18 Disability and Vocational Rehabilitation in Rural and Remote Australasia

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Summary and conclusions

Learning Objectives

By the end of this chapter, you should be able to:

- Outline the legislative and policy foundations of rehabilitation in Australasia.
- Specify the frameworks for the vocational rehabilitation services to rural and remote Australasian settings.
- Examine any links between vocational rehabilitation services and a unique occupational ecology of rural Australasia.

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- Identify and evaluate the feasibility vocational rehabilitation service qualities that would be appropriate for indigenous people of Australasia.
- Discuss strategies to improve vocational rehabilitation service delivery in rural Australia.

Introduction

Australasia comprises Australia and New Zealand and islands or territories. Australia comprises a vast continent of 2.9 million square miles with 85% of its population of 23 million residents along the South and Eastern coastal areas. About a third of Australia's population lives in rural or remote areas (Australian Bureau of Statistics, ABS, 2010). The Australian Bureau of Statistics (2001, 2010) defined rural and remoteness to be areas with a population census of 1–199, peri-urban communities as those with a population of 200–999 and urban as with a population census of 100,000. In Australia, common perceptions of the term "rural" could range from rural farming areas, remote areas and desert to non-metropolitan (Humphreys et al., 2012).

Comparatively, New Zealand is an archipelago comprised of two main islands, many smaller islands, inlets and inland and oceanic waters. It is a smaller nation, with a population of 4.5 million. The North Island is New Zealand's most populous island, with a population of around 3.5 million over an area of approximately 44,000 square miles. The South Island, the larger of the two at approximately 58,000 square miles, is divided longitudinally by an alpine range and is home to just 1 million people. Rural in the New Zealand context is divided into four categories defined by levels of interaction and dependence on nearby urban areas: rural area with high urban influence, moderate urban influence, low urban influence and highly rural/remote (Statistics New Zealand, 2006). Statistics New Zealand defined rural centres as those with populations of 300–999; and to distinguish between true rule dwellers and others in rural settlements or towns. A rural settlement with high urban influence will have significant dependence on urban centres for employment, with much of the population travelling to engage in employment. About 12% of the population of New Zealand live in rural areas with high urban influence and 3% live in rural remote areas (Statistics New Zealand, 2008).

Nonetheless, despite the huge differences in land mass, the two countries in their rehabilitation and healthcare provisioning are significantly influenced by geography with availability and access of services lower in the rural and remote regions compared to urban centres. For both countries, comparatively, highly rural or remote areas have smaller, largely self-employed populations with little dependence on urban areas for employment. People with disabilities in rural and remote Australia therefore face a double disadvantage with respect to lack of employment opportunities associated with rural living as well as lack of vocational rehabilitation services to support their work participation with employment (Gething, 1997).

This chapter considers disability and vocational rehabilitation services in rural and remote Australasia, covering the legal and policy frameworks for vocational rehabilitation in Australasia and the structures for implementation and significance of work and employment to health rural living. It then discusses work opportunity and disability in rural and remote Australasia. This includes vocational rehabilitation service needs and utilisation by the vulnerable and historically disadvantaged indigenous populations of Australasia, significant proportions of who are rural and remote community dwellers. Finally, the chapter considers strategies for the enhancement of vocational rehabilitation services in rural and remote Australasia as well as issues for research and other forms of scholarship.

Vocational Rehabilitation Services in Australasia

Vocational rehabilitation services are designed to provide work access, retention and development support, taking into account the specific disability-related needs of the individual, type of work and occupational environment. Specific vocational rehabilitation services provided in the Australasian region include preparation for working; job search strategies including resume prep-

aration, interview skills training, on-the-job support and employer disability support interventions; small business management and self-employment (Buys, Matthews, & Randall, 2015). Vocational rehabilitation service policies of Australasia are authorised by a number of legal mechanisms.

History and Evolution of Services Vocational rehabilitation has a mixed history starting from a background of charitable relief and evolving through a complex system of social security and compensation. Its development continues to be characterised by long periods of neglect then intense bursts of legislative activity (Mendelsohn, 1979). It floats somewhere between welfare versus compensation.

An early example of a welfare mentality towards disability or injury is one of the founding powers in the 1901 Australian Constitution. In Clause 51 xxiii, the federal government has the power to make laws with respect to invalid pensions for people with chronic illness and disability. A Royal Commission on Old-Age Pensions was conducted during 1905–1906, and in December 1910, the invalid pension replaced a scheme that had operated in one of the states. Subsequent developments are summarised in Table 18.1.

Reflection Exercise
Consider the evolution of rehabilitation support services in Australia as in Table 18.1. What aspects relate to empowerment of people with disability and how? To what extent does the evolution of rehabilitation services reflect partnership with people with disabilities to enhance their vocational participation?

The development of vocational rehabilitation was aided in part by advances in medicine with greater survival rates for those with injuries and chronic conditions. It was also a product of the greater awareness of the community's obligation for war veterans.

A government Commonwealth Rehabilitation Service began around 1948, no doubt in response to the needs of World War II veterans. Charities and specific disability groups, such as Society for the Blind, provided vocational services. A major impetus was the expansion of the Commonwealth Rehabilitation Service development of vocational rehabilitation in response to compensable injuries, and for the most part, this has been the mainstay of the profession of rehabilitation counselling in Australia. New Zealand had an analogous history in the development of vocational rehabilitation services.

