PREPARING OCCUPATIONAL THERAPISTS AND PHYSIOTHERAPISTS FOR COMMUNITY BASED REHABILITATION

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ABSTRACT

The traditional institutional based medical model approach to rehabilitation is expensive, often inappropriate, inefficient and does not meet the needs of most people with disabilities. The escalating cost of health care, the increasing economic constraints, and the shortfalls in service provision have all contributed to the urgent need to develop innovative ways to utilise therapists in the community. Although the move from institutional care to community care is occurring in both the developed and developing world, the infrastructure and funding arrangements varies and therefore the models that are adopted for different countries are necessarily different. Preparing therapists to change practice from traditional institutional services to community services is a professional imperative, especially in developing countries. Such preparation requires special consideration of the complex contextual issues, as well as the reorganisation and reconceptualisation of the philosophies underpinning therapy education and the structural ways in which educationalists teach therapists to provide care. The most vital factor to consider is that the therapists must adopt a major change in attitude to both service delivery models and to their roles as therapists. For the purpose of this chapter, the authors have chosen to focus on the delivery of therapy services using a generic CBR model used in many developing countries. Information has been drawn largely from the authors' experiences of working in developing countries as well as preparing undergraduate and graduate therapists for such work. The chapter discusses the importance of educational and cultural considerations, and of developing reasoning skills in community based rehabilitation (CBR), in the praparation of therapists for community practice. The authors go on to focus on the content areas that specifically need to be addressed to facilitate the process of 'settling in' of therapists and creating an environment for successful outcomes in rehabilitation, such as CBR, community development and disability; therapy, teaching and management skills; generic professional principles, and context specific information.

BACKGROUND

As a consequence of the Ottawa Charter in 1986 and the earlier introduction of community based rehabilitation (CBR) as a strategy to provide 'health for all' (WHO, 1976) health policy has shifted emphasis from institution to community care, with an emphasis on health and wellness and universal access. These major changes have necessitated a shift in emphasis from the institutional medical model to alternative models of health care delivery. This move from institution to the community has generated a significant change in many of the features of health care delivery, mostly to the benefit of the consumer. The impetus for change, coupled with the increasing economic constraints worldwide, provided an urgent need to develop innovative ways of utilising available

health personnel; such personnel are an even more scarce resource in developing countries and require special management.

Traditionally, the major sources of employment and opportunity for therapists (for ease of writing, physiotherapists and occupational therapists will be referred to as therapists) have been medical institutions such as hospitals and rehabilitation centres. Health and rehabilitation services historically have been situated in specialised institutions and while this concentration has significantly advanced the scientific and research base of professional practice it has left observable shortfalls in clinical practice. Institutions provide specialised services for the few disabled people who have access to the institution, while those in rural communities are often denied access to any rehabilitation services. In both developing and developed countries, the majority of people with disabilities do not require the sophisticated technology and highly specialised care provided by therapists in institutions (Peat, 1990). Community based rehabilitation is an approach that has been used primarily in developing countries to facilitate the provision of rehabilitation services to rural and remote areas, where the numbers of people with disabilities are numerous but where the resources are few (Twible & Henley, 1993).

Institutions are usually hospitals or specialist rehabilitation facilities located in major urban areas where it is relatively easy to attract professionally qualified allied health professionals such as physiotherapists and occupational therapists. These university-educated therapists (with a 4-year degree) would come from an entirely different educational background than those 'locally trained' therapists (with training ranging from 3 months to 1 year) who are most commonly found in rural and remote regions of the country. Most of the university-educated therapists' undergraduate programs, even in developing countries, would have been based on curricula that follow the traditional medical model. As a consequence, most graduates of these programs prefer to remain in the large centres and work in the specialist institutions, where they feel more comfortable, have access to technology and resources with which they are familiar and receive more recognition for their work. There are, however a few university programs that are exception to the norm. Several South African schools, such as the University of Cape Town have integrated substantial content relating to community practice into its curriculum (Futter, 1998); the school at the University of the Western Cape has based its entire curriculum on a CBR model (Mpofu, 1998). Similar integrations to greater and lesser degrees can be found in universities in Israel (Maas, 1996) and in some occupational therapy programs in Australia and Canada.

