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Policy development and implementation for disability services in rural New South Wales, Australia

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Abstract
Throughout their lives, all people, including those who have a disability, use a broad range of community services. Community services are important in assisting people with a range of impairments to participate in their communities. Vast geographic distances and a lack of therapists in rural and remote regions of Australia pose significant barriers for implementing policy aimed at supporting people with a disability. The aim of this study was to investigate the extent to which metropolitan-formulated policy encompassed the unique geographic, demographic, and sociocultural challenges experienced by rural therapists and people with a disability in New South Wales (NSW). Twenty-seven policy documents were reviewed and categorized into tier 1 (higher level strategic policies) and tier 2 (specific operational policies). Tier 1 policy documents provided consistent messages about the need to develop strategies and service delivery options to address geographic, cultural, and age-related barriers facing all people in NSW including those who have a disability. Tier 2 documents revealed a lack of attention to the practical differences between implementing the policy principles in metropolitan compared with rural areas. Study findings identify that the implementation of metropolitan-formulated policy does not always encompass the unique challenges experienced by therapists providing services to rural people with a disability and their carers. This study highlights the importance of “rural proofing” policy to consider people who live and work in rural areas.
Background

Australia is a federation made up of six States and two Territories involving three levels of government: federal, state and local. In Australia and many other countries, public servants formulate and administer policy in line with government goals and priorities (Althaus, Bridgman, & Davis, 2007). Policy tends to be centrally written; however policy documents should encompass and reflect the views and requirements of the diverse populations to whom they apply (Grin & Van de Graaf, 1996).

Australia is a large island continent spanning a land area of almost 7.7 million square kilometers (Australian Bureau of Statistics, 2012). Australia is one of the most urbanized countries in the world, with the population concentrated in the capital cities and around the south eastern coastal fringe (National Sustainability Council, 2013). The rural population, accounting for approximately 30% of the total population is spread thinly across huge distances (Australian Bureau of Statistics, 2011b). In a country as geographically large and diverse as Australia, designing policy that is representative and inclusive of people living in metropolitan, regional, rural, and remote areas is challenging. Historically, European settlement in Australia occurred outward from points of first settlement, which commonly became state capitals at federation in 1901. According to Peters (2006, p.61) this settlement pattern resulted in “city centric policy making” with centralization in the state capital cities across all policy areas including health, welfare, and education. Brown (2006, p. 18) reported that centralization resulted in “the extension of large government departments, bureaucracies, commissions and statutory authorities, quasi-non-government organisations and, more recently, the
engagement of non-government organisations and not-for-profit organisations in service delivery.”

There is evidence that people living in rural and remote areas now experience more socioeconomic and health inequalities than urban dwellers, placing even greater importance on the development of inclusive policies that redress geographic disadvantage (Peters, 2006; Swindlehurst, 2005; Wakerman et al., 2008). Despite the need for rural considerations, Peters reported a lack of understanding of rural issues by politicians and public servants. For example, there are policy challenges in attracting and retaining qualified people prepared to work in rural areas (Chisholm, Russell, & Humphreys, 2011).

In a strategy aimed at mitigating rural inequities, the UK government adopted a “rural proofing” approach (The Countryside Agency, 2002). Rural proofing denotes the need for policy makers to consider the impact policies will have in rural communities during design and implementation (Swindlehurst, 2005, p. 13). Across UK government departments, a checklist of questions alerts policy makers to rural issues with the aim of ensuring policy is delivered effectively and efficiently, thereby improving equity of access to services for those living in rural communities (Commission for Rural Communities, 2009; Swindlehurst, Deaville, Wynn-Jones, & Mitchinson, 2005).

Policy implementation has been highlighted as a crucial stage in the policy process (deLeon & deLion, 2002) and there has been criticism of the UK rural proofing approach
as it allows policy makers to rely on a checklist rather than consult with local rural representatives about implementation (Atterton, 2008). Moret-Hartman, Knoester, Hekster, and van de Wilt (2006) pointed out that experiences will differ for people living in different parts of a government jurisdiction and for those with different needs and opportunities so that a “one size fits all” approach may result in misunderstanding of policy intent and implementation. These criticisms notwithstanding, the UK approach has been credited with raising the awareness of metropolitan-based bureaucrats to the advantages and challenges faced by rural communities (Atterton, 2008). In terms of land mass size, population distribution, and rural geography, there are considerable differences between the UK and Australia, with arguably a greater need for rural proof policy in Australia.