Legal and Policy Instruments The Australian Disability Services Act (Australian Government, 1986) makes provision for the availability of services to people with disabilities in rural and remote communities of Australia. This followed a review of services for people with disabilities (Handicapped Persons Review, 1985). The main recommendation from the review was to move away from "sheltered workshops" to that of community integration, especially in relation to employment. Later amendments of the Australian Disability Services Act established standards for disability services.

In New Zealand, access to vocational rehabilitation services is provided for in the case of injury through the Accident Compensation (AC) Act of 2001. Access to vocational rehabilitation for those with non-accident-related disability and mental health issues is managed through the Ministry of Social Development. In 2008 New Zealand ratified the Convention on the Rights of Persons with Disability, building on the work of earlier legislation such as the Bill of Rights Act 1990, which provided people with disability the same legal rights and entitlements as all New Zealanders and protects them from discrimination. The New Zealand government also provided the framework to commence the process to remove the barriers which prevent people with disabilities from participating fully in society (Office for Disability Issues, 2016), and from 2016 this strategy is being reviewed. In addition,

Table 18.1 A chronology of key changes in rehabilitation-related social security and other benefits in Australia

Year	Allowance	Description
1908	Invalid and Old-Age Pensions Act 1908	Invalid pension of 10 shillings per week
1928	Employment injury benefits	Workers' compensation introduced in New South Wales funded by compulsory employer contributions
1948	Commonwealth Rehabilitation Service	An invalid pension was paid for those completing vocational training
1967	Sheltered employment allowance	For those persons who qualified for an invalid pension and were employed in a sheltered workshop
1983	Mobility allowance	For persons unable to use public transport for work or vocational training
1983	Rehabilitation allowance	For those persons assisted through the Commonwealth Rehabilitation Service
1983	Healthcare cards	For those who gave up an invalid pension or sheltered employment to take up open employment – free of income test for 12 months
1983	Rehabilitation allowance	Paid to people undertaking a commonwealth rehabilitation programme and for 6 months after completion of vocational counselling programme
1991	Disability reform package	Disability support pension replaces invalid pension; emphasis on rehabilitation, self-sufficiency, work readiness, incentives to employers for hiring persons with disabilities
1997	Job network	Commonwealth employment service replaced by a subsidised private network of services for jobseekers
2006	Welfare to work reforms	Obligation on welfare recipients to work part-time or to look for work; rehabilitation and workforce re-entry assistance was also provided
2013	National Disability Insurance Scheme	Limited vocational rehabilitation services, emphasis on disability services and case management. Emphasis is on consumer choice as to the services he or she needs in the context life domains of importance to him or her

Source: Australian Bureau of Statistics (1988), Daniels (2011)

the New Zealand government has also adopted strategies to support improved health outcomes for its indigenous people, the Maori. *He Korowai Oranga* is a "high-level strategy that supports the Ministry of Health and district health boards (DHBs) to improve Māori health by interlinking implementation of the New Zealand Health Strategy, New Zealand Disability Strategy, and New Zealand Public Health and Disability Act 2000" (Ministry of Health, 2015). The overall aim of this integrated service strategy is to enable Maori families to maximise their health and well-being (Harwood, 2010).

Service Provision Approaches The three broad approaches in implementing policies to assist people with disability to find and maintain work are a generalised disability support service that operates across the life span, a social welfare system approach that operates for adults with disabilities that seeks to minimise reliance on social security (e.g. reliance on disability pensions) and the maximising of early return to work (Herscovitch & Stanton, 2008; McKenzie, 2016; Rockwell, 1939). In Australia, the demand for more efficient vocational rehabilitation resources is, in part, designed to relieve government fiscal pressures by reducing the number of disability pension recipients.

Employment services under the social welfare system are delivered by a network of contracted organisations that provide direct jobseeking support and placement. Return-to-work rehabilitation services seek to minimise economic risk to both the worker with disability and employer by utilising early intervention strategies (Buys, Matthews, & Randall, 2010; Heads of Workers Compensation Authorities Australia and New Zealand, 2015; Safe Work Australia, 2011). The transportability or use of these vocational rehabilitation service models to rural and remote Australasia community settings is unknown.

In Australia vocational rehabilitation services are provided at both the state and federal government levels. There is a degree of complementarity in service provision for persons with a disability in

Australia, with a split between vocational and community living rehabilitation services. The federal government has primary responsibility for employment services in relation to disability. The state governments, on the other hand, deal mainly with allied areas such as family support, housing, community living issues or community services. This is unlike in New Zealand where vocational rehabilitation services operate as the responsibility of the central government, with local government having little responsibility for the support and rehabilitation of those with disability, injury or mental health issues. Delivery of these services is undertaken at a community level, with government organisations, not-for-profit organisations and private enterprise, all being represented in the market of vocational rehabilitation service providers. However, the implementation of these vocational rehabilitation services among Australasian rural and remote communities is questionable, with widespread defunding of local or regional social services by the central governments and consequent attrition of services (Alston, 2002). Furthermore, rural to urban migration continues to deplete the human resource base of rural and remote Australasia, including vocational rehabilitation provisioning. Moreover, many small rural towns, some of which housed occupational rehabilitation services, increasingly are reducing to ghost towns due to attrition of population to the larger urban centres, further adding to the scarcity of employment and work support services (Alston, 2000). The service gaps would include in the provisioning of vocational rehabilitation services.