In terms of health care providers, there is also a constancy across English speaking developed countries in the employment patterns of therapists. Studies show that 90% of therapists are employed in institutional care (Partridge, 1987; Burnett, 1991; Health and Welfare Canada and the Canadian Association of Occupational Therapists Task Force, 1987). From the authors' experiences, in developing countries where therapists are university qualified, the preference for institutional employment is also evident. Another factor of relevance, in therapy service provision is the number of therapists working in proportion to the population. In English speaking developed counties the average physiotherapist : population ratio is 1:1400, which is considered to fall well short of these countries' requirements. In developing countries the situation is more critical with an estimated average therapist : population ratio of 1:550,000. In some countries the situation is dramatically worse; for example, in India the ratio is 1:1,215,000 (Peat, 1990). Because of this lack of

rehabilitation health personnel, it is contingent upon the educators and policy makers to support alternative models of health care delivery and for educators to ensure that therapists are sufficiently prepared with the requisite knowledge and skills to accept the challenge of employment in venues alternative to institutions, such as in community settings.

In summary, the traditional institutional based medical model approach to rehabilitation is expensive, often inappropriate, inefficient and does not meet the needs of most people with disabilities. The escalating cost of health care, the increasing economic constraints, and the shortfalls in service provision have all contributed to the urgent need to develop innovative ways to utilise therapists in the community(Henley & Twible, 1996).

CHANGING PHILOSOPHIES

Although the move from institutional care to community care is occurring in both the developed and developing world, the infrastructure and funding arrangements varies and therefore the models that are adopted for different countries are necessarily different. Preparing therapists to change practice from traditional institutional services to community services is a professional imperative, especially in developing countries. Such preparation requires special consideration of the complex contextual issues, as well as the reorganisation and reconceptualisation of the philosophies underpinning therapy education and the structural ways in which educationalists teach therapists to provide care (culture, politics, environment, social structure, service delivery models - medical vs others, etc.). The most vital factor to consider is that the therapists must adopt a major change in attitude to both service delivery models and to their roles as therapists under these different models. The major differences between institution based therapy and CBR are outlined in Table 1a, 1b,.& 1c.

Preparing Therapists For Community Practice

For the purpose of this chapter, we have chosen to focus on the delivery of therapy services using a generic CBR model used in many developing countries. Information has been drawn largely from our experiences of working in developing countries as well as preparing undergraduate and graduate therapists for such work. The following section deals with cultural and educational considerations when designing educational sessions to orientate and prepare therapists for working in CBR in developing countries. However, the ideal environment in which such information should be provided is in the therapists' undergraduate curricula throughout the world. It is in undergraduate education that attitudes are established and can be most readily influenced, so that graduate therapists are provided with the requisite knowledge, attitudes and skills to work in both institutional and community settings in any country. Finally, consideration must be made of the competencies of the education providers for they are the ones who will undoubtedly exert influence over the learning of their therapists. Faculty who are aware of different service delivery models such as CBR are most likely to incorporate CBR approaches in their teaching activities; however, it is important for all educators to incorporate such information into their teaching, not just those who specialise in CBR.

Cultural Considerations

In most societies the provision of health care involves many different interactions among people whose needs and views on what constitutes health care may be vastly different from each other and from the service provider. This difference can pose problems for both the provider and the recipient

if care is not taken to facilitate the process. When people from different backgrounds come together in a therapy interaction, that interaction is influenced by many factors and the overlap of knowledge and influence between the participants will vary from one situation to another. In some cases, the amount of overlap or sharing will be great; in others, especially if one or more of the participants comes from another culture with a very different medical system, the overlap will be much less. The example in Figure 1 demonstrates a situation where there is a significant amount of overlap (Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995). Obviously, the greater the overlap, the easier the interaction and the less the overlap among participants, the more challenging will be the interaction for the therapist to effect a successful outcome.

