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ORIGINAL ARTICLE

Recruitment and retention of allied health professionals in the disability sector in rural and remote New South Wales, Australia*

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Abstract

Background People with disability living in rural areas are vulnerable to the loss of access to allied health services due to a critical shortage of allied health professionals (AHPs). This study aimed to investigate recruitment and retention issues of importance to AHPs providing services to people with disability in rural New South Wales, Australia.

Method Focus groups and semistructured interviews were conducted with 97 purposively sampled service providers in the disability sector. Interviews and focus groups were digitally recorded and transcribed. A modified grounded theory approach using thematic analysis and constant comparison was used to analyse the data.

Results Three major themes relating to recruitment and retention were identified: (a) flexible recruitment, (b) retention strategies that work, and (c) challenges to retention.

Conclusions AHPs in the disability sector identified some of the same issues influencing recruitment and retention as AHPs in the health, education, and private sectors. Several unique issues were also identified that will assist policymakers to improve recruitment and retention of AHPs employed in the disability sector in rural areas.

Keywords: *disability workforce, rural, allied health*

Introduction

Historically, shortages of health professionals in rural areas have been a major issue, not just in Australia but globally. The World Health Organization and the Australian Productivity Commission have highlighted the importance of fostering policies that support the recruitment and retention of health professionals in rural and remote areas (Australian Government Department of Health and Ageing, 2008; World Health Organization, 2010). In Australia, 30.4% of the population lives outside metropolitan areas (Australian Bureau of Statistics, 2011b); however, the ratio of allied health professionals (AHPs) per population is low. In 2006, there were 64 allied health workers per 100,000 population in rural and remote areas compared to 354 per

100,000 in major cities (Australian Institute of Health and Welfare, 2009). In New South Wales (NSW), the most populous state in Australia, 29.7% of people live in rural and remote areas while 25.8% of occupational therapists, 21.6% of physiotherapists, and 23.3% of speech pathologists and audiologists live in the same areas (Australian Bureau of Statistics, 2011a). The need and demand for allied health services has grown due to increases in the proportion of older people in the Australian population and the recognition of the importance of allied health input into the management of disability and chronic diseases (Dew et al., 2012; National Health Workforce Taskforce, 2009).

Wark, Hussain, and Edwards (2013) note that in rural Australia access to relevant and appropriate

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services is particularly important to people with specific support and health needs, such as people with intellectual disability. Some rural and remote areas of NSW have higher prevalence of disability compared to metropolitan locations (Australian Bureau of Statistics, 2009). Consequently, access to allied health services in some rural and remote areas and within some professional groups is problematic and results in unmet demand for services (Australian Health Workforce Advisory Committee, 2006).

AHPs assist people to participate fully in their families, employment, and communities. AHPs include a broad group of university educated professionals including physiotherapists, occupational therapists, speech pathologists, and psychologists. Their supply is critical to health, quality of life, and community participation, particularly for those with significant disability including cognitive, neurological, and physical impairments that result in difficulty performing activities of daily living including communication (Wilson, Lewis, & Murray, 2009). Compared to their medical counterparts, larger numbers of AHPs are leaving the health workforce by moving to other positions both within and outside allied health, reducing their participation by working part-time or casual, or retiring (Keane, Lincoln, & Smith, 2012; Leach, Segal, & May, 2010). High turnover of AHPs leads to increased recruitment costs, which diverts financial resources from other important activities such as treatment and education services (Chisholm, Russell, & Humphreys, 2011). Hence, issues influencing recruitment and retention of rural AHPs warrant investigation.

Adequate supply of AHPs involves both recruitment of suitably qualified and skilled professionals and their retention within rural and remote areas. Research has shown that the factors influencing retention of AHPs in rural areas include lack of professional support, limited career structure, social isolation, poor promotion possibilities, and low job satisfaction (Campbell, McAllister, & Eley, 2012; Chisholm et al., 2011; Keane et al., 2012). In contrast, Keane et al. (2012), studying the rural allied health workforce in NSW, reported high levels of job satisfaction. They identified the following “pull” factors for recruitment and retention of AHPs in rural positions: attraction to rural lifestyle, married or having family in the area, low cost of living, rural origin, personal engagement in the community, advanced work roles, a broad variety of challenging clinical work, and making a difference. Keane and colleagues also identified “push” factors that resulted in AHPs leaving rural positions: lack of employment opportunities for spouses, perceived inadequacy of

secondary schools, age-related issues (retirement, desire for younger peer social interaction, and intention to travel), limited opportunity for career advancement, unmanageable workloads, and inadequate access to continuing professional development.