Significance of Work and Employment to Healthy Rural Living

Work participation makes for health and wellbeing with disability through the latent role functions that work engagement provides (Janlert & Hammarstrom, 2009). Latent roles are those the enactment of which adds to meaningful living and interconnectedness with social others, providing structure to everyday activities. In rural and remote communities with their sparse populations, work role-related routines become even more significant to personal identity and functioning, as dwellers have limited access to social amenities. In other words, the supplemental social and infrastructural amenities often taken for granted in urban centres are typically lacking or constrained so that work engagement is the primary role to interact with others. But, formal work positions are less prevalent in rural and remote regions compared to urban centres (ABS, 2012; Fragar et al., 2010) so that people with disability in rural and remote settings are at elevated risk of unemployment (ABS, 2001; AIHW, 2005). Furthermore the sparse availability of vocational rehabilitation services in rural and remote Australasia would disadvantage those who might benefit from such services (Gittoes, Mpofu, & Matthews, 2011; Pelling & Butler, 2016).

Unemployment on its own is significant risk to health status, while long-term lack of work participation could result in disability (Murphy & Athanasou, 1999). For instance, unemployment is associated with poorer mental health due to social isolation, as well as from the loss of a work role personal identity, important to a sense of meaningfulness to life (Fragar et al., 2010; Waghorn, Collister, Killackey, & Sherring, 2007). For instance, in a study by Fragar et al., unemployed or permanently unable to work rural and remote New South Wales (Australia) residents were shown to have significantly higher levels of psychological distress when compared to those employed or retired. However, rural and remote community dwellers may also be so work engaged as to neglect their healthcare needs and which, if unattended to, could also result in long-term disability and unemployment (McGrath, 2015). For instance, they may be averse to seeking the external help of community outsiders who may be vocational and health professional counsellors (Pelling & Bulter, 2016).

Types of Occupations Rural and remote Australasia is heterogeneous in regard to work role opportunities and occupations (ABS, 2001; AIHW, 2005; Fragar et al., 2010). Summary data on paid employment positions in rural and remote Australia and New Zealand could not be accessed. However, the study by Fragar et al. is the major exception. NSW is typical of the more populous states of federal Australia in having great areas of

rural and remote territory with very sparse social services (Gething, 1997).

Fragar et al. (2010) reported 87% of 2639 residents of a rural and remote region of NSW were in paid employment. About four-fifths of the 13% not in paid employment from the Fragar et al. study were retirees (n = 796) or permanently unable to work (n = 151) with the rest being students or carers (n = 143) or unemployed (n = 52). Statistics New Zealand (2001) reported, in highly rural/remote areas, the labour force participation rate was 76.7% in the South Island and lower in the North Island at 71.2%. The rate of self-employment in highly rural/remote areas at this time was twice the national average at 26.1%, where those who were paid employees were just 48.6% compared to the national average of 77.2%. These data suggest that employment participation is challenged in a rural and remote region of Australia and New Zealand and that vocational rehabilitation services would be an important resource for workers in this regional setting.

A question of interest to scoping the likely needs of vocational rehabilitation services in a typical rural and remote Australasian region is the types of occupations available and their prevalence. Based on the Australian and New Zealand Standard Classification of Occupations (ANZSCO) (ABS, 2009), Fragar et al. (2010) documented the title (and proportion) of paid employment positions in rural and remote New South Wales (NSW). These were as follows: clerical, administrative and sales workers (.19); occupation not specified (.14); farmers and farm managers (.12); machinery operators, drivers and labourers (.10); other managers (.09); education professionals (.09); other professionals (.08); technicians and trade workers (.07); other community and personnel service workers (.06); and health professionals and health welfare workers (.06). From these data it is apparent that service-related professions (clerical, administrative and sales workers; technicians and trade workers and other community and personnel service workers) are the most prevalent, accounting for about 31% of paid employment positions, followed by farming-related occupations (farmers and farm managers, machinery operators, drivers, labours) at 24% of the positions and closely followed by education, health and other professional positions at 23% of the positions. A significant minority of paid employment (14%) comprises occupations not specified. While these figures are based on only one region of Australia and may not be representative of the prevalence of paid employment positions in Australasia, they nevertheless provide for a nuanced view that occupations and employment positions in a major rural and remote region of Australia are other than farming activity and in fact service oriented (see also Alston, 2000).

The prevalence of "other unspecified" occupations in rural and remote NSW regions suggests the likely prevalence of temporary and opportunity positions that are downstream to other major occupations. The high proportion of rural and remote community residents reporting to be retired (30%) or permanently unable to work (6%) may occur partly from a lack of vocational rehabilitation services for employment retention or continuation and also from a lack of alternative or viable work opportunities with rural living. Finally those self-reporting as unemployed were not necessarily without any form of employment – only not in paid employment. Many of the women working in Australian family farms may not consider themselves in paid employed positions, even though they have significant work participation (Alston, 2000; Fragar et al., 2010), and some may require vocational rehabilitation services. This situation is not dissimilar in New Zealand, where unpaid family workers in highly rural and remote areas were at 9.5% (Statistics New Zealand, 2001). It is unclear from the study by Fragar et al. as to what proportion of those in retirement or unable to work or unemployed were with disability or for disability-related reasons.

