Case Study Seven:

A rural provider builds capability

This rural provider focussed on building local capacity to deliver therapeutic supports in rural and remote locations. AHAs lived locally and had their own individual specialised skill sets which were then carefully matched with the NDIS participant. The provider recruited AHAs from various backgrounds, such as teachers, artists, and music therapists. The organisation also provided in-house training.

Benefits

Rural NDIS participants often preferred to work with people from their own town, so recruiting AHAs from the local population who had local knowledge and were accessible to participants was effective. This also benefitted communication and relationships between the AHAs and the participants, and reduced travel time for workers.

Challenges

The major challenge was in developing an AHAs' 'understanding of space and connection within a capacity-building role'. (Rural provider). Traditionally, supporting people with disability had been more about doing things for them, rather than building the participant's capacity to be able to do things for themselves. It has sometimes been difficult finding enough community members interested in becoming an AHA. In addition, rural and remote AHP students have found it hard to be away from their home base for the time taken to complete a degree.

Strategies for success

- Used a stepping-stone model whereby they gradually introduced new experiences and skills to the participant – thus building capacity one step at a time
- Provided in-house delegation training for AHPs entering the workforce
- Provided in-house training for AHAs with client-specific training to specific allied health plans
- A future strategy is to link up with the local TAFE to train the AHAs that they have employed in the Certificate IV in Allied Health Assistance. This is a preferred option rather than completing online courses offered by metropolitan RTOs. Another suggested future strategy was for students to study for a diploma or associate degree locally, accounting for one or two years of an allied health degree. This would mean they did not have to leave home for the full degree. And they would have gained confidence and knowledge before leaving their community to complete their degree in a metropolitan area.

Key principles of good practice

- Matched individual AHA skillsets with the participant needs and attributes
- Created pathways to employ local members of the community as AHAs
- Provided in-house delegation training provided for AHPs entering the workforce
- Provided AHAs with client-specific training to deliver AHP plans under the delegation of an AHP
- Facilitated career progression by supporting AHAs to complete their initial AHP studies in their local rural or remote community before transferring to complete the degree in a metropolitan location.