People who have a disability are among those affected by public policy decisions (Jongbloed, 2003; Prince, 2011). As noted by Bigby (2011), all people, including those who have a disability, use a broad range of public facilities and community services at different times in their lives. Community services include therapy provided by occupational and physiotherapists, speech pathologists, and psychologists (collectively referred to as therapists). Therapy intervention has an important role in assisting people with a range of impairments to participate in their communities (Dew et al., 2012). There is a recognized shortage of therapists living and working in rural areas of Australia (Chisholm, et al., 2011; Denham & Shaddock, 2004). This workforce shortage has an impact on therapists and people with a disability and their carers. Therapists who work in rural areas may be required to travel extensively to deliver outreach services to people in
more remote communities (Lincoln et al., 2013) and they live and work in small communities alongside the people to whom they provide a service (Allan, Crockett, Ball, Alston, & Whittenbury, 2007). The shortage of rural therapists also means that people with a disability wait for a long time or travel a long way to access therapy services (Dew et al., 2013).

Policy related to service delivery to Aboriginal people is of particular interest because of the large proportion of Aboriginal people living in remote communities in Australia (Steering Committee for the Review of Government Service Provision, 2003). Aboriginal and Torres Strait Islander people who, according to the Australian Institute of Health and Welfare (2011), are 2.4 times more likely to have a disability than nonindigenous Australians, account for only 5% of disability service users, including therapy.

Current Disability Policy in Australia

In 2009, the National Disability Agreement (NDA) was introduced by the Australian government as an instrument to guide the provision of supports to people with a disability. The stated objective of the NDA is to provide people with a disability and their carers an enhanced quality of life and opportunities to participate as valued members of the community (Council of Australian Governments, 2012). A National Disability Strategy, 2010-2020, based on the NDA, provides a policy framework to guide government activity across mainstream and disability-specific areas of public policy with the aim of greater inclusion of people with a disability (Council of Australian Governments, 2011). Similar to countries like Canada and the United States where
overarching policies exist at the federal level, each of the six Australian states and two territories develop policies for local implementation. Unlike the United States and the UK, and similar to Canada, in Australia, local governments are instruments of state governments and as such have limited input into policy, further divorcing policy formulation from the places where implementation occurs within local communities (Brackertz, 2013; Brown, 2006; Martin, Paget, & Walisser, 2012).

Current New South Wales Disability Policy

Located on the southeastern part of the Australian continent, New South Wales (NSW) is the most populated and heavily industrialized state, with a population of 7.29 million spread across a total geographical area of 80,642 square kilometers equalling 10.0% of Australia’s total land area (Australian Bureau of Statistics, 2012; 2013). Based on broad consultation with people with a disability, their carers and service providers, the NSW government introduced a 10-year disability strategy, known as Stronger Together: A New Direction for Disability Services in NSW: 2006–2016, with a commitment of additional funding of AUD$5.5 billion (NSW Government, 2006). The Stronger Together disability reforms have gained bipartisan support, which have resulted in continued implementation of the policy across parliamentary terms in NSW, including a recent change of government. In recognition of the importance of therapy, an additional AUD$63 million from the total Stronger Together enhancements was allocated to providing therapy and behavior support (NSW Government, 2010).
Development and implementation of policy in line with legislation and government direction are the remit of the NSW Department of Family and Community Services from its central office situated in Australia’s largest city and NSW capital, Sydney. Policies developed at the central level are implemented across NSW through services delivered at a regional level. During the policy development stage, regional office staff members have opportunities to comment on draft policy documents.

The study reported here forms part of a larger study that aims to review, develop, implement, and evaluate evidence-based policies that will promote timely and effective therapy service delivery to people with a disability living in rural and remote communities. The study is being conducted in the large regional area of western NSW (Veitch, Lincoln, et al., 2012). In this paper, we report on content analysis of key government policy documents to discover the extent to which metropolitan-formulated policy encompasses the unique geographic challenges experienced by therapists providing services to rural people with a disability and their carers in western NSW.