Research Review Question

List the key findings of the Fragar et al., study as described above. What are the major strengths and limitations of the study for informing vocational rehabilitation services in Australia? How might the study have been conducted to enhance its informational value to vocational rehabilitation services design and implementation in Australia?

Disability in Rural and Remote Settings

About 20–25% of the Australia's 7 million people living in rural and remote Australia have a disability (Australia Bureau of Statistics, 2009). A comparable prevalence rate has been reported for New Zealand, where 25% of the national population are reported to have a disability of some description, with rural centres such as Northland (29%) and Taranaki (30%) experiencing higher rates of disability than the national average and urban areas such as Auckland (19%) reporting lower figures (Statistics NZ, 2013). Disability among rural and remote community dwellers also varies by sex. As an example, disability is 20–30% more prevalent among men in the rural and remote areas compared to the urban centres (National Rural Health Alliance, 2009). It is unclear as to how rural living is a contributing factor to the high prevalence of disability among men in rural and remote areas and whether men with disability tend to move to rural and remote areas. Nonetheless, across jurisdictions, people in rural and remote regions carry significant risk from avoidable disability due to inadequate or inaccessible healthcare services as well as to longer distances from comprehensive healthcare centres, poorly developed health infrastructure and a scarcity of rehabilitation counselling or psychological services in such settings (Gittoes et al., 2011; McGrath, 2015; National Rural Health Alliance Inc., 2013). For those with advanced age and with chronic illness and disabilities, rural living offers fewer infrastructural supports, presenting significant health and mobility hardship to residents and their families (Winterton & Warburton, 2011).

People with disability in Australia experience a disproportionate level of unemployment compared to the general population (e.g. see Fig. 18.1).

Rural and remote area dwellers with disability carry significant limitations to their employment capacity. The work role marginalisation of people with disability also in part arises from their vulnerability to becoming chronically fatigued and being susceptible to secondary mental health conditions (Craig, Tran, Wijesuriya, & Middleton, 2012; Craig et al., 2015a). For instance, in a study by Craig et al., people with a disability reported higher levels of chronic fatigue than non-disabled, to the point where they would be workforce challenged (Craig et al., 2012). Those with a disability or unemployed had rates of probable psychological disorder ranging up to a very high and disturbing 70% (Fragar et al., 2010). The stressors from living with disability in rural and remote regions might in themselves increase risk for fatigue and mental health conditions, which will certainly impact their vocational lives.

There is evidence to suggest that rehabilitation service design and implementation might explain employment outcomes with disability than rurality or geographical location (Harradine et al., 2004; Mpofu, Craig, Millington, Murphy, & Dorstyn, 2015). For instance, Harradine et al. concluded from their 2-year longitudinal study that return-to-work outcomes were similar among NSW rural and urban residents with traumatic brain injury. They ascribed the equity of return-to-work outcomes to implementation of an integrated rehabilitation service network across inpatient, outpatient and community outreach care settings. But inter-agency cooperation is least likely in rural and remote Australia, where there are very few disability and rehabilitation providers in the first place, in addition to poorer infrastructure and high professional staff turnover.

Research Review Question

Construct a chart on employment participation rates with and without disability as in Fig. 18.1 for a country setting you are familiar with and spanning the same time period. How do employment rates in the country setting you are familiar with compare to those for Australia? What may explain any similarities or differences you observe?

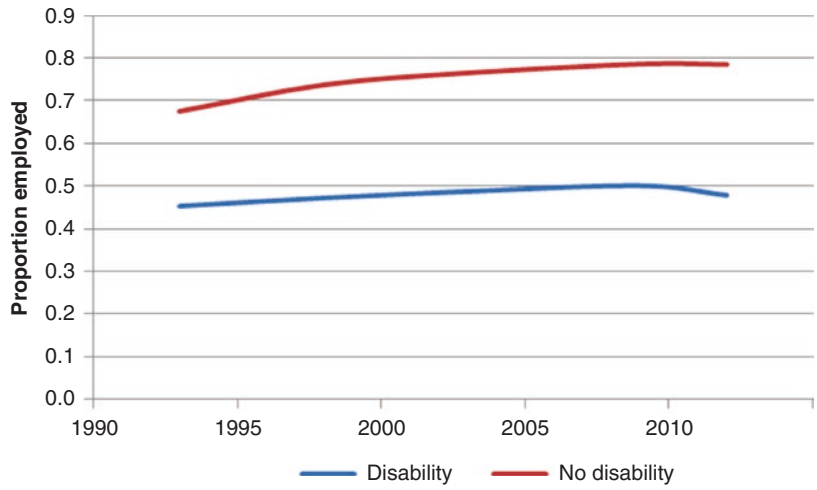

Fig. 18.1 Employment rate for persons with and without a disability in Australia, 1998–2012

Work and Disability in Rural and Remote Australasia

As previously noted, there is evidence to suggest that residents of rural and remote communities of Australasia have lower work or employment opportunities and wellbeing compared to others in urban centres (Alston, 2002; Cheers, 1990). Residents of rural and remote areas also have lower incomes and lower levels of education, adding to their lack of competitiveness for employment positions outside their communities of origin (AIHW, 2007). This would be true especially of impoverished remote and rural communities rather than those with flourishing agro- and/or eco-tourism-related industry.