Educational Considerations

Today, all education programs should prepare therapists to work in multiple environments and a primary objective of educators should be to develop the required competencies in its graduates. Education about alternative service delivery models including CBR needs to be embedded across the curricula and permeate all aspects of the educational process. No one experience will be adequate to ensure that the learner acquires the requisite skills to influence their practice totally. It is the type and method of education that is the crucial factor in improving competence (Carpio & Majumdar, 1992; Robison, 1996).

Workshops and other small group activities have been a useful means of facilitating cultural competency and reasoning skills in CBR, as they challenge the values and biases of the therapists as well as provide opportunities for application of knowledge and skills to expanded local case studies derived from real CBR encounters; these case studies are designed to provide detailed social, geographical, and physical information about clients and the environments in which they live (Henley & Twible, 1999).

The first step in developing competence is recognising and understanding the basic human condition. From this starting point, therapists must develop a compassion for their fellow human beings and a cultural attitude, and as such understand the need for and adopt a client/family-centred approach to practice It is the type and method of education that is the crucial factor in improving competency (Robison, 1996). Therefore, educators must provide learning experiences which establish knowledge-seeking behaviours in therapists who routinely view the client's and family's problems by exploring the 'client's stories' (Clemson, Fitzgerald & Mullavey-O'Byrne, 1999). This information cannot simply be encapsulated into lectures and tutorials, but a variety of methods should be incorporated across the curricula.

Developing Reasoning Skills in CBR

Reasoning in a CBR context is no different from clinical reasoning in other ways. It simply requires consideration of another variable (CBR) which is a vital dimension in effecting a positive outcome in a therapy intervention. Awareness of CBR and using knowledge about CBR are critical elements and opportunities for therapist learning related to these elements need to permeate the curricula.

Enhancing self-monitoring skills is considered to be a favourable way of improving reasoning in any therapy situation (Boud & Walker, 1991; Refshauge & Higgs, 1994; Carnevali, 1995). One

way of facilitating the process is to systematically apply a series of questions or an organisational framework to facilitate this conscious reflection (Bridge & Twible, 1997). In considering reasoning in a CBR and different cultural context, therapists must be 'prompted' to consider culture and other contextual factors routinely throughout their interactions with clients (ie assessment, intervention and evaluation phases of service provision). One strategy is to link these contextual factors to the existing clinical reasoning within the curricula so that culture and community factors are incorporated into all case study analyses that therapists undertake.

In all reasoning situations, novice therapists often make errors because cues are missed and/or underpinning knowledge is missing. Having some means to check current knowledge and understanding is essential, because in practice it is not acceptable to interact with a client without any idea of what the client's potential dysfunction might be (Bridge & Twible, 1997). Awareness of the local context is crucial to the therapist's ability to function in a different environment. For example, the therapist may lack knowledge about the importance of specific role tasks of a female carer within a particular family group and may assume knowledge; the therapist then may suggest inappropriate therapy strategies for the carer. In some client interactions, such lack of awareness may result in the therapist omitting a component of the rehabilitation program that is important to the client in their everyday life. For this reason, therapists need to become sensitised through repeated exposure to real-life case studies which they can critically analyse and propose solutions.

The two most problematic areas that novices face are "problem sensing or noticing" and "problem validation or intervening". (Neistadt, 1992; Rogers & Holm, 1991; Boud & Walker, 1991). Therapists' difficulties lie with firstly recognising the need to acquire the knowledge and secondly applying that knowledge effectively in the therapy process. Therefore, educationally, it is imperative to address both knowledge awareness and the application of newly acquired knowledge.

- **Problem sensing**

Problem sensing requires attending to incoming information and reflecting on its meaning. Development of the ability to notice and attend to cues appropriately in the therapy situation is crucial. The original image of the client is formed automatically as incoming information from the initial encounter with the client and their immediate environment is processed. This processing happens in relation to current values and beliefs and includes predictions extrapolated from theory, past experience and current knowledge of the local context. For example, in inter-cultural interactions cues may be missed because the therapist does not pick up the cultural prompt (ie, that consideration of culture is important) or the therapist does not have culture-specific knowledge related to the specific client.