Keane et al.’s (2012) research identified a range of factors that influence AHPs’ recruitment and retention; however, most participants in that research were working in government health services or private practice. Some of the issues faced by these AHPs could be similar in the disability sector; however, differences in the workforce and the nature of work characteristics may mean recruitment and retention issues in this group are different. Specifically, the disability sector in Australia has AHPs employed by government and nongovernment organisations (NGOs; Lowe, Adams, & O’Kane, 2007) that provide assessment and intervention through a range of specialist support services to people with a disability, including case management, behaviour support, and early childhood intervention. Furthermore, disability sector AHPs support clients with a broad range of conditions and needs. This includes children and adults with lifelong intellectual and developmental disability (e.g., cerebral palsy, autism spectrum disorder, and Down syndrome) and people with acquired disability (e.g., brain or spinal cord injury, or degenerative neurological conditions, such as multiple sclerosis). People with such disabilities often require life-long assistance, particularly at transition points, such as starting school and leaving home. Given the long-term, complex nature of the difficulties experienced by people with disability, arguably continuity and retention of AHPs may be more important for this group.

Denham and Shaddock (2004) is the only study that specifically examined retention of AHPs in the disability sector. They found some similar issues to Keane, Smith, Lincoln, and Fisher (2011) and the following issues specific to the disability workforce: team size, in particular the need for a “critical mass” of staff; management issues; unevenly distributed and limited resources; the need for regular professional supervision; and the disincentive of a flat career structure. It is of interest that Keane, Lincoln, Rolfe, and Smith (2013) also found that management issues were a push factor for AHPs employed in the public sector working in rural and remote areas. Denham and Shaddock’s results suggest that the size and organisation of the AHP workforce within the disability sector in rural areas may lead to some unique issues in AHP retention.

In Australia, according to the Productivity Commission, the introduction of a National Disability Insurance Scheme (NDIS) will create further

demand for disability services but a supply shortage in staff to provide these (Australian Government Productivity Commission, 2011). Under the NSW *Stronger Together* program, disability services in NSW have benefited from a substantial increase in funding (Ageing, Disability and Home Care, 2006). Although this program has included significant enhancements to both government and nongovernment therapy services and the numbers of AHPs has increased, difficulties in recruiting and retaining AHPs to the disability sector in rural and remote communities still remain (Chisholm et al., 2011; Keane et al., 2013). Chisholm et al. (2011) report that the numbers of AHPs working in any organisation drops sharply as remoteness increases. These recruitment and retention problems limit the capacity of the sector to deliver enhanced services despite increases in funding. As the NDIS for Australia is rolled out, people with disability living in rural areas are vulnerable to the loss of access to allied health services due to critical shortages of AHPs to provide them. Hence, it is important to understand the factors that will influence AHPs to be recruited and remain working in the disability sector. The aim of this study was to investigate AHP workforce recruitment and retention issues from the perspective of front-line AHPs and other service providers in the disability sector in rural and remote western NSW.

Method

Setting

This research was conducted in western NSW. Western NSW accounts for more than 70% of the land area of the state of NSW. In 2011, the estimated resident population was nearly 570,000 (8.2% of the NSW). The region's population is dispersed among regional towns of 20–40,000 residents, smaller towns of 1–3,000 residents, and isolated rural communities of less than 1,000 people. Some people live on remote properties (farms) many kilometres from their nearest neighbours and hundreds of kilometres from towns.

Participants and recruitment

Initial recruitment was undertaken with the assistance of government agencies and NGOs providing services to people with a disability and their carers in western NSW. These organisations circulated information about the research to staff working as or with therapists. Staff who were interested in discussing the recruitment and retention of therapists in rural areas then made contact with the research team. Purposeful

(Creswell, 2009) and snowballing (Bryman, 2012) sampling techniques were used to identify a broad range of participants, including AHPs, early childhood workers, case managers, behaviour support workers, and NGO managers employed in the disability sector in western NSW. We canvassed this range of participants as therapists in the disability sector generally work as part of teams involving other professionals. In rural areas therapy positions (and other professional positions) can remain vacant for lengthy periods, and we wanted to ensure a good representation of government and nongovernment service providers. Furthermore, theoretical sampling (Creswell, 2009) strategies were used to ensure participants represented a diverse range of experiences based on gender, age, geographic location, type of organisation, and employment role. All volunteers who could attend a focus group or participate in a phone interview were included.

Data collection

Focus groups and interviews were conducted by the third and fourth authors between March and July 2011. Ten focus groups involving 92 participants and five individual interviews were held across geographic locations in western NSW to ensure that all participants had access to a group or interview without unreasonable travel, including via telephone link for two participants working in outlying areas. The size of the groups ranged from two to 16 participants. The focus groups ran for 2 hours on average and the individual interviews for 1 hour. At the commencement of each focus group, participants were reminded of the need for confidentiality such that issues raised in the group remained within that setting and were not discussed with others outside the group.