Australasia presents diversity of work and employment opportunities: agribusiness, eco-tourism, cultural tourism with indigenous communities, mining, and related service sectors. The presence and significance of work and employment opportunity in the rural and remote community sectors vary by the specific region. Some rural and remote industries, such as mining, may be a boon for employment for local communities given it usually results in proportionally significant recruitment of local labour. However, this is not always guaranteed, as mining companies may prefer to ferry in a large proportion of their labour force (Carrington & Pereira, 2011). Moreover, the collateral cost of the mining industry to the local agro-industry and eco-cultural tourism from severe contamination of the land, water and resources from pollutants (Franks, Brereton, & Moran, 2010), which if uncontrolled, may become a hidden cause of widespread disability among the rural community dwellers. Extraction industries also have the potential to cause serious damage to eco-tourism, especially when they close, often leaving behind huge unsightly galleys and earthen dump walls from the mining pits. Furthermore, indigenous cultural communities with rich cultural tourism may experience irreparable damage to their historic shrines central to their way of life from large-scale mining activities. Vocational rehabilitation needs and solutions generated by external or migrant resource extractions industry to rural and remote Australia have not been documented.

Vocational rehabilitation services for migrant workers are provided through their human resource departments not available to the local rural populace. With large itinerant workers such as in extraction industries, vocational rehabilitation services should address the mental health needs arising from the workers' diminished sense of involvement or of detachment from local community, which would contribute to occupational, work health and safety risks for work-related injury.

Indigenous Australasians Indigenous people are among the most impoverished in rural and

remote Australasia (Alston, 2000). Both Australia and New Zealand have indigenous populations (Aborigine Torres Strait Islander (ATSI) =2% of the population and Maori =15%, respectively) (ABS, 2010; Harwood, 2010). Indigenous people also comprise a significant minority in the rural and remote regions of Australia and New Zealand (8–64% and 15%, respectively; AIHW, 2008; Statistics New Zealand, 2008; Watts & Carlson, 2002). About 24% of ATSI live in remote areas compared to only 1% of the general Australian population (AIHW, 2008).

Indigenous people in both Australia and New Zealand have historical disadvantage in accessing rehabilitation and health services, including vocational or employment services (Kendall & Marshall, 2004, New Zealand Disability Survey, 2013). For instance, Maori, New Zealand's indigenous people, experience a disproportionally higher disability rate of 26% than non-Maori, and a majority experience debilitating mental health and intellectual conditions (New Zealand Disability Survey, 2013). Additionally, ATSI peoples have a rate of mental health and physical disability 6–10 times that of the general population of Australia mostly from interpersonal violence, accidents, falls and self-harm (Dudgeon, Milroy, & Walker, 2014; Keightley, Ratnayake, Minore, Katt, Cameron, White et al., 2009; Kendall et al., 2004, Parker, 2016; Vos, Barker, Stanley, & Lopez, 2007). For example, in the Kimberly region, common causes of traumatic brain injury among the ABTSI were from interpersonal violence (46.5%), horse-riding accidents (14.6%), motor vehicle accidents (10.3%), falls (7%) and self-harm (5.9%). The unemployment rate among indigenous ATSI is estimated at two to three times that of the general population of Australia (Alston, 2000; ABS, 2012); Maori people also experience an unemployment rate twice that of non-Maori New Zealanders (Statistics New Zealand, 2015a). Yet, ATSI and Maori have the lowest rate of utilisation of government social services, including vocational rehabilitation (Kendall et al., 2004; Mauri Ora Associates, 2010). For instance, while Maori people represent around 15.6% of the population, they only account for 11.55% of all accident rehabilitation compensation claims (Mauri Ora Associates, 2010). The lower utilisation of health services and the subsequent impact on health status have been attributed in part to limited access to culturally appropriate services (Harwood, 2010) and the disconnection with cultural identity experienced by many Maori, as a product of increasing urbanisation of Maori. *Te Whare Tapa Wha* is a holistic model of Maori health developed by Dr. Mason Durie in 1998, which identifies four equal foundation stones of Maori health: physical health, spiritual health, thoughts and feelings and the extended family. This model uses the four walls of a house (or whare) to symbolise the equal importance of each construct. Key to the success of this and other related models of Maori health is the need for individuals to have a secure Maori identity and to be connected to concepts central to Maori, such as iwi (one's tribe) (Ratima, Edwards, Crengle, Smylie, & Anderson, 2006). Government initiatives in New Zealand such as Whanau Ora and He Korowai Ora seek to address factors cultural appropriateness (including delivery of wellbeing rather than illness-focused services) in the provision of services, as well as supporting Maori to reconnect culturally. The vocational rehabilitation needs of ATSI and Maori people may be neglected from being excluded from the workforce by meagre opportunities for paid employment in their communities, by cultural insensitivity of services and, if with disability, by the "triple jeopardy" of being with disability while ATSI or Maori and rural living.

Reflection Learning Exercise

The research evidence cited in this section suggests lower engagement by indigenous Australasians with vocational rehabilitation services. Construct and describe a vocational services programme that would engage indigenous Australasians. Say how and why the programme you propose would be successful with indigenous people? How is the programme you proposed similar to and different from what others proposed for use with marginalised population in a country setting you are aware?