Another important factor to consider is peoples' beliefs about health and illness, including beliefs about the cause of any illness they experience, what kind of illness it is, the natural course which the illness will take and how it should be treated. Some explanations are common to groups of people and may be seen as having a cultural basis. The sources we draw upon to inform us about our state of health and to explain it to others are popular, professional and traditional (Kleinman, 1980). Authors use the term "explanatory models" to describe the explanations for illness and disability given by health practitioners and their clients and to distinguish between lay explanatory models and the clinical models used by health practitioners.

It is often difficult to match the therapist's perception of a particular illness and/or disability with the client's understanding of their experience of it. The disparity is likely to be even greater when the client and the health professional come from different cultural backgrounds. Thus any therapy interaction can involve a perspective from multiple cultures and several systems within each culture. Narrative reasoning ('client's story') and history taking exercises are an integral part of the therapist/client interaction and therefore consideration of the cultural and other influences should routinely be considered as part of this process. Once awareness has been established, the therapist is able to identify the knowledge that needs to be acquired.

- **Knowledge acquisition**

Therapists usually know to acquire knowledge from the available literature, if they perceive that their current knowledge base is lacking. For CBR and relevant cultural information there are other important sources, such as local CBR workers, cultural informants or brokers, as well as the clients, family members and other community members. The therapist then assimilates all available sources of knowledge and validates the information for the current clinical situation.

- **Using local knowledge appropriately /problem validation**

This local knowledge can then be used to determine the form of the assessment of the client through observation of their performance of functional activities and the physical examination. One of the most useful tools that a therapist in a CBR setting can adopt is a model of functional assessment (See figure 2). This model, adapted from an OT model (Reed & Sanderson, 1980) has been used successfully for the past 5 years by students and therapists in rural CBR projects in southern India. The model sets the client at the centre of the assessment process so that all decisions about management are made from the client's perspective. Using local knowledge, the therapist begins to develop the working hypotheses, validates assessment findings, selects and implements a management program, having considered the implications, assessed the risks and determined the expected outcomes. The focus in problem validation is on the examination of discrepancies between the original clinical image and the real and gradually unfolding scenario (Bridge & Twible, 1997), including the application of local knowledge.

- **Frameworks to facilitate reasoning ability**

Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, (1995) have identified key principles to consider in acquiring local knowledge and provide frameworks for exploring local issues relevant to individual practitioners and the client population, as well as suggested guidelines for developing policy for the management of clients from diverse backgrounds. Such frameworks would be useful tools with which the therapist should become familiar, to facilitate the transition from one therapy environment to another.

Strategies for Action

Now that we have laid down the conceptual foundation for developing attitude change and specific reasoning approaches, we can attend to the content areas that specifically need to be addressed to facilitate the process of 'settling in' and creating an environment for successful outcomes in rehabilitation.

There are four major areas that need consideration:

- CBR, community development and disability
- Therapy, teaching & management skills
- Generic professional principles
- Context specific information and issues

CBR, COMMUNITY DEVELOPMENT AND DISABILITY

CBR means different things to different people in different parts of the world. Therapists must be well oriented to different models of service delivery and their relative strengths and weaknesses. This also entails a thorough understanding of and an affinity for community development philosophies and strategies, where the focus of attention lies with the community and the individual client. Thus, therapy practice will be community based (in its full context) rather than simply transferring practice from the institution to the community. Additionally, alternative models of management structures for CBR programs should be explored, including the hierarchical structure of the organisation and the varying responsibilities of the different levels of voluntary and paid personnel.

Therapists should have an understanding of disability and its effect on families. It is important for them to understand the impact of disability in the context of the different environments in which therapists may be working, with the constraints that will be imposed on the clients, their families and their communities. In CBR it is crucial that the therapist has a strong belief in client/family-centred practice and that all aspects of therapy, from problem identification to intervention, are directed by meeting the needs of the client and family carers (Clemson, Fitzgerald & Mullavey-O'Byrne, 1999).

THERAPY, TEACHING AND MANAGEMENT SKILLS

- **Therapy**

As outlined previously, there is a significant shift in reasoning needed to successfully move from institution based to community based therapy. The process of therapy in the community should be based on a problem solving approach that is functional in orientation and is driven by the environment, cultural, social and other contextual factors.