A semistructured interview guide was developed based on policy document and literature reviews and consultations with policymakers and senior staff members undertaken in an earlier stage of the research program (Veitch, Dew, et al., 2012; Veitch, Lincoln, et al., 2012). During the focus groups and interviews, participants were asked questions about the workforce issues impacting on AHPs' employment and service delivery. To prompt discussion, the following issues were explored: recruitment and retention strategies, job-related travel, isolation from peers, access to professional support and development, access to equipment and resources, opportunities to use specialist skills, use of technology, financial incentives, personal and family issues, and preparation for rural/remote work and life. Within the structure of the focus group/interview guide,

there were significant opportunities for free-ranging discussion during which participants indicated a variety of workforce practices and challenges for AHPs working in the sector and geographic area. Using the principle of theoretical sampling, emerging issues from one focus group or interview were further explored in subsequent groups and interviews until theoretical saturation was reached and no new issues emerged (Bryman, 2001).

During the focus groups, large, visible sheets of paper were used to record emerging themes, thereby allowing participants to follow the flow of discussion and providing a prompt for further discussion. Additionally, with participants' consent, all focus groups and interviews were digitally recorded and transcribed.

Data analysis

A modified grounded theory approach using thematic analysis and constant comparison was used to analyse transcript data (Braun & Clarke, 2006). The third author conducted the initial analysis, and, in order to verify the emerging themes, the fourth author performed an analysis check on a randomly selected 10% of the transcripts. Each transcript was read and emerging issues were noted on a data coversheet. Once each transcript was reviewed in this way, constant comparison was used within and between transcripts to identify similar and divergent issues. Similar issues were then grouped to form emerging themes. Emerging themes were then discussed with the other authors until a consensus on the themes was reached. A summary of the themes was sent to participants with an invitation to provide additional comments or suggest changes. No amendments were requested by participants.

Early on in the data analysis, recruitment and retention issues were identified as separate yet related influences on workforce. Three themes emerged related to these issues, each with several subthemes.

Ethics

This study was approved by the Human Research Ethics Committee of The University of Sydney (03-2011/13514). Written consent was obtained from all study participants. All transcripts were de-identified and all data were kept confidential.

Results

A total of 82 of the 97 service providers provided demographic information. Fifteen focus group

participants chose not to complete the demographic questionnaire. Eighty-eight percent of the respondents were females, 37% were aged 31–41 years, 72% were born in the area, and 60% had children ($M=1.5$). The mean number of years living in western NSW was 21, with mean durations of 5 years employment in their current position and a mean of 10 years working in disability. Respectively, 48% were employed by specialist NGOs and 65% worked full-time. The largest proportion of participants (40.2%) were employed as AHPs. Table 1 provides a summary of the demographic characteristics of the participants.

Three major themes relating to recruitment and retention were identified: (a) flexible recruitment, (b) retention strategies that work, and (c) challenges to retention. Each of these major themes consisted of multiple subthemes, which are summarised in Table 2. Themes are reported here using quotations from the transcripts.

Major theme 1: Flexible recruitment

Participants reported that flexible recruitment practices were needed to reduce competition between sectors and the proportion of AHPs employed under tenuous employment arrangements. Incentives were suggested as a possible strategy to enhance recruitment efforts.

Competition between sectors

When speaking about recruitment, participants referred frequently to competition between the government-funded agencies of disability, education, and health, and NGOs providing disability services. This situation resulted in the development of recruitment incentive packages by some employers and this, in turn, led to wide variations in pay and conditions available to AHPs in the disability sector. A participant explained:

We're [government agency 1] generally paying our therapists probably about \$15–25,000 a year more than what you're getting in [government agency 2] because we recognise skills as specialised qualifications. So there's a huge discrepancy between what you would get working between [government agency 1] and [government agency 2] in the same town.

Hence an employer's ability to offer favourable pay and conditions was reported to significantly affect the recruitment of AHPs.

Table 1. Demographic characteristics of participants (N = 82)

	<i>n</i>	%
Gender		
Females	72	87.8
Marital status		
Single	22	26.8
With partner	60	73.2
Age range (years)		
20–30	22	26.8
31–40	30	36.6
41–50	20	24.4
51–60	8	9.8
61+	2	2.4
Born rural		
Yes	59	72.0
No	23	28.0
Current position		
AHPs	33	40.2
NGO management	17	20.7
Case manager	18	22.0
Behaviour support worker	2	2.4
Teacher	4	4.9
Therapy assistant	1	1.2
Other	4	4.9
Employment status		
Full-time	53	64.6
Part-time	29	35.4
Employer		
Government	28	34.1
NGO	39	47.6
Health	11	13.4
Other	4	4.9

Tenuous employment conditions

Participants reported that tenuous employment conditions were least likely to result in recruitment of AHPs in the disability sector. Slow recruitment processes, “bridging employment arrangements,” and short-term and casual contracts were reported to negatively affect recruitment. Slow recruitment processes exacerbated temporary employment arrangements as AHPs were placed on short-term and casual contracts while recruitment was completed. This exchange from one of the focus groups illustrates the impact of slow recruitment processes:

The other thing is that with recruitment, the bureaucracy of [organisation] taking so long to, I mean, we all know it ... People get married and divorced before they get their letter of offer. It’s just got to be said that a lot of really good people were lost in the process ...