Strategies to Enhance Service Delivery

The considerably reduced employment and labour force participation rates in people with disabilities, along with increased barriers to improving vocational rehabilitation in Australia, is a clarion call to invest increased resources into strategies that enhance vocational rehabilitation service delivery and outcomes. Vocational rehabilitation models developed for urban employment settings may not necessarily translate to rural and remote community work settings without significant adaptation (Gething, 1997). Nonetheless, employment participation strategies, which have been shown to have evidence such as integration of vocational services into publicly funded mental health services in Australia, hold promise with rural and remote setting populations.

Other prospect approaches entail constructing tailored employment participation support services responsive to the work or occupational ecology of the specific rural and remote areas and developing incentive schemes that assist the unemployed to establish small business (e.g. www.budget.gov.au/2007-08/ministerial/html/dotars-13.htm). The following strategies to enhance the service delivery and vocational rehabilitation are proposed.

Improving Vocational Rehabilitation Counsellor Skills and Interventions in Australasia

One practical strategy for enhancing service delivery of vocational rehabilitation is to improve vocational counsellor skills and provide effective pragmatic interventions (Buys, Matthews, & Randall, 2010; Matthews, Buys, Randall, Marfels, Niehaus, & Bauer, 2013; Middleton et al., 2014). For instance, Buys et al. (2010) concluded that improving the competency of counselling skills of rehabilitation and vocational case managers and providing interventions with an evidence base shown to translate to the workplace should significantly enhance service delivery and vocational rehabilitation outcomes. Arguably, the efficacy of vocational rehabilitation will be related to effective vocational counsellor skills such as the ability to interact, be empathic and communicate and motivate people with disabilities, as well as the capacity to take into consideration the systemic barriers that people with disabilities face when seeking employment. Australian vocational rehabilitation services offers case services coordination and counselling regardless of employment location (Buys et al., 2010). The rehabilitation counsellors from the Buys et al. study perceived to be with insufficient time for their roles likely from high caseloads and their counselling role would likely be diminished with work role overload.

The training of vocational rehabilitation counsellors working in rural remote areas in cultural knowledge and awareness and cultural sensitivity and security skills would especially be important (Dungeon et al., 2014; National Disability and Care Alliance, 2014). Cultural knowledge and awareness is from learning about a culture and its often unwritten rules of membership. Cultural sensitivity and competence is when cultural knowledge and awareness are appropriately applied in social service provisioning. As referred to rehabilitation service provision, cultural security refers to adoption and use of practices that respect the cultural rights, values and expectations of culturally and linguistically diverse others (Western Australia Department of Health, 2006).

Culturally safe vocational rehabilitation services would be particularly important in the provisioning of vocational rehabilitation services to ATSI and Maori people among other culturally and linguistically diverse groups with rural and remote residence. It is imperative for vocational rehabilitation counsellors from mainstream Australasian culture who numerically outnumber ATSI and Maori to understand the meaning of work and context of employment for these marginalised people (National Disability and Care Alliance, 2014). Culturally secure practices entail an accurate understanding by counsellors not only of the other different culture but of the interaction between cultures that mediates the success

of vocational rehabilitation services (Dudgeon, Milroy, & Wakler, 2014). There is no end point in seeking cultural competency as a counsellor – only continuous reflective learning.

Culturally Safe Practices with ATSI and Maori The types and qualities of extant vocational rehabilitation services with ATSI and Maori are largely undocumented (Kendall et al., 2004). Although disparities of rehabilitation and health status among indigenous people compared to non-indigenous people is nothing new and is not simply limited to indigenous populations of Australasia (Harwood, 2010; Wyeth, Derrett, Hokowhitu, & Samaranayaka, 2013), it calls for urgent consideration in livelihood settings in which they are predominantly domiciled. Many ATSI and Maori localities have little to no social or employment support services. Many ATSI and Maori people needing health-related support services may be referrals from other regional communities (Doyle, 2012), adding to their burden to access the same services as other citizens (Bolch, Johnston, Giles, Whitehead, Phillips, & Crotty, 2005). Vocational rehabilitation services policy in Australia should mandate benchmarks of service quality with this historically disposed and vulnerable population. Such benchmarks should seek to not only close the gap in vocational services for ATSI and Maori people but to prioritise cultural safety considerations in the design and implementation of the services (Kendal et al., 2004; Watts & Carlson, 2002). A social justice approach to vocational rehabilitation services with ATSI and Maori is imperative in view of the long history of deprivation, dispossession and cultural violations by state and federal governments.

As an example of culturally safe services with the Maori of New Zealand, the Treaty of Waitangi, New Zealand's founding document, recognises the rights of Maori as partners in the Treaty. Although interpretation of the Treaty can at times be a point of controversy, the principles adopted by the NZ government with regard to health are:

- Partnership: involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- Participation: requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services
- Protection: involves the government working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices (New Zealand Ministry of Health, 2014)

The New Zealand Ministry of Health also has implemented Whāia Te Ao Mārama: the Māori Disability Action Plan 2012–2017 based on the indigenous Whanau Ora approach which places whanau or family systems at the centre. This approach recognises that for many Maori, the extended family is regarded as a source of strength, support, wisdom and identity (O'Hagan, Reynolds, and Smith, 2012). This system focuses on supporting whanau to achieve outcomes and access support in a range of areas (from healthcare, education, social services, etc.). Extending such an indigenous culture-friendly approach to vocational rehabilitation services would enhance uptake and access by ATSI and Maori people in rural and remote settings.

