunteers are assisted by intermediate level workers, with limited access to qualified health and rehabilitation professionals. In other contexts there are a variety of staffing models (e.g. multi-disciplinary teams, or individual practitioners, usually with professional qualifications). Across all contexts, however, CBR workers rarely work in discipline-specific roles but tend to take on more generic tasks akin to rehabilitation co-ordination or case management. The rehabilitation co-ordinator is the 'facilitator' and 'organiser' of a person's rehabilitation in the community and promotes communication and co-ordination between the client, the client's family, health and community services, and all stakeholders involved in the client's rehabilitation. Regardless of context, family members play a vital role in CBR.

A key strength of the community-based rehabilitation model is the enhanced opportunity for provision of education and training of others (i.e., family, support workers) and skill sharing with those in the immediate social network surrounding the client. This social 'ecology' of the person includes their family, friends, and work colleagues, as well as the community and services supporting the person. Greater collaboration with the community and empowerment of the support network of people and services surrounding the client is possible in a CBR model and enables the client to make sustainable gains. For example, family members may be involved in rehabilitation sessions for the purposes of education and training (about disability, empowerment, therapy, goal setting, support services, independence, and the provision of practical advice). Furthermore, collaboration with others (work colleagues, friends, and paid support workers) who may be in a position to help the client to achieve their goals is also possible in a CBR model.

The use of networks of formal and informal services to create a complete response to consumer needs is common in CBR. It is also generally agreed that CBR is implemented through the development of strong interrelationships between families, communities, people with disabilities and the appropriate health, education, vocational and social services. This networking can manifest in opportunities for family training, education and involvement, improved accessibility to services for caregivers and enhanced co-operation between family members and service providers.

Goal planning

Individualized goal planning is a central aspect of collaborative and empowering rehabilitation, guiding a rehabilitation program in accordance with a client's needs and desires. Client centred goals also are a way of working towards and measuring outcomes aimed at achieving community reintegration and 'participation', which are the main aim of CBR programs. The measurement of goal attainment is also a way of monitoring an individual's progress. Involvement of family and friends can enhance goal planning and goal achievement through greater collaboration. Goal orientation also enhances the responsiveness of community rehabilitation, as goals evolve over time or alter in response to client and environmental changes.

Future challenges for CBR

As the transfer of skills to clients, family and community members is central to CBR, the provision of effective training is a key challenge. In instances where the community-based model relies on intermediate level workers, community workers or family members, appropriate training will be required at multiple levels. Additionally, with a corresponding shift in professional roles, specialised training will be necessary to enable professionals to

take on more strategic and more empowering roles in CBR (Lang, 2011). Further critical issues in CBR include the relationships between rehabilitation professionals and people with disabilities, the enhancement of networks and partnerships, especially with disabled people's organisations and governments as well as greater connection with communities. The philosophy of client empowerment as well as empowerment of families, others and community members is central to CBR, which requires a shift in thinking of health professionals from being 'expert' towards being 'facilitators' and 'partners'. For CBR to become a viable model for the delivery of health services in industrialised countries, a competency framework is needed, together with strong leadership to facilitate the translation of theory into practice. Further, collaboration is required among practitioners, policy makers, unions, consumers, educators and professional associations to support this transformation (Kendall, Muenchberger, & Catalano, 2009).

Rapidly growing research interest in CBR theory, interventions, outcomes, and evidence is apparent. It is reflected in calls for improvement of the rigour and reporting of CBR in research and project evaluations (Finkenflugel, Cornielje, & Velema, 2007), and more innovative methodologies (Kuipers, Wirz, & Hartley, 2008). The expansiveness of CBR enables CBR as a paradigm to recognise something of the complexity of disability and human rights and to propose frameworks for advancement. Further, the evolutionary nature of CBR and its responsiveness to critiques as reflected in the new CBR guidelines and matrix (WHO, UNESCO, ILO, & IDDC, 2010), indicate that the CBR model is now ready to be examined more rigorously, applied more consistently, and integrated more effectively into national and international policy making. While its application in developing countries is established, the potential for greater implementation in economically developed countries remains a challenge which would need further commitment and require shifts in workforce, training, policy, and structural realities (Kendall, et al., 2009).

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