Because of the nature of the disabilities encountered in the community, the emphasis in therapy is on management of the disability rather than on 'treatment or cure'. Therapists, in designing management plans, focus on minimising the client's impairments (eg. lengthening short muscles), preventing complications (eg pressure sores) and building on the client's capacities (eg advancing their intellectual capability) to maximise their potential to be able to contribute to their community life. Therapy in the community proceeds at a pace which is a graded step-by-step process, usually attending to one or two problems at a time, and is incorporated into the daily life patterns of the client and their family. It is essential that goals are set with the client that are realistic and achievable, given the demands that are made on the client and the carers in carrying out their normal daily activities.

One of the most important skills therapists need to sharpen is their observations skills. Observation pervades the therapist's life. It requires that the therapist notice and process everything that s/he sees and encounters, including the society, the physical environment of the village, as well as observing the client and family in their own environment, to determine life roles as well as the constraints and benefits of the physical environment in which the client lives. Such finely tuned observations skills will facilitate the therapist's ability to analyse the client's daily activities more effectively when determining problems and looking for appropriate solutions.

Another feature is that the therapist needs to seek out and develop potential sources for the human and material resources that may be needed in future planning of therapy. Local easily available material resources are employed and adapted to suit the needs of the individual client (eg., sandbags for strength training or support for positioning); similarly, local craftsmen such as carpenters and shoemakers are used to make and adapt equipment (eg. walking frames and adapted footwear).

An aspect of therapy that is often neglected in a CBR setting is that of documentation or record keeping. When a new client is seen, it is important that accurate baseline measures are taken and that regular reviews of progress are made by the attending health worker or therapist so that effective therapy programs can be instituted and evaluated. At the field level, such records are invaluable in effective communication between workers who manage the same client and for measurement of normal progress over time. At the project level, the project holder can use the records as a measure of the effectiveness of service provision and can use the information to successfully argue for increased funding.

Clients' assessment findings and management plans must be kept in a simple readable format that is easily accessible by all health workers involved in their care. This requires careful design of an assessment protocol that is functional, easily recorded, meaningful to the worker and the client, and problems for intervention are identified and written in simple functional terms. The problems are prioritised in collaboration with the client and carers and the goals of therapy are written from the client's perspective; that is, the goal describes what the client will be able to achieve, under what conditions and by when. Too often, therapists' aims are written which are not measurable and describe the therapist's plan of action, not what the client will achieve.

- **Teaching**

Therapists are naturally teachers as part of their professional role in that they teach clients and clients' families how to carry out home programs. However, in community practice teaching becomes a primary focus of their professional activities. Also of importance is that therapists use a 'train the trainer' approach with health care workers in teaching therapy skills, rather than the direct simpler approach of teaching a skill on a one-to-one basis with a client. Therapists must expand their knowledge of educational psychology to include such topic areas as learning theories, learning styles and different models of teaching and facilitating learning. Experiential learning has proven to be one of the most valuable modes of knowledge and skill delivery when therapists teach local health workers or village people. Theory can be provided in a formal session, but the formal translation of that theory into practice is an essential step in the process to ensure that technology transfer occurs.

Therapists' newly acquired knowledge and skills in teaching and learning theory are then applied to developing teaching packages as a basis for conducting formal and informal educational sessions in the community with various levels of groups including health care workers, families and the general public. Teaching packages should be developed so that they can stand alone and be used by others. Inherent in the development of teaching packages is recognition of the importance of communication at different levels, designing packages to suit the levels of learners (lay vs professional). The salient features within teaching packages are outlined in Table 2.

- **Management skills**

Management skills of a different nature are required of therapists working in the community compared to the skills required for institution practice. The community therapist requires a broad but extensive knowledge of the organisational structure and lines of authority of the agency for which they are working as well as that of the community in which they will be working. This information includes knowing the existing established systems in operation, such as medical and rehabilitation facilities in the area, referral patterns, access to other sorts of funding and services. In addition, their knowledge base of problem solving strategies that can be used to manage structural or organisational challenges will need to be expanded.