Reflection Learning Exercise
Examine the utility of the construct of cultural safety in the context of provisioning of vocational rehabilitation services to indigenous populations. What would be the key qualities of culturally safe vocational rehabilitation services with indigenous people? How may such services be similar or different from mainstream vocational rehabilitation services?

Strengthening Social and Technological Networks

Developing and improving the social and technological networks of people with disabilities are

important objectives that will in most cases have a positive influence on quality of life and social and vocational participation (Craig, Moses, Tran, McIsaac, & Kirkup, 2002; Craig, Nicholson Perry, Guest, Tran, & Middleton, 2015b; Craig, Tran, McIsaac, & Boord, 2005; Guthrie & Harvey, 1994; Murphy, Middleton, Quirk, De Wolf, & Cameron, 2011). Craig et al. (2015b) and Murphy et al. (2011) have shown social support to be significant predictor of social participation in people with severe impairment such as spinal cord injury. Ryan and colleagues (Ryan et al., 2010) showed that social support, in this case, in the form of caregivers' support to the client, strengthened commitment to the goals of those with the disability and was crucial to successful rehabilitation and return to work outcomes.

Likewise, the development and utilisation of assistive technology can result in great benefits, not only psychologically but also in social and vocational participation, as people with disabilities are able to regain lost function through technological assistance (Craig et al., 2005). For instance, eye gaze and voice activation technology have resulted in substantial improvements in capacity to function in the workplace for many people with disabilities, allowing them to be employment competitive (Craig et al., 2005). For individuals with severe disability (e.g. those with no or little arm function), novel interfaces such as eye gaze and brain wave activity have been developed, which provide capacity to control external electrical devices essential for employment readiness (Craig, et al., 2002, 2005). These state-of-the-art technologies are largely unavailable to rural and remote communities adding to their vocational rehabilitation services deprivation.

Other technological innovation that would considerably improve service delivery and rehabilitation vocational outcomes for people with disability in rural and remote settings includes video-teleconferencing communication (Forum, 2006). Video teleconferencing involves technology that allows people to be linked together through wherever they are geographically. The people involved can hear and/or see each other and respond interactively. This type of technology provides assistance for people with disabilities, given the assistive technology controls available (Craig et al., 2005). Teleconferencing in the form of telehealth and tele-rehabilitation is also becoming very important for improving health in people with disability (Agostini, Moja, Banzi, Pistotti, Tonin, Venneri, & Turolla, 2015). These work and employment enabling technologies would readily apply to service and technical trade occupations in rural and remote settings which are linked to parent business hubs in the major urban centres. The evidence for the utilisation of video-conferencing-based technologies in the provisioning of vocational rehabilitation services in the Australia region is yet to be gathered and aggregated.

Research Needs

Research is needed on the personal resourcing of people with disabilities for vocational engagement in rural and remote areas. In this regard, vocational rehabilitation interventions based on supporting motivation, hope and optimism in vocational roles would be important. Research evidence is also needed on the transportability of evidence-based vocational rehabilitation interventions within rural and remote settings, including the cultural-contextual validity of decisions from the vocational rehabilitation assessment being implemented. Furthermore, evidence is needed on vocational rehabilitation interventions that would work with ATSI and Maori peoples in the rural and remote areas and which are designed to assist them to engage in work that they find both meaningful and productive. The efficacy of existing rehabilitation services with cultural minorities in rural and remote Australia cannot be assumed.

Improving Motivation and Optimism/Hope in People with Disabilities

Motivation, optimism and hope are essential personal resources for successful vocational participation with disability (Craig, 2012; Wagner & McMahon, 2004). Evidence is needed on the

types of personal resourcing interventions premised on motivation, optimism and hope to enhance the occupational resilience of people with disability in rural and remote settings. The relative isolation of rural living makes it imperative that motivation, hope and optimism are enhanced, leading to robust mental health and eventual successful vocational participation. Furthermore, living with a disability presents with ongoing challenges as the process of adjustment for successful work participation occurs over an extended period of time. The related adjustment process is less well understood and studied in the context of vocational rehabilitation in rural and remote settings. Personal resourcing in terms of motivation, hope and optimism may make a difference to vocational participation in low-resource rural and remote areas.

Developing and trialling strategies for increasing motivation and promoting optimism and hope will therefore be a crucial step in enhancing vocational rehabilitation with people with disabilities in rural and remote settings (Kortte, Stevenson, Hosey, Castillo & Wegener, 2012). For instance, vocational rehabilitation interventions with people with disability premised on boosting the personal resourcing for resilient work participation may include working with the person with disability to adopt "survival mode"-oriented behaviours for full community inclusion (Livneh & Parker, 2005). White, Magin, Attia, Sturm, Carter and Pollack (2012) found stroke survivors with internal locus of control to report lower levels of psychological distress with a higher internal locus of control. Internal locus of control is aligned with personal motivation, hope and optimism.