We’ve had that happen a few times when they’ve actually advertised, interviewed and by the time they’ve been ready to offer a position, the best two or three candidates have got other jobs.

Incentives

The possibility of paying relocation expenses as an incentive to bring AHPs to work in rural areas was discussed by the focus groups. In one group, employees from one NGO described the incentives they received to work in a rural area:

We got a relocation package. So we’re both on a new grad[uate] package as well which includes all our professional development and training. So it’s a two year and then at the end of two years we get a bonus if we complete the package.

Although there are set pay levels within different sectors employing AHPs, participants appreciated that incentives could offset some of the discrepancies in remuneration that occur for AHPs working in regional and rural areas.

Major theme 2: Retention strategies that work

Participants spontaneously identified factors that had contributed to their own or colleagues’ retention in the rural disability sector (i.e., “pull factors”).

Table 2. Summary of themes and subthemes

Major theme	Subthemes
Timely, stable, and flexible recruitment	Competition between sectors Tenuous employment conditions Incentives
Retention strategies that work	Choice of work location Professional support structure Good access to continuing professional development (CPD)
Challenges to retention	Embarrassment of waiting lists, slow processes, and lack of available services Lack of professional autonomy Burdensome management and administration Travel burden Inflexible and inequitable work arrangements

AHPs recognised that the government sector had taken deliberate steps to improve recruitment and retention rates in recent years. Participants identified three strategies that were effective in improving perceived retention rates of AHPs in western NSW: choice of location, professional support structures, and good access to continuing professional development.

Choice of location

AHPs' ability to have some choice about the location of their work and hence living arrangements was perceived as a factor contributing to retention. Participants also recognised that this sometimes created an unequal distribution of services in the area. This recruitment strategy affects clients' equity of access to AHPs so that this recruitment and retention initiative, while successful, created an uncomfortable tension for some participants, as illustrated in this quote:

Yes and I think again many of the people that we're getting are out of Sydney and they like to be located closer to [capital city] so they can travel back and see family and friends. But again it does also promote some issues of travel and equity of access I suppose because if somebody, if there's a whole lot of people located in one town that's going to affect who's going to be able to provide the service, or how much time are they going to spend travelling.

Professional support structure

Perceived good access to continuing professional development activities and supervision from more experienced senior grade AHPs was also reported to promote retention of rural AHPs in the disability sector.

Clinical supervision is great, I'm about to have mine this afternoon, can't wait, but I suppose it's become

better since, I've only recently just gotten a [senior therapist] and that has improved my supervision. Up until then I was going six months without any clinical supervision, because my senior was doing two people's job on three days a week, so there just wasn't the opportunity for that clinical supervision to take place.

Nonetheless, because of the vast geographic distances in the region, support may be difficult to access as frequently as it may be needed, as indicated in this quote from a participant: "I have to travel to my supervisor who's two hours away. I'm supposed to do that fortnightly. It doesn't happen." The issue of ready availability of support and supervision is particularly important for new graduates. One participant said, "I guess that's one of the harder things for a new graduate in rural areas is that you don't have that support. It's really hard to develop your skills and probably a little slower to develop them."

A few of the larger NGOs also had the capacity to provide less experienced staff with support, as reported by this participant: "We [NGO] are very fortunate in having really senior therapy staff and that is very attractive for the new grads coming in because they know they're going to have that mentorship from very strong therapists." Not all NGOs have this capacity, as illustrated by another participant: "We're constrained by how much supervision and support and professional development that we need to provide that staff member so that we can take them on."

Good access to continuing professional development

Access to professional development was identified by participants as an important factor in satisfaction with their employment, as indicated by this participant: "One of the great benefits of working for the [government] and not being in private practice is the professional development opportunities they have."

Another participant employed in a NGO expanded on this, particularly in relation to new graduates:

New graduates that have come from metropolitan areas that have gone to teams such as our [regional town] team and what's attracted them has been the ... professional development and training opportunities. So there's certain training that is mandatory training that all staff need to do and then depending on experience levels and I guess your previous experience, there's a range of other training in the core clinical areas for each discipline and that's a real draw card. And also we have a new graduate package so they receive funding to go to conferences.

Not all NGOs are able to offer as much professional development as that indicated above, as reflected in the following quote:

We [NGO] really struggle with professional development because of cost and if you're in an NGO and you're wanting to do something that costs, like some of the courses that we've looked at are into the thousands of dollars and the way that we've made some of them cost effective is to actually merge with some of the other NGOs locally and, you know, join with [another organisation] to do a particular training that they also need to cover. But that's probably a big thing too if there's not the money.