In order for the therapist to operate successfully in a community environment, they need to have high levels of skills in the following areas: communication at different levels - with management, workers, families, peers, etc; teamwork and leadership; negotiation and conflict resolution; networking; organisation and time management. They must exhibit responsibility for themselves and others in management of the workplace and also be able to provide peer support opportunities for learning and constructive feedback.

Generic professional attributes

The most successful therapist will exhibit certain attributes which are generic to their professional performance. Working in a community environment requires creativity on the part of the therapist as s/he will be met continuously with unique challenges, in providing a realistic service, in finding and adapting equipment needs of individual clients and in many other areas. Therapists must take the initiative, often, in creating opportunities to get things done. Many of the issues that need to be tackled in the community are often difficult, the solutions are not always obvious, or the timing is wrong at the given moment. Bringing about realistic change requires the therapist to understand the 'big picture' and the importance of a gradual developmental process (the journey of a thousand miles begins with the first step). Inherent to success in any situation is the acceptance of what can and cannot be changed. The powerful combination of therapist attributes of perseverance, patience, diplomacy and tact will facilitate their day-to-day survival during times of stress and over time will help them to overcome apparently insurmountable obstacles. One must have the belief that change does not occur overnight, but like water dripping on stone, change will happen eventually with perseverance.

There are a number of 'psychosocial' environmental issues which need to be addressed, especially when the therapist comes from a background that is totally different from the community context in which s/he is providing services. The first issue is that of 'project needs vs personal or

individual needs'; the therapist must recognise that the needs of the project should take priority over individual needs, because the therapist is there primarily to provide a community service. There is a danger that those who put their individual needs first will end up contributing little to the workplace; this is another example of a shift in attitude that makes the transition for the therapist from institution to the community an easier one.

Therapists also must be overtly conscious of their image, or how they are perceived by others, whether the project holder, the health worker or the villagers themselves. Working in a community requires psychological preparation for the 'professional expert' role or 'senior management'; this role is very different from the usual status of a therapist among therapists in an institution. Expectations that senior management and others may have of the therapist and the therapist's expectations of what can be delivered may be mismatched; such issues need to be explored and realistic parameters established early, for the benefit of all stakeholders and the service. Therapists therefore must exhibit good reasoning skills to be able to readily assess the situation, recognise their own strengths and limitations and give a realistic estimate of what they will be able to achieve and why. Explanations must be given in a language or in terms that will be familiar to the recipients, so that no confusion remains. Finally, therapists must also be aware of their responsibility to succeed in this environment and the global consequences for mismanagement of same.

Context specific information and issues - knowing where you're going and what you might be doing. This section can be divided into three sub-sections, for ease of clarification: i) common disability information; ii) country details; and iii) personal issues to consider.

- **Common disability information**

It is important to obtain from multiple sources, including the potential host or employer, information relating to the types, incidence and prevalence of different disabilities in the community in which the therapist will be working. The therapist will necessarily be confronted with disabilities and pathologies with which s/he is not familiar, especially if the therapist is moving from one country to another. Ideally, if the potential employer can provide case studies based on real client scenarios, the therapist will be best equipped to determine the similarities and differences between what is expected and what is already known from previous experience. Access to such information is often difficult when the therapist is already working in the rural or remote community; therefore, having such information as a resource beforehand is invaluable. Additional information can be sought from government agencies, non-government agencies, and from colleagues who have worked in such environments. A strategy that is encouraged is to establish a network of colleagues in one's home country to access information and technical resource material if it is required and cannot be obtained 'in country' or from a local source. However, if technical information is brought with the therapist, it should be used as their knowledge resource and not simply transferred to the new environment without the appropriate adaptations to suit the local context.

- **Country details**

Prior to departure the therapist should be thoroughly familiar with the background to the new country, including its history, politics, geography etc. This information is often available in good guide books and through the relevant consulates. Today, of course, much information is also available

through the Internet. On a broad level, information about the health care system and service delivery models in use can be obtained; however, detailed information will need to be acquired on arrival, through consultation with the agencies involved in the provision of health and rehabilitation services.