**Method**

*The Setting*

The western region of NSW accounts for 72% of the geographical area of the state but only 9% of the population. The estimated resident population in 2011 was nearly 570,000, (Australian Bureau of Statistics, 2011a). This population is scattered among large regional towns with populations of 20,000–40,000, smaller towns of 1,000–3,000 people, and isolated rural communities of less than 1,000 people. Some people live on
remote properties (farms) many kilometers from their nearest neighbors and hundreds of kilometers from towns. The large land area and dispersed population create significant challenges for providing supports to people with a disability and their carers who live in rural and remote areas of western NSW (Dew et al., 2013).

Policy Document Identification

Purposive (Creswell, 2007) and snowballing (Bryman, 2012) sampling techniques were used to collect 27 policy documents providing current direction to staff working in government disability services in NSW released from 2002 to 2011. The start date of 2002 was determined by two key policy documents released in that year that related to the eligibility of people with a disability accessing government disability services. These two policy documents were initially provided by government staff along with six other documents that they identified as relevant to the study. A further two policies were identified by searching the initial eight for related documents. Author KB was seconded to work on the project and through her insider knowledge, an additional eight policy documents were identified. NSW government websites were searched directly to access a further nine documents.

Policy Document Analysis

A summary was made of the key policy content for each document resulting in the 27 documents being divided into two tiers: Tier 1 comprised of high-level, overarching strategic policy documents that provided the context within which NSW government services are funded and delivered; Tier 2 contained specific operational policies that are
directly related to the implementation of Tier 1 policies in NSW government services for people with a disability. The analysis was conducted by author AD with subsequent discussion between all authors.

An iterative content analysis approach (Bryman, 2012) was used to identify components within each tier and document relevant to rural therapy service delivery by asking: (How) does this document: (1) consider or adapt implementation of policy in rural/remote areas of NSW? (2) relate to people with a disability living in rural/remote NSW? and (3) relate to rural/remote people of Aboriginal and Torres Strait Islander background? (In addition, and related to the operational nature of the Tier 2 documents, a further question was applied to documents at that level: (4) How is this document relevant to therapists who support people with a disability in rural/remote areas of NSW?) For each policy, this approach led to the identification of content strengths and gaps related to the delivery of therapy services to people with a disability in rural/remote areas. In the description of the results and accompanying tables, each document has been given an identifying label. The Appendix provides publication details for each document.

Findings

Tier 1 Policy Documents

Twelve Tier 1 documents were identified. Table 1 is a list of the documents by year of release according to their level of coverage in four content areas: (1) applicability across government agencies; (2) disability content; (3) rural/remote content; and (4) Aboriginal/Torres Strait Islander content. Table 1 demonstrates that the majority of Tier 1
documents contained content related to consultation with people of Aboriginal and Torres Strait Islander background, consideration of policy application in rural areas, and reference to people with a disability.

**Applicability Across Government Agencies**

Tier 1 policy documents provide a blueprint for a whole-of-government approach to service provision to NSW citizens including people with a disability, regardless of where they live, based on evidence-based principles of early intervention, person-centeredness, and capacity building within a whole-of-government context. Document T1.8 specifies that every government policy document must take into account the needs of people with a disability, those living in rural and regional NSW, Aboriginal people, and people from culturally and linguistically diverse (CALD) backgrounds. The Tier 1 documents indicate a shift in government policy towards greater consideration of minority groups’ needs within mainstream government and community services. For example, in document T1.7, page 2, the need for all government departments to be involved in planning for the needs of people with a disability is stated as “It is vital that people with a disability and their carers can use government services such as transport, health and education, just like everyone else”.

Because of the aging of the NSW population, documents T1.8 and T1.9 identified the need for government agencies, including therapy service providers, to respond to an
anticipated increase in aging-related disability. Of relevance to this study, as the majority of therapists employed in disability services are women, T1.9 also identified the low workforce participation rates among some groups of women and recommended flexible workforce recruitment and retention models across government agencies to address these imbalances.