Working and living in a rural area means there are additional costs of attending workshops and conferences beyond the training fees or registration costs, as indicated by this participant: "And again it's the accommodation, because if it was here, quite often we could afford to go to all the things but when you have to go [elsewhere], you've got travel and accommodation." Access to professional development can also vary depending on organisational constraints such as funding cycles. The following exchange in one of the focus groups indicates the impact of a "travel ban" placed on employees in a government organisation:

It was very isolating, because we use our meetings, our regional meetings as professional development. It's really isolating when you can't go.

Because of your travel ban?

Yes. They tried to do teleconferences and things like that. It's not the same as being able to sit down and have a conversation about a client with somebody.

This quote indicates that an unintended consequence of savings measures such as "travel bans" may affect retention and ultimately result in

increased recruitment costs in the longer term. This situation underscores the complexity of decision-making in organisations in the rural disability sector in NSW.

Major theme 3: Challenges to retention

Participants identified a range of factors that operated as challenges to retention of AHPs in the disability sector (i.e., "push factors"). Five subthemes are listed in Table 2 that capture the major issues that were perceived to be barriers to retention of AHPs in the disability sector.

Embarrassment of waiting lists, slow processes, and lack of available services

Participants' embarrassment and frustration regarding their inability to meet the needs and expectations of the clients with whom they work was evident. Waiting lists, slow processes, and lack of services were an embarrassment to these front-line workers who regularly interact with clients and carers with high levels of need. Similarly, participants recognised they were not implementing the philosophical stances of their organisations, namely, family-centred and evidence-based practice, due to policy and workforce constraints—even though they had a strong desire to do so.

It's a joke in the sense that family-centred practice is, and in reality, since they've given "lip service" at least to family-centred practice, it's much more difficult to actually provide family-centred practice ... let's face it, in reality a lot of the families we're actually working with actually need that whole approach, because the cases are so complex, and you can't be looking at feeding issues without appropriate seating and the whole ... anyway we won't go there.

Participants were aware of what was necessary for best practice for their clients with disability; however, their inability to deliver family-centred care due to waiting lists, slow processes, and lack of services influenced their desire to remain working in the sector.

Lack of professional autonomy

AHPs are university educated to exercise clinical and professional judgement in their interventions with clients and interactions with other professionals. However, participants reported systems for caseload and waiting list management undermined their

capacity for autonomy in clinical decision-making. One participant said:

We don't really have a say who we do get to pick up. If someone comes up as a high priority it's "that's your next client" ... it would be nice to be able to know who is on the waiting list and what their priorities are as well. We're trained at university to be able to prioritise clients, and we don't have that.

The following exchange in a focus group highlights this issue further:

There's no power left ... I've been seven years with the department and I know you used to have a lot more say in what you did and how you did it and even being able to see the referrals as they came through. Everything seems to be slowly removed from the practitioner to the managers or the senior managers.

But it also comes down to, if say [speech pathologist] drove to [place] to see someone and then a week later you find out that same person needs OT as well, there's no continuity and "OK, we're going to [place]; can we look through the list of who in [place] might be down for a service but they haven't been prioritised?" I mean it's a two hour drive. It's just stupid.

So the geography, in that alone, it has to balance out the priority.

Well those clients that need multiple services have been prioritised by separate services as, "Well actually they're a really high priority for both of these two together but separately they're only ..." you know speech might be really high but OT is quite low.

Focus group participants perceived that the inability of AHPs to exercise autonomous decision-making regarding the management of their clients impacted negatively on their retention in the disability sector.

Burdensome management and administration

The next subtheme identified by participants was burdensome management and administration. Participants reported experienced AHPs tended to be promoted into management roles where they did less clinical work. This in turn created recruitment difficulties for front-line positions and sometimes tenuous employment arrangements while AHPs acted temporarily in senior positions. The net result was often the retention of senior AHPs/managers but flow-on recruitment and retention difficulties

for front-line positions. It should be noted that at the time the focus groups were conducted the government disability sector was in the process of establishing new senior AHP roles, which may have made this situation more acute.

Participants also perceived that administrative and "paperwork" requirements were increasing. Many participants described these requirements as onerous and felt they had a direct impact on job satisfaction and retention, as illustrated by the following quotes:

But all our work's tied up with bloody paperwork. Like, I can go and see a client and then I've got two days worth of paperwork. You've got to do forms if you need a new piece of equipment, which can take three hours.

But it gets a bit more ironic because of the demands that you enter everything in the [client management system]. You're spending so much time entering data into the [client management system] because you have to be accountable for everything. I think a lot of time is wasted where we could be actually working with clients. Every phone call, every single thing has to be entered into the [client management system], and I think they're supposed to allow you three days to get stuff into it. Well, I'm over a month behind in the whole process and I find it's all very tiresome, and I'm seeing less and less clients with all the paperwork that's got to be done.