Local knowledge is also imperative in developing a thorough understanding of the local traditions, customs and culture of the area to be visited. Some differences which often are noticed by foreign therapists and which provide unique challenges are related to concepts of time, attitudes towards independence, as well as child developmental and functional norms for the country. As mentioned in an earlier section, therapists must attune their consciousness to recognise the similarities and differences between this new country and their own. Such sensitivity requires a recognition of and thorough understanding of ones own culture. Without a full appreciation of ones own culture it is difficult to recognise the nuances of another.

- **Personal 'housekeeping' issues**

Therapists should consider all aspects of their intended adventure - why they are going, what do they want to get from the experience and what do they hope to contribute and achieve. Certain challenges are not country specific, but are common to many people venturing into an unfamiliar environment. The less developed the environment, often the more difficult the transition becomes, but this is also not necessarily the case. However, before making the decision to go to another country, therapists must frankly and honestly determine their expectations, explore the realities of life in the new country and whether their expectations match these realities. There are many sources of information as mentioned previously. One of the best sources of information for facing the realities of living in a different country is to speak to those who have been there before and frankly inquire about the difficulties they encountered and the strategies they employed to cope with the problems.

Reflection is invaluable is determining what is important to ones own physical and mental health; how will the therapist cope with differing levels of physical comfort, facilities, hygiene, privacy, lack of family and friends as their network of support, lack of professional support; the list is endless, but each person should think carefully about all aspects of their personal and professional life to confront such difficulties before they arise. Taking care of ones physical and mental health becomes a priority, if the transition into a new environment and new way of life is to be successful. As mentioned before, the therapist's observation skills become particularly well sharpened, in a professional capacity; however, in the personal arena such observation skills will also become a great asset. The general process of ' finding what works' can be facilitated by finding a mentor or support persons who can act as cultural brokers; this local reference group or person can be valuable for reality checks and to validate ideas or approaches.

Finally, at the end of the therapist's time in any country it is important for them to actively seek a debriefing session with their work colleagues and senior management; to evaluate the experience, their contributions to the service and recommendations for change for the future. It is also important to recognise that the therapist must face re-entry issues when returning to their country of origin, which people often find just as difficult or more difficult to manage than the initial move to a new and different environment. For example, the experiences that were most meaningful to them when they lived in another country are not important to their colleagues at home, which often becomes deflating to the therapist on their return.

CONCLUSION

The varied situations in which graduates work emphasise the importance of understanding the unique nature of "people from different environments", recognising that each individual person presents differently and assumptions cannot be applied to all people associated with a particular group. Not only does the therapist need to consider their clinical competencies, communication skills, innovative strategies, a person-oriented attitude and compassion in therapy interactions, but there are other factors relating to management and organisation as well as personal considerations for therapists moving from institutions to the community.

If therapists develop good reasoning skills they can function well in any context by thinking through the issues related to their individual situation, whether at home or abroad. Though the focus of this chapter has been on educating therapists for CBR in developing countries, all therapists working in institutions could benefit significantly by applying the principles of CBR practice to their everyday workplace and would allow the transition from institutional care to community care to occur with relative ease.

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Table 1a. Differences in service provision in institution-based and CBR models - structural issues

Feature	Traditional Institution Based OT & PT	OT & PT in CBR
Historical Factors	• service in hospitals and specialist centres	• rarely provided in the community • if provided, uses an institutional approach
Location of Service	• city based • centralised	• rural and remote communities and disadvantaged urban communities • decentralised
Facility	• purpose built centre that is well equipped	• home or local community centre with minimal resources
Allocation of Resources	• lots of money spent on facilities and equipment	• limited resources - focus of funds is on training and support
Types of Resources	• high technology • high cost • sophisticated • expectation that therapy is dependent on and driven by the technology available • limits resources to those commercially available which require high cost, skilled technical support and high maintenance and are often unsuitable	• low technology • low cost • uses only what is available • adapts local materials and environment to suit client's needs • uses local human resources to make materials that are lo cost, low maintenance and adapted to the local environment (therefore reliable)
Type of Service	• sophisticated, highly specialist care • city based	• generalist care • easily accessible & available to all
Integration	• separate from the community	• integrated into the community
Cost	• limited to those who can afford service • limited to those who can access service	• focus on rural and disadvantaged groups • usually provided at no or low cost
Staff / Population Ratio	• high • university qualified therapists • accredited internationally	• low • "therapists" usually composed of therapy assistants trained in short courses or locally trained health workers • rarely have access to university qualified therapists