*Disability Content*

In the two NSW State Plans, T1.5 and T1.12, there is recognition of the need to integrate service delivery and improve client access for individuals with complex needs living in rural and remote communities. Document T1.12 identified the need to “increase opportunities for people with a disability by providing supports that meet their individual needs and realize their potential” (p. 29). Three target areas were proposed to achieve this goal: (1) person-centered approaches through the provision of an option for individualized funding arrangements; (2) increasing participation of people with disabilities in employment or further education; and (3) increasing the proportion of people aged 5 years and older with profound and severe disabilities involved in out-of-home activities.

Consistent with the direction for human services outlined in state plans T1.5 and T1.12 is document T1.6, Stronger Together, supported by significant funding enhancements to provide a blueprint for the future direction of services to people with a disability in NSW from 2006 to 2016. Indicative of the consistency of this policy with the previously mentioned state plans, the stated aims of T1.1 and T1.6 are to strengthen families,
improve early intervention responses, promote community inclusion, and build system
capacity and accountability for people with a disability.

T1.10 and T1.11 highlighted the low participation rates of Aboriginal and CALD people
with a disability in disability-specific services. T1.4 outlined the mechanisms for
disability service planning to occur at the regional level with central coordination. This
approach is designed to ensure that services reflect local needs and population
characteristics including those of people from Aboriginal and CALD backgrounds. Under
this policy framework, government agency regional planning teams consult with
communities to identify current and potential local and regional priorities and service
gaps.

*Rural/Remote Content*

Nine of the 12 Tier 1 documents directly address rural and remote policy application. Of
note, the new state government plan (T1.12) highlights the importance of growth in
regional areas, including rural and remote locations, with a “whole of state” (p. 5)
approach aimed at increasing regional population numbers and access to jobs along with
sustainable management of natural resources. This document states that specific
requirements and gaps identified through local community consultations should be
reflected in policy development.

T1.7 outlined agreements between government departments to ensure that people with a
disability could access therapy services from the geographically closest and most
convenient government outlet. The agreements between government departments, for example between NSW Health and the then department of Ageing, Disability and Home Care\(^1\), were designed to redress the inequalities experienced by people living in regional towns and rural areas due to lack of specialist disability support such as therapy.

**Aboriginal or Torres Strait Islander Content**

All Tier 1 policy documents included content related to Aboriginal and Torres Strait Islander people. Within T1.2, the health, education, and social needs of NSW Aboriginal and Torres Strait Islander citizens were identified as requiring specific policy attention due to the identified discrepancies in these areas compared with non-Aboriginal people. T1.2 and T1.3 provide a detailed commitment by state and federal governments to work together to plan and deliver services to people of Aboriginal background. Linked to these documents is T1.10, the Aboriginal Policy Statement. Building on these previous policy documents, Goal 26 in T1.12 identified the need to foster opportunities and partnerships with Aboriginal people through whole-of-government approaches to social inclusion, health, education, decision-making, and cultural identity. Within T1.3, there was recognition that different approaches would be needed according to geographic location. No mention of this was made in T1.2 or T1.10.

Tier 1 policy documents contain consistent messages. These messages relate to the need to develop strategies and service delivery options to address geographic, demographic, and sociocultural barriers facing all people in NSW including those who have a disability.

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\(^1\) Ageing, Disability and Home Care is now part of the Department of Family and Community Services.
Tier 2 Policy Documents

Fifteen Tier 2 documents were written specifically for implementation in the government agency’s direct services for people with a disability. These policies were consistent with the relevant NSW legislation (e.g., the Disability Services Act 1993), and many make references to Tier 1 and other Tier 2 policy documents. Table 2 provides an overview, by year of release, of the Tier 2 documents according to four content areas: (1) service access; (2) risk management; (3) staff performance; and (4) rural/remote content. As shown in Table 2, in relation to their relevance to therapists, documents were found to cluster around three broad topics: service access, risk management, and staff performance. Rural proofing was found to be largely absent at the Tier 2 level.

Service Access

In order to allocate the scarce specialist community access resources in the disability sector (e.g., therapy, case management, behavior support), two documents (T2.13 and T2.14) provide guidance to government agency staff about eligibility and service access priority for individuals with a disability. T2.14 provides a set of criteria for determining low, moderate, high, or immediate priority. There are no statements within this policy that make allowance for the difficulty encountered by rural staff in prioritizing clients’ access to service when staff travel great distances to remote locations on an infrequent basis.
Risk Management

Twelve of the 15 Tier 2 documents included risk management strategies with 9 related to working with individuals with a disability and the remaining 3 related to risks encountered by staff in their work duties. T2.19 was related to T2.14 in that clients who were experiencing swallowing difficulties were deemed to be experiencing life-threatening risk and as such were allocated as having an immediate need to be seen by a speech pathologist. There was no indication of an alternative risk management procedure that could be applied in the circumstance, as may occur in rural and remote areas, that a speech pathologist is unavailable within a reasonable distance of the client.

Document T2.16 provided a risk management framework for staff to identify, assess, minimize, monitor, and review risk for eligible clients with a developmental disability. There was no discussion of any potential different or additional considerations of client risk associated with geographic isolation.

T2.24 proposed strategies for managing risk and preventing workplace injuries and illnesses. One area of Workplace Health and Safety risk covered in the associated T2.25 was the time and distance workers travelled to perform their duties. T2.25 also outlined a risk management approach to driving for work purposes. Among other risk factors, the policy identified time spent driving and driver fatigue as two potential dangers. The policy suggested drivers share driving with colleagues, take a break every 2 h, stay overnight on longer trips, avoid consecutive days of driving over longer distances, and
make alternative arrangements such as changing start/finish times of meetings, reducing meeting frequency, and using technology rather than travelling to face-to-face meetings. These recommendations were cognizant of the issues faced by rural and remote employees who drive long distances.

Staff Performance

Thirteen of the 15 policies related to staff performance. Document T2.15 outlined the key principles governing the way staff provided services to children and young people with a disability. This included a focus on family-centered practice and working in partnership with families to promote community participation, the goal of prevention and early intervention, the need for cultural and linguistic sensitivity, and the requirement to adhere to child protection legislation. The policy did not mention the particular needs of staff working in rural areas in responding to these service standards.

T2.17 identified the potential conflicts between the duties and responsibilities of government employees in serving the public interest and an employee’s private interests. Related to this policy was T2.26 that required full-time employees to obtain permission and address conflict of interest issues when undertaking private work outside of their government role. These policy documents do not acknowledge the specific challenges faced by employees who live and work in rural areas.

Discipline-specific practice packages T2.20, T2.21, T2.22, and T2.23 were aimed at ensuring consistent practices within the therapy disciplines around professional
responsibilities, support and development, service delivery models, and administration.

T2.27 provided guidance and support to managers and employees in performance planning and appraisal. The policy determined that an annual “excellence” plan with 6-monthly reviews was required for all staff and this was developed and monitored through regular manager and employee contact. The policy document detailed that regular support and supervision did not need to be face to face so that employees who were situated remotely from their supervisor could undertake this process via telephone, which is mindful of the needs of rural and remote employees.

T2.18 applied to all formal research projects funded or supported by the government agency. The policy recognized the importance of research in contributing to evidence-based practice. The policy identified that regional research priorities were to be set at the local level, and responsibility for this research resided at the regional level in consultation with the central department responsible for overseeing research. This type of policy framework recognizes the difference between regions and allows for accommodation for rural and remote locations.

**Rural/Remote Content**

Only documents T2.18, T2.25 and T2.27 specifically mentioned how the policies may apply or be adapted in regional, rural, and remote settings at the Tier 2 level. The remaining 12 documents did not address geographic differences in policy implementation.
Discussion

The documents analyzed in this study were developed centrally and implemented at the regional level under supervision from the central office in what might be described as a top-down approach (Hallsworth, 2011). Grin and Van Graaf (1996) argued that policy will only be effective if both the target population (the people who will experience the consequences of a policy when implemented) and the implementers consider the proposed policy measure meaningful. To be effective, the proposed policy should make sense in the light of problems perceived by the target population (e.g., lack of rural therapy services). According to Grin and Van Graaf (1996), there is a need to identify the policy’s target populations and involve them in the process of policy development. It is important to understand the policies that inform the provision of disability services in rural and remote areas and to establish mechanisms to capture the views of the “target population.” Similarly, in discussing the role of rural local government in Canada, Martin, et al. (2012, p. 33) described a process of “facilitative intervention” aimed at building local capacity and ensuring policy and provision are tailored to local conditions.

Within the larger study, stakeholders were asked about the implementation of disability policy (Veitch, Dew, et al., 2012). Participants reported a mismatch between the policy intent and the way implementation was experienced by therapists and the people with a disability for whom it was written. It appeared that policy makers’ focus on formulation and implementation of policy was not generally informed by the therapists and individuals with a disability and their carers. Indeed, it appears that little policy
information feeds back into the policy formulation process from the target population and some feedback is filtered, or reinterpreted, at the management level.

In the context of this study, Tier 2 documents operationalized the broader, whole-of-government policies identified in Tier 1. It appears from the results of the Tier 2 documents that, contrary to the advice of Grin and Van Graaf (1996), there was little consideration of factors, such as geographic location and workforce distribution, or how these might be taken into account during the implementation process. Indeed, content analysis of Tier 2 documents revealed a lack of attention to the practical differences of implementing the policy principles in rural areas in the majority of documents reviewed. This lack of attention to implementation differences may be due to a lack of awareness or experience of rural differences, as described by Peters (2006), or it may reflect a presumption on the part of policy makers that implementation is consistent regardless of context. In addition, time pressures on policy makers, the short policy cycle, tokenistic consultation processes that may occur after policy formulation and consulting with the “wrong” target populations may also contribute to unrepresentative policy (Gleeson, Legge, O’Neill, & Pfeffer, 2011).

One example of the dilemma faced by rural therapists in implementing policy is related to the large geographic distances between where a person with a disability lives and where the therapist is based. Despite policies T2.14 and T2.19, the distance between therapist and client may mean the therapist is unable to respond in a timely manner to clients prioritized as having an immediate need, such as a child with swallowing problems (Dew
et al., 2013). Priority status benchmarks may be difficult to adhere to when therapists visit rural and remote areas on an irregular basis.

Another example of the mismatch between metropolitan-formulated policy and rural implementation relates to workforce shortages and work practices. There is an established worldwide shortage of therapists and particular challenges in recruiting therapists to work in rural and regional areas (Lincoln et al., 2013). Rural recruitment incentives may lead to proportionally larger numbers of new graduate therapists working in rural positions. New graduates require intensive professional supervision. Supervision via telephone, as suggested in T2.27, is not ideal for new graduates who may be less inclined to seek supervision from a geographically distant supervisor.

Another rural workforce issue relates to travel. Therapists working in rural areas may be required to travel alone through remote areas with few towns in which to take breaks. Although therapists may wish to minimize overnight stays, the pressure of work demands may necessitate travel over long distances on consecutive days and, while teleconferences are common among rural practitioners, there are still times when face-to-face meetings are preferred or required (Chedid, Dew, & Veitch, 2013). Therefore, T2.11 suggestions outlining safe driving practices while eminently sensible, and particularly relevant for rural and remote employees, require flexibility in implementation for therapists currently working in rural areas (Dew et al., 2013).
In relation to T2.17 and T2.26, the potential for conflicts of interest may more readily arise for rural therapists than for their metropolitan counterparts. Living and working in rural communities may mean that employees socialize with community members who are also their clients. Their children may go to the same school; they may shop in the same supermarket and attend the same community events (Allan, et al., 2007). Similarly, rural practitioners may from time to time be asked to engage in private paid work in order to fill a gap in their local community (O'Toole, Schoo, Stagnitti, & Cuss, 2008). Consideration of geographic factors must be outlined, particularly for part-time and casual rural practitioners and their managers, to address these situations within current policies.

Despite acknowledgement of the differences between metropolitan and rural, and the direction provided in T1.8 for all government policy documents to take into account the needs of people with a disability regardless of location, Tier 2 policy documents provided limited direction to employees about applying or adapting policy to address the specific needs of people living and working in rural and regional NSW. In short, there was no policy rural-proofing (Swindlehurst, 2005, p. 13) at the departmental, Tier 2 level. By way of example, in the UK rural-proofing checklist, three questions are particularly relevant to the policies reviewed in this study: Question 3, “Will the cost of delivery be higher in rural areas where clients are more widely dispersed or economies of scale are harder to achieve?” Question 4, “Will the policy affect travel needs or the ease and cost of travel?” and Question 11, “Is the policy targeted at the disadvantaged?” (The Countryside Agency, 2002, pp. 3–4). In contrast to the UK experience, the lack of rural
proofing in the NSW disability policy context represents a major gap in ensuring the relevance of these documents to staff working in regional, rural, and remote areas.

Bigby, Fyffe, and Ozanne (2007) previously described the obstacles and tensions of implementing disability policy. They argued that the implementation of state policies relies not only on the state agency but also action and cooperation of complex networks (local governments, nongovernment organizations, federal governments) in a way that does not consider the complexity of the systems that are impacted by policy implementation. In her overview of the historical changes in disability policy in Canada over the past century, Jongbloed (2003) warned of the dangers of overlapping policy paradigms so that “policies based on different views of disability co-exist” (p. 208), resulting in a lack of a “unified, comprehensive policy toward people with disability” (p. 207). McNally (2004), in reviewing the first 3 years of Valuing People, the UK’s policy for people with intellectual disabilities, noted that policy is “rich in ideology and presentation but comparatively poor in implementation” (p. 327). This sentiment appears equally relevant in the NSW context in relation to policy affecting the lives of people with a disability who live in rural and remote areas.

Limitations

Policy landscapes are constantly changing. This study provides a snapshot of NSW government policy covering a 14-year period. We did not attempt to look at the impact of earlier policies. There were challenges in keeping up-to-date with new policy directions and documents, particularly given the change in state government 6 months after the
commencement of the project. New policies are emerging, which were not reviewed for this paper. However, this is the first NSW disability policy review study with a particular focus on rural and remote therapy issues. There are parallels between the NSW and Australian context and that of other countries where geography and centralized government provide similar challenges to rural policy implementation (Iezzoni, Killeen, & O'Day, 2006; Martin, et al., 2012).

Conclusion

Over the past 30 years in Australia and other western countries, government policy has shifted from a welfare- to a rights-based view of the inclusion of people with a disability. In this study, the overarching (Tier 1) policy documents reflect this shift in practice. Given the finding in this paper of a significant disconnect between policy at the operational (Tier 2) level in relation to rural and remote issues, it may be fruitful to conduct the same analysis in other Australian states and potentially in other countries with similar rural geography such as Canada and the United States. This issue has been identified and researched in both the UK (Atterton, 2008; Swindlehurst, 2005; Swindlehurst, et al., 2005) and, through this study, Australia.

This study identified the need for policy development to include the perspectives of people who live and work in rural areas. This policy rural proofing requires more than the insertion of broad statements of intent to include, for example, “how to” accommodate rural and remote issues through the development and systematic application of a rural “checklist” similar to that developed in the UK (The Countryside Agency, 2002). This
will lead to the development of policy that is more relevant to rural settings and enhance adherence and implementation at the local level as rural therapists (and other staff) will recognize their work environments within the policy documents. People with a disability and their carers will experience benefits from policy that supports their inclusion and participation in the environments in which they live. The mandatory inclusion of rural stakeholders within policy development groups may help address this situation as would the development of uniquely Australian based criteria for rural proofing future policy.
Appendix: Reviewed Policy Documents

Tier 1 Documents


**Tier 2 Documents**


References


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<thead>
<tr>
<th>Identifier</th>
<th>Policy Document Title and Year</th>
<th>Applicable across government agencies</th>
<th>Disability content</th>
<th>Rural/Remote content</th>
<th>Aboriginal Torres Strait Islander content</th>
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<td>T1.1</td>
<td><em>Living in the Community and Putting Children First, 2002</em></td>
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<td><em>Two Ways Together Partnerships, 2003-2012</em></td>
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