Travel burden

The need to travel as part of work role requirements was also identified as a challenge to retention of AHPs in the rural disability sector. Due to the geographic size and location of the region, and its relative isolation compared to the rest of NSW, services tend to be clustered in larger regional centres (hubs) with outreach to more remote areas (spokes). With a predominately female workforce, overnight stays were seen as particularly problematic for participants with other caring responsibilities, such as for young children. One participant said:

When my kids were going to school and I was working and I had to travel I was always in dread that my husband would not pick up the children. I've had the school call me in [outreach place] to say "please pick up your child."

The following exchange between focus group participants further highlighted this issue:

But then there's the overnight stays that your team would need to do, and that's the thing that's not really attractive to a lot of people—doing overnight stays, especially once you get young families.

And it is, it's quite hard. I know just even travel to [an outreach to town] for a day let alone an overnight trip I have to make sure I've got someone to take my kids to school, someone to pick them up and be home because it's a long day and I'm gone before they're awake.

As suggested in the above quote, a number of participants indicated that they would rather travel longer hours in a day than stay away from home overnight. The discussion at one focus group illustrated this dilemma:

Then you've got that two and a half hour drive home.

And that's an OH&S [occupational health and safety] risk then isn't it?

But I choose to do that because otherwise I have to stay over. I mean [organisation] is happy for me to stay over but to do that, that's too much of a ...

And you're exhausted the next day and you've got to front up at work and still do a full day's work. Or, if you stay over, you tend to put a couple of clients on the end of the day. So you'll see one at 6.00 pm and another one at 7.30 pm, and you just get back to your motel at 9.00 pm and then you're up and out at 8.30 am.

It is exhausting isn't it, and it does impact on your life.

Inflexible and inequitable work arrangements

Despite policy documents promoting flexible work practices for employees in the disability sector, participants indicated that AHP shortages in regional and rural areas resulted in overt and covert pressure to work full-time and forego flexible work arrangements. Hence, the final subtheme was “inflexible and inequitable work arrangements.” This was reported to have a negative impact on retention. This exchange in one focus group highlighted this issue:

That's an issue with [employer], the part-time option as a family person, it's just not available.

They don't offer part-time?

No. I would prefer to work part-time, but I can't. I either have a full-time contract or I leave my job.

What's that about?

If push comes to shove they'll give it to you, but you have to go through a process where you have to reveal your whole life to several layers of management to get that.

So what about the flexible work practices policy?

Is absolutely ridiculous, it doesn't exist.

It isn't implemented?

I was told when I was recruited, “Yes, we're family friendly, we're flexible, you'll get two flexi days a month.” And then when I got the job, I found out that no, it doesn't exist.

A similar story was told by a participant in another focus group:

They're trying to advertise my position at the moment to backfill and they're saying no less than four days a week. Four days is huge when you've got kids. So people don't apply because they don't think “well I can negotiate that out.” So they say “oh, they're definite about the four days,” rather than saying “we're interested in an experienced [AHP], happy to negotiate, come and tell me what you'd like, you know, let's enter into a dialogue about the recruitment process.” So we're very 1950s, 1960s in our recruitment strategy.

Discussion

These findings support our original proposition that the rural disability AHP workforce may have different issues influencing their recruitment and retention than their colleagues in the health, education, and private sectors. Participants identified that successful recruitment practices required flexibility. They described competition between sectors and organisations to recruit AHPs and an abundance of tenuous employment arrangements that were not attractive. This is a new finding that may be unique to the disability sector as Keane et al. (2012) did not identify these themes in their study of the general rural allied health workforce in NSW. Several participants in our study reported that incentive packages attracted them to their rural position, indicating that this strategy may be worth consideration by employers. Although incentive packages have been discussed in the rural medical workforce, they are rarely discussed for AHPs (Bärnighausen & Bloom, 2009).

Another significant finding of this research was the reported movement between the government, non-government, disability, health, education, and private sectors in rural areas in response to wage differentials. Often AHPs who enjoyed and were committed to living in a particular rural area reported moving between sectors to gain wage increases. In effect, these circumstances resulted in no net increase in the size of the AHP workforce or the subsequent services provided. Hence, the recruitment of new AHPs into rural areas needs to become a focus, and the findings regarding recruitment incentives in this study are important.

Previous recent research in this area examining the general AHP workforce in NSW identified a range of personal and professional influences on retention (Keane et al., 2012). Our research echoed those findings in terms of access to continuing professional development (CPD) being an influential factor. In our case, good access to CPD was a “pull factor” in terms of both recruitment and retention for AHPs working in the government organisations.