Optimism and hope build personal resilience by strengthening inner resources that buffer against the impacts of negative life events, with the consequence that the individual comes to expect that their life goals can be achieved despite the barriers (Craig, 2012; Korte et al., 2012), including vocational goals. Traits such as hope and optimism build resilience and facilitate greater psychosocial and vocational engagement (Craig, 2012; Kortte, et al., 2012). Wagner and McMahon (2004) concluded that the person with the disability may be more motivated to participate in the rehabilitation process if the future benefits are made clear. However, a focus on environment contingencies for vocational goal attainment with disability would likely result in greater occupational success than with internal locus of control alone. The conditions under which locus of control as motivational personal resourcing in vocational settings transitions to a healthy balance between external and internal sources are have not been researched, although findings would be important to the design of person and context sensitive vocational rehabilitation interventions in rural and remote regions.

Reliable and Valid Vocational Rehabilitation Service Protocols

Research is also needed on the accurate and sensitive functional assessment of people with disability to optimise vocational success in rural and remote settings. For instance, vocational rehabilitation services within rural and remote communities should also increasingly prioritise work with environmental health departments to proactively address and redress the social impact of industries with significant risk for occupational hazards or those that have the potential to degrade employment opportunities for the residents. Where technology innovations are adopted, these should take into account the relatively lower levels of literacy among rural and remote Australian communities, so as to yield valid data for vocational advising. Cultural community members such as ATSI and Maori people may find technology-based data collection on their vocational rehabilitation needs too impersonal and off-putting, with the result that they may resist using those tools (Steohens, Wargent, Catherall, Timms, Graham, & Clough, 2013). Evidence is needed on technologies that work in providing vocational rehabilitation services in rural and remote Australasia.

Vocational Rehabilitation Models for Rural and Remote Areas

Research is needed on vocational rehabilitation models that would work in rural and remote Australasia. These would need to be informed by the community dwellers utilising participatory action research approaches (Gauld, Smith, & Kendall, 2011). Community-based rehabilitation models (Kuipers, Gauld, Kendall, Smith, & Bowen, 2013) appear to hold high promise with ATSI and Maori people in their use of local resource persons for service access and utilisation. ATSI and Maori liaison counsellors would be a major asset in vocational service provisioning from their intimate knowledge of lived work experiences as indigenous people. The specific roles ATSI and Maori vocational rehabilitation counsellors would engage are in need of research documentation and implementation trialling in remote and rural communities.

Summary

Vocational rehabilitation is a key strategy for increasing employment rates of people with disabilities in Australasia. A number of conclusions follow from research evidence considered in this chapter. Rural and remote country settings present with an occupational ecology characterised by low employment demand levels and restrictions in the availability of rehabilitation services for those who would benefit from such services. Community-driven employment demands will influence work participation opportunities as well as the quality and range of employment support services. In the context of rural and remote Australasia, vocational rehabilitation services for employees in service and farming and farming type of occupations will likely have high levels of demand, as compared to those that may be required for professionals. For service-related occupations in rural and remote Australia, which in essence are similar to those in the urban centres, it may well be that the same proven vocational rehabilitation services used in urban areas might well transport to rural and remote settings. It will also mean that vocational rehabilitation professionals in rural and remote Australian communities increase their understanding, counselling and communication skills to work effectively with farmers and farm employees who may have occupation-related injuries or health conditions that impact their work capacity. With workers in less well-known occupations, in particular, the need would be for vocational rehabilitation professionals to have a solid foundation in identifying and supporting use of transferrable work skills. Furthermore, it is crucial that policymakers and vocation service providers consider the needs of the unemployed and disabled, especially those with mental health problems in rural and remote settings.

The nature of economic activities in rural and remote regions is influenced by the specific area's proximity to urban centres that have established vocational rehabilitation services. The unregulated appropriation of rural and remote community resources by extraction and other external industry with no return of investment to local communities can be a major driver of disability and disadvantage among community members. Future research will be needed to address this significant problem.

In both Australia and New Zealand, vocational rehabilitation services tied to social security policy arrangements are intended as an overall response to disability. Mainstream vocational rehabilitation services may also be poorly aligned with indigenous populations in rural and remote areas of Australasia who have an historical disadvantage, whose rich cultural heritage is generally poorly appreciated. A more holistic and socially

Research Review Question

Propose a brief research proposal to investigate a vocational rehabilitation service aspect of choice. Outline the goals of the research and how it might be implemented. Consider the aspects you would build into the design of the study to be translatable into real vocational rehabilitation service provisioning.

networked approach would better suit many ATSI and Māori peoples in addressing their vocational rehabilitation needs. The significance of work role to rural and remote living will likely be sustained even with advances in technology that bridges the physical space divide, and it hoped that technology-enabled work roles will enhance new vocational opportunities for those in rural and remote settings.

Discussion Questions

1. Outline the legislative and policy foundations of rehabilitation in Australasia. How have the legal and policy instruments been assets or impediments to the vocational rehabilitation services in Australasia?
2. Specify the frameworks for the vocational rehabilitation services to rural and remote settings of Australasia. What are their strengths and limitations?
3. Examine any links between vocational rehabilitation services and a unique occupational ecology of rural Australasia. Which of the links make for effective vocational rehabilitation services? Which links could be strengthened and with what potential benefits?
4. Identity and evaluate the feasibility vocational rehabilitation service qualities that would be appropriate for indigenous people of Australasia.
5. Discuss strategies to improve vocational rehabilitation service delivery in rural Australia.

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