Table 1b. Differences in service provision in institution-based and CBR models -therapy issues

Feature	Traditional Institution Based OT & PT	OT & PT in CBR
OT & PT Roles	• direct service provision to the client • 1:1 therapist:client ratio • rarely works in groups • allocates therapy time according to individual needs • ideal care to a few	• mainly indirect • acts as expert resource • teaches/trains local health workers and families to carry out day-to-day therapy • 1therapist:to a given population ratio • often works in groups • allocates time based on needs of the population • good basic care to all
Professional Kudos	• high - preferred employment option for therapists	• low - seen as a poor alternative to institutional employment
Professional Skills	• professional skills are protected and guarded	• transfer of skills to empower multiple levels of workers and families
Locus of Control	• therapist centred	• client/family centred
Status as an Expert	• therapist is seen as the expert • their knowledge and judgements are rarely directly questioned	• therapist is seen as a resource with expert knowledge about disability and pathology • client and family are seen as the expert about day to day functional issues and contextual factors
Knowledge and Information Flow	• is usually one way from therapist to patient - if at all. • not often presented in a form that is consumer friendly	• is a partnership approach based on a two-way flow • mutual respect of both parties and what they have to contribute • usually presented in a form that is consumer friendly and accessible to all involved
Therapy Decisions	• decisions about care rarely involve family	• decisions about management always involve client/family

Feature	Traditional Institution Based OT & PT	OT & PT in CBR
Model of Communication	• use specialist jargon	• use lay terminology that is consumer friendly
Therapeutic Approach	• curative • based on medical science • uses medical model for case reasoning • limits therapy and approaches to the scope of pathologies encountered • best suited for managing short term illnesses and acute problems • focuses on short term care	• manages the disability • based on a problem solving approach with a focus on function • uses a pragmatic functional model for case reasoning • uses many health models and options • best suited for managing chronic diseases and disabilities • focuses on long term solutions
Cultural Competency of Therapist	• Often low - rarely considers cultural factors • therapy often in conflict with cultural values	• High - always considers cultural factors and provides therapy with these factors in mind
Knowledge and Skills Required	• traditional therapy	• management, teaching, networking, organisational, health promotion, as well as therapy skills
Environmental Considerations	• rarely considered • treatment is confined to presenting pathology • patient is discharged from centre rather than prepared for re-entry into the home environment	• always considered • intervention is needs generated and considers social, cultural, physical and other environmental factors • client's program is generated from home based needs

Table 1c. Differences in service provision in institution-based and CBR models -professional issues

Feature	Traditional Institution Based OT & PT	OT & PT in CBR
Generation of Knowledge Treatment Approaches	• High • Clinical reasoning, evidence based practice and research generates knowledge related to treatment issues	• Low • draws upon knowledge derived from institutional practice • uses creativity to adapt knowledge to local context
Generation of Knowledge - Service Delivery Approaches	• Low • tends to provide same therapy regardless of context	• High • uses and evaluates a variety of models to suit context
Research Emphasis	• disease/pathology based - efficacy trials • uses experimental vs control approaches to compare treatments • uses traditional quantitative measures	• functional outcomes • service delivery models • matching approaches to meet needs • efficiency and efficacy • uses quantitative and qualitative measures

Table 2. Features of the ideal teaching package

Features of A Teaching Package
Aims of the teaching package
Objectives of sessionOverview of session and time required
Resources required
Preparation (including before and the day of the workshop)
Venue requirements and layout (accounting for group size)
Teaching, learning and evaluation plan
Group Leader instructions
Workshop script - sufficiently detailed to lead presenter through the process step-by-step
Suggested adaptations/modifications to the session
References and other useful literature as resource material
Evaluation of the session - outline of strategies and instructions immediate response to sessions – what they enjoyed short term learning that occurred long term learning through application in the field
Appendices
Overheads
case studies
other teaching materials
participant handouts
evaluation forms