Common across the present study and the Keane et al. (2012) and Denham and Shaddock (2004) studies was the negative impact of reduced services and resources. For our participants this manifested as embarrassment when communicating to clients and carers with high needs regarding service provision, and frustration that the AHPs were unable to implement the philosophical approaches of family-centred practice and evidence-based practice espoused by their organisations. This embarrassment and frustration may, for some, lead to professional burnout and, for others, a decision to move to other sectors within the rural area (Buykx, Humphreys, Wakerman, & Pashen, 2010).

There are two overarching solutions to this problem. The first is to increase the size of the rural AHP workforce and address the perception that AHPs are difficult to attract to rural areas. Given the reported increase in allied health graduates that has occurred (Health Workforce Australia, 2012), there is no longer an undersupply of AHPs to take up rural and remote positions, so emphasis on recruitment and retention is key. The creation of new positions will ensure that services match demand. In line with this, new strategies that maximise disability workforce recruitment and retention in rural and remote areas need to be developed. The second is to reduce expectations and service demand through alternative service delivery methods. For example, service delivery through technology may reduce travel and increase the frequency of client contact, thus addressing two retention issues simultaneously.

Previous research has not identified the impact of promotion of AHPs into management roles on retention and service delivery in rural areas. Our results show that although promotion into management roles assists with retention, it exacerbates the workload demands and existing retention problems of front-line AHPs. This is exemplified by the reports of “top heavy” organisations where senior AHPs have been retained but not replaced at the front line, thus reducing the capability to provide services and exacerbating retention problems. In some cases these promotions were temporary or “acting” roles, and this resulted in attempts to “back fill” front-line positions using temporary employment arrangements. Participants reported that temporary or contract positions were more difficult to recruit into. This observation underscores the needs for concerted effort to recruit and retain new AHPs in rural areas, rather than simply redistributing the existing ones. Promotion of talented AHPs is inevitable in any organisation; however, increasing the size of the workforce rather than simply promoting movement within and between sectors is important.

Finally, our finding that reduced autonomy of AHPs in the rural disability sector was a “push” factor against retention is also significant. Apparently, an unintended consequence of managerial policies designed to manage the workflow and workload of AHPs in parts of the disability sector may inadvertently contribute to work dissatisfaction and retention. Policies aimed at promoting reasonable workloads for AHPs who work in high demand environments and equity of access for clients appear to decrease work satisfaction because of reduced autonomy in managing individual clients and case-loads. These policies are universally applied throughout NSW, so further exploration of the impact of the policies on work satisfaction of AHPs in the disability sector across NSW warrants investigation.

Strengths and limitations

The size of the sample in this research is a strength; however, the fact that all participants were recruited from western NSW and involved in the disability sector may limit the generalisability of the results. Caution should be exercised when relying on research findings about the general AHP workforce to inform policy development in the disability sector. Further research is needed comparing the perceptions about allied health recruitment and retention in metropolitan areas and other employment sectors.

Conclusion

Organisations and managers should incorporate the findings of this research into policy design that promotes recruitment and retention of AHPs to improve access to therapy services for people with a disability in rural and remote locations.

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References

- Ageing, Disability and Home Care. (2006). *Stronger together: A new direction for disability services in NSW 2006–2016. The second phase 2011–2016*. Sydney, Australia: Department of Human Services NSW.
- Australian Bureau of Statistics (ABS). (2009). *Disability, Australia, 2009*. (4446.0). Retrieved June 19, 2013, from Australian Bureau of Statistics website: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4446.0main+features42009>
- Australian Bureau of Statistics (ABS). (2011a). Table generated 4 March 2013 using *Census of population and housing 2011, employment, income and unpaid work classifications, section of state/urban centres and localities geography* [Table Builder data cube]. Retrieved from <http://www.abs.gov.au/websitedbs/censushome.nsf/home/tablebuilder?opendocument&navpos=240>
- Australian Bureau of Statistics (ABS). (2011b). Table generated 4 March 2013 using *Census of population and housing 2011, section of state/urban centres and localities geography* [Table Builder data cube]. Retrieved from <http://www.abs.gov.au/websitedbs/censushome.nsf/home/tablebuilder?opendocument&navpos=240>
- Australian Government Department of Health and Ageing. (2008). *Report on the audit of health workforce in rural and regional Australia: April 2008*. Canberra, ACT: Commonwealth of Australia.
- Australian Government Productivity Commission. (2011). *Disability care and support* (Report No. 54). Canberra, ACT: Author.
- Australian Health Workforce Advisory Committee. (2006). *The Australian allied health workforce: An overview of workforce planning issues* (AHWAC Report 2006.1). Sydney, NSW: Author.
- Australian Institute of Health and Welfare. (2009). *Health and community services labour force* (National health labour force series number 42. Cat. no. HWL 43). Canberra, ACT: Author.
- Bärnighausen, T., & Bloom, D. E. (2009). Financial incentives for return of service in underserved areas: A systematic review. *BMC Health Services Research*, 9(May), 86. doi:10.1186/1472-6963-9-86
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101. doi:10.1191/1478088706qp063oa
- Bryman, A. (2001). Sampling. In A. Bryman (Ed.), *Social research methods* (3rd ed., pp. 529–533). Oxford, UK: Oxford University Press.
- Bryman, A. (2012). *Social research methods* (4th ed.). Oxford, UK: Oxford University Press.
- Buykx, P., Humphreys, J., Wakeman, J., & Pashen, D. (2010). Systematic review of effective retention incentives for health workers in rural and remote areas: Towards evidence-based policy. *Australian Journal of Rural Health*, 18, 102–109. doi:10.1111/j.1440-1584.2010.01139.x
- Campbell, N., McAllister, L., & Eley, D. (2012). The influence of motivation in recruitment and retention of rural and remote allied health professionals: A literature review. *Rural and Remote Health*, 12(1900). Retrieved from <http://www.rrh.org.au>
- Chisholm, M., Russell, D., & Humphreys, J. (2011). Measuring rural allied health workforce turnover and retention: What are the patterns, determinants and costs? *Australian Journal of Rural Health*, 19, 81–88. doi:10.1111/j.1440-1584.2011.01188.x
- Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Los Angeles, CA: Sage.
- Denham, L. A., & Shaddock, A. J. (2004). Recruitment and retention of rural allied health professionals in developmental disability services in New South Wales. *Australian Journal of Rural Health*, 12, 28–29. doi:10.1111/j.1440-1584.2004.00546.x
- Dew, A., Veitch, C., Lincoln, M., Brentnall, J., Bulkeley, K., Gallego, G., ... Griffiths, S. (2012). The need for new models for delivery of therapy intervention to people with a disability in rural and remote areas of Australia. *Journal of Intellectual & Developmental Disability*, 37, 50–53. doi:10.3109/13668250.2011.644269
- Health Workforce Australia. (2012). *Annual report 2011–2012*. Retrieved March 4, 2013, from https://www.hwa.gov.au/sites/uploads/HWA-Annual-Report-2011-2012_0.pdf
- Keane, S., Lincoln, M., Rolfe, M., & Smith, T. (2013). Retention of the rural allied health workforce in New South Wales: A comparison of public and private practitioners. *BMC Health Services Research*, 13(32). doi:10.1186/1472-6963-13-32
- Keane, S., Lincoln, M., & Smith, T. (2012). Retention of allied health professionals in rural New South Wales: A thematic analysis of focus group discussions. *BMC Health Services Research*, 12(175). doi:10.1186/1472-6963-12-175
- Keane, S., Smith, T., Lincoln, M., & Fisher, K. (2011). Survey of the rural allied health workforce in New South Wales to inform recruitment and retention. *Australian Journal of Rural Health*, 19, 38–44. doi:10.1111/j.1440-1584.2010.01175.x
- Leach, M. J., Segal, L., & May, E. (2010). Lost opportunities with Australia's health workforce? *The Medical Journal of Australia*, 193, 167–172.
- Lowe, S., Adams, R., & O'Kane, A. (2007). *A framework for the categorization of the Australian health professional workforce: Discussion paper*. Deakin, ACT: Services for Australian Rural and Remote Health (SARRAH).
- National Health Workforce Taskforce. (2009). *Health workforce in Australia and factors for current shortages*. Retrieved March 11, 2013, from <http://www.ahwo.gov.au/documents/NHWT/The%20health%20workforce%20in%20Australia%20and%20factors%20influencing%20current%20shortages.pdf>

- Veitch, C., Dew, A., Bulkeley, K., Lincoln, M., Bundy, A., Gallego, G., & Griffiths, S. (2012). Issues affecting practitioner workforce and service delivery to people with a disability in rural and remote New South Wales: Perspectives of policy-makers, senior managers and practitioners. *Rural and Remote Health, 12*(1903). Retrieved from <http://www.rrh.org.au>
- Veitch, C., Lincoln, M., Bundy, A., Gallego, G., Dew, A., Bulkeley, K., ... Griffiths, S. (2012). Integrating evidence into policy and sustainable disability services delivery in western New South Wales, Australia: The “wobbly hub and double spokes” project. *BMC Health Services Research, 12*(70). doi:10.1186/1472-6963-12-70
- Wark, S., Hussain, R., & Edwards, H. (2013). Rural and remote area service provision for people aging with intellectual disability. *Journal of Policy and Practice in Intellectual Disabilities, 10*, 62–70. doi:10.1111/jppi.12017
- Wilson, R. D., Lewis, S. A., & Murray, P. K. (2009). Trends in the rehabilitation therapist workforce in underserved areas: 1980–2000. *Journal of Rural Health, 25*, 26–32. doi:10.1111/j.1748-0361.2009.00195.x
- World Health Organization. (2010). *Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations*. Geneva, Switzerland: Author. Retrieved from http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf