Victorian Allied Health Workforce Research Program

Psychology Workforce Report

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Psychology Workforce Report

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Abbreviations and acronyms

ABS	Australian Bureau of Statistics
AH	Allied health
AHP	Allied health practitioner
AHPRA	Australian Health Practitioner Regulation Authority
AHWQ2	Allied Health Workforce Questionnaire 2
AIHW	Australian Institute of Health and Welfare
APS	Australian Psychology Society
APAC	Australian Psychology Accreditation Council
CPD	Continuing professional development
DET	Department of Education and Training
EBA	Enterprise bargaining agreement
EFT	Equivalent full time
GP	General practitioner
HWA	Health Workforce Australia
MBS	Medical Benefits Scheme
NFP	Not for profit
PBA	Psychology Board of Australia

Executive summary

Overview

This report provides an overview of the psychology workforce in Victoria in 2016 - 2017. It is based on survey responses from 1,223 individual psychologists (approximately 14% of psychologists registered in Victoria in December 2016 with the Psychology Board of Australia (PBA) (PBA, 2017)), five focus groups involving 11 participants, and surveys from 261 government, non-government, and private organisational respondents that provide psychology services across more than 1,112 different locations or sites in Victoria.

Public sector and older employees were over-represented in the survey sample. Twenty-one (21%) of the survey respondents were aged 35 year and under compared to 29% of psychologists as reported in the 2015 Australian Institute of Health and Welfare (AIHW) data from registered psychologists (AIHW, 2016).

Key findings

Psychologists	AHWQ2 survey	AIHW 2015 [a]	PBA,2016 [b]
Victorian population	1,223	8,814	9,218
Female	81%	80%	80%
Aboriginal and / or Torres Strait Islander	0	.003%	
Australian trained	95%	93%	
Age 35 years and under 55 years and older	21% 33%	29% 25%	
Median age (years)	47		
Median income / annum	$70,000 to 79,999		
Public sector	50%	28%	
Not for profit (NFP) sector	9%	51% (NFP and Private sectors)	
Private sector	19%		
Principal area of endorsement Endorsement as % of total number of endorsements	Clinical psychology 64%		Clinical psychology 56%
Principle area of practice	Mental health counselling		
Reporting advanced practice role	8%		
Work with allied health assistants	15%		
Reported use of telehealth	10%		
First qualification to practise	Clinical Masters 25%		
Hold PhD	10%		
Intention to stay in profession for more than 5 years	82%		
Work for two or more employers	22%		
Of those with a supervisor, psychologist as supervisor	81%		
% of workforce in non-metro areas	30%		

[a] Source: AIHW, 2016 [b]Source: PBA, 2017[3]

Psychologists were generally satisfied with their jobs, particularly the opportunities for work / life balance, professional challenge and autonomy. The psychology profession is relatively stable, with the majority (82%) intending to remain within the profession for at least five years.

Demand for psychologists was difficult to quantify because of a lack of systematic approaches to measuring demand for allied health services. However, there was some limited evidence of unmet needs for psychology services including long waiting times; an inability to provide services or in some cases, lack of ability to provide certain specialised services or the most appropriate evidence based practice.

The research findings did not suggest that there was a shortage of psychologists; rather, there is a lack of appropriately funded and graded positions within the community to meet the needs of clients. In other words, there were insufficient funded psychology positions to meet client needs, but no shortage of psychologists to fill those positions if they were available. While there were numerous packaged funding sources to provide funding for individual clients to receive psychology services from private practitioners, the variability of private service accessibility, provision and funding appears to limit access to services for some clients. Psychology services are still stigmatised to some of the most vulnerable clients.

Psychologists are highly qualified. Sixty nine per cent (69%) of respondents have worked in another profession before entering psychology; predominantly teaching or another health care profession. Psychologists are required to achieve post-graduate qualifications in order to be eligible to register with the PBA. This makes training psychologists time consuming and expensive in comparison to other health care professions, such as social work, nursing, occupational therapy and counsellors, whose work often overlaps with psychology work.

Psychology has supervision requirements for those without general registration and continuing professional development requirements for the maintenance of registration which include peer consultation. Currently 28% of registered psychologists in Victoria are board-approved supervisors for students and provisional psychologists. The costs of meeting these supervision requirements are sometimes met by the employer; otherwise, they must be met by the psychologist themselves. The supervision requirements for psychologists were seen to create a disincentive for some services to employ psychologists due to the high costs of providing this requirement. Lack of access to supervision limits the capacity to train and employ more junior psychologists in small services, rural and regional areas. Similarly, some practising psychologists perceived that maintaining the standards required for registration were overly onerous.

Psychologists work across a number of generic roles. In some cases, their advanced credentials increases their employability, however in other roles (such as mental health) psychologists perceive that they are less competitive due to their higher pay and a lack of understanding of their specific contribution to a multidisciplinary team environment.

The psychology workforce is predominantly clinical. Respondents to this research would like to have clearer career development pathways including continuing professional development opportunities, mentorship and opportunities to undertake research. Research activities and partnerships increased the career development opportunities for psychologists.

There were no systemic skills gaps identified within the profession. A range of professional and broad transferrable skills were identified, particularly for those working in private practice. There was also a perception that some new graduates applied only a narrow range of therapeutic tools to their practice. Non-medical prescribing is seen as a future opportunity for the psychology workforce.

A very strong theme, which was identified by more than half of the survey respondents, was general dissatisfaction with the a perceived ‘two-tiered’ psychology workforce, in which psychologists who are endorsed clinical psychologists are preferential providers of specific services and receive a higher reimbursement for services under the Medicare Benefits Scheme (MBS). This was seen as inequitable because some current practising providers have difficulty accessing clinical endorsement due to the cost

of training and / or restrictive entry requirements, and because it fails to equitably recognise the extensive skill and experience of practising psychologists.

Conclusions

Key areas of forward consideration for the psychology workforce include:

- Undertaking a review of the entry-to-practice training pathways including pathways which consider previous professions or careers (particularly those from teaching and other health professions that are likely to have transferrable skills and bring valuable attributes to the profession) to provide a more flexible workforce that optimises the value of potential entrants to the profession to help meet community need.
- Provision of training pathways that provide a sufficiently broad range of experiences to support psychologists entering a wide range of appropriate practice areas.
- Further investigation and review into the understanding of supervision, peer consultation and mentoring as this appeared to be the cause of concern for many respondents.
- Review the impact of privatisation and fee-for –service payments on the workforce
- Consider the potential for implementation of regionally-based communities of practice (potentially brokered by the Primary Health Networks) or other models to increase interdisciplinary collaboration and team-based care for the benefit of clients.
- Review service accessibility (including reviewing the potential gap between MBS funded services and public funded services).
- Review the MBS preferential reimbursement system for endorsed psychologists and other contributors to the perception of a two-tiered and hierarchical workforce within psychology.
- Investigate further how different models of care, including advanced practice, extended scope, rural generalist, multi-disciplinary, transdisciplinary, allied health assistant delegation, telehealth, integrated clinical management software, and information and data sharing systems may be used to improve the ability of the profession to meet community need and enhance career development and engagement.

Introduction

The Victorian Allied Health Workforce Research Program (the program) aims to contribute to the evidence base of 27 selected Victorian allied health (AH) professions in the public, private and not-for-profit (NFP) sectors in Victoria. The data will be used to inform the policies and programs of the Department of Health and Human Services, provide a platform of evidence on which to build further understanding and development of the AH workforce, as well as guide any improvements to the associated education and training system.

This report presents the data arising from research on the occupational therapy workforce in Victoria.

Please note:

Terminology used in this report reflects that used in the survey process by Southern Cross University, rather than standard Department of Health and Human Services terminology.

The 11 profession specific reports which form the meso and micro levels of this research (as described in the methods section) are based on similar but not identical surveys varied to meet the individual requirements of each investigated profession. Comparative data reflecting the Victorian state context is included wherever possible. While significant effort has been made to make each of these reports as consistent as possible in its presentation of material, differences in available comparative data and other profession specific differences have resulted in some variations in the material included and its presentation.

Throughout these reports the terms *grade* (e.g. 1, 2, 3 etc.) or *level* (junior, intermediate, senior) are used in both the text and quotes from research participants. The term grade refers to the different employment classifications used in the enterprise bargaining agreements (EBA) that individuals may be employed under. These EBAs (awards) generally cover the public sector employees and larger private sector organisations. These grades determine pay rates and benefits, and in some cases job responsibilities and job titles. The exact description and meaning of each grade will vary with the different awards. For individuals who were not employed under these awards (e.g. private business owners, contractors etc.) the term level was used to try and equate their job responsibilities and pay to those employed under the formal EBA structure. These terms were also used to determine the breakdown and specific issues relating to junior, intermediate and more senior members of the specific professions in Victoria.

Background

Who are psychologists?

Psychologists are experts in human behaviour. They use scientific approaches to study the factors that influence the way people think, feel and learn, and use evidence-based research, strategies and interventions to inform how they work to assist individuals, families, groups and organisations. Psychologists work in contexts such as schools, hospitals, community health services, courts, prisons, businesses, the defence forces and private practice (Australian Psychological Society, 2015a, Health Workforce Australia, 2014a).

Psychology is a registrable health profession under the *National Registration and Accreditation Scheme / Australian Health Practitioners Regulation Agency* (AHPRA). To practise in Australia, psychologists must be registered with the Psychology Board of Australia (PBA).

There are currently a number of steps and different pathways to achieving general registration as a psychologist (Australian Psychological Society, 2015b):

Step 1 involves completion of a three-year undergraduate psychology sequence accredited by the Australian Psychology Accreditation Council (APAC).

Step 2 the fourth year in the sequence, is achieved by completing an APAC-accredited honours degree or postgraduate diploma in psychology.

Step 3 involves a choice of three possible paths:

– 4 + 2 internship pathway: employment in a psychological role, gaining provisional registration with the PBA, then completing a two-year internship with supervised practice, **or**

– 5 + 1 internship pathway: completing an additional one year accredited *Graduate Diploma of Professional Psychology*, gaining provisional registration with the PBA, then completing a one-year internship with supervised practice, **or**

– APAC-accredited postgraduate professional psychology degree pathway: a minimum two-year APAC-accredited postgraduate degree (fifth and sixth year of study). APAC-accredited professional postgraduate degrees involve coursework, placements (requiring provisional registration) and a thesis. Degrees are offered in nine areas of practice:

- clinical neuro psychology
- clinical psychology
- community psychology
- counselling
- educational and developmental psychology
- forensic psychology
- health psychology
- organisational psychology
- sports and exercise psychology

On completion of Step 3 graduates must successfully complete the National Psychology Examination to be eligible for general registration with the PBA.

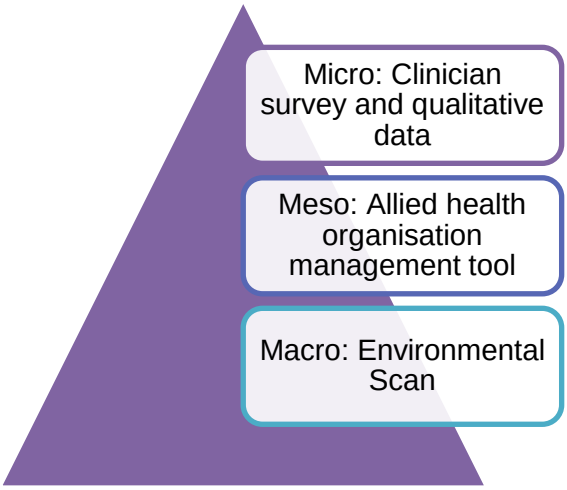
Step 4 is open to individuals who have completed an APAC-accredited postgraduate professional psychology degree. It provides the opportunity to obtain a psychology area of practice endorsement. The process involves completion of a registrar program approved by the PBA. This program involves psychological practice, supervision with a supervisor approved by the PBA and active continuing professional development. The areas of practice endorsement align with the nine areas in which postgraduate professional degrees are offered.

Nationally, 37% of psychologists have an endorsement in one or more area(s). In December 2016, a total of 3,438 endorsements were held by Victorian psychologists, while 91% of endorsed psychologists hold only one endorsement, some hold up to six endorsements (PBA, 2017).

Method

A three-tiered approach was used to capture workforce data at macro, meso and micro levels (Figure 1).

Figure 1: Three-tiered research approach



Macro

Environmental scan

The environmental scan examined 27 AH professions in Victoria during the first six months of the research program. The process involved engagement with each of the professional associations regarding workforce trends and issues alongside an analysis of a range of existing data sources. A 'snapshot' was generated for each profession which included key workforce statistics, workforce trends and issues presently affecting the profession, and those likely to affect the profession in the future. An environmental scan has been produced as a stand-alone document for each profession. Relevant findings from the occupational therapy environmental scan have been incorporated into this report.

Meso and micro level data

Subsequent to the environmental scan, four professions (physiotherapy, sonography, speech pathology and allied health assistance) were analysed in depth in 2015 – 16. A further three professions (occupational therapy, social work and psychology) were analysed during 2016 – 17. This analysis included organisational and individual level approaches as described below. These professions were selected by the Department of Health and Human Services for further study because they were either high priority professions or they were unregistered professions with limited existing data available. The in-depth analysis involved the use of a semi-standardised survey and focus groups with both standardised and profession specific questions.

In year one of the research program, three separate surveys were used to access data at an individual (Allied Health Workforce Questionnaire), team (Allied Health Organisation Mapping Tool) and organisation level (Allied Health Human Resources Tool). For this, second stage of the program, the questions from the three surveys were combined into a single tool (Allied Health Workforce Questionnaire 2 (AHWQ2)), and internal survey logic was used to direct respondents to the appropriate questions according to their role/s or perspective within an organisation.

The AHWQ2 collected the following information:

At the organisational level, team leaders, managers or directors of human resources were asked to provide information about the geographic location, numbers and grades of staff, skill set, recruitment and retention issues, and organisational contexts of the profession. It was completed at a regional or organisational level, typically by a team leader or human resources department, to provide detailed information about the workforce structure and organisation.

Individual clinician data captured information about education and training, the nature of work, location of work, job satisfaction and career development opportunities, as well as open ended questions exploring issues that the profession specifically identified as being important.

Participants who completed the AHWQ2 were invited to provide their contact details for future follow-up.

Focus groups

Survey respondents who agreed to be followed-up via email were invited to participate in one of five focus groups. One group was specifically for early career professionals, while the remainder were heterogeneous, but designed to include a mixture of participants according to rurality and public, private and NFP sectors. Two individual interviews were also conducted. One of these interviews was scheduled to accommodate a participant who experienced difficulties joining the online conference. The other interview was scheduled in response to an experienced clinician nominating to attend the early career focus group and being unable to attend any of the other scheduled focus groups. The focus groups explored issues that were highlighted in the survey responses. The questions were developed in consultation with the reference groups and Department of Health and Human Services. Each focus group was held via teleconference using Zoom and was approximately 90 minutes. The focus groups were recorded and detailed contemporaneous notes were taken and used as the basis for analysis. Where necessary the recordings were accessed for clarity or confirmation.

Research governance

The research was overseen by an overarching research advisory group comprising experts from many health disciplines and sectors. In addition, each of the three professions had a discipline specific reference group comprising members of the profession who represented specific sectors or subgroups (such as new graduates, public, private and NFP sectors, and academics). The advisory group and the reference groups were consulted about the research approach, survey distribution methods and engagement strategies, as well as providing substantial input into the survey content and piloting. The discipline specific reference groups also advised on the content of the focus group questions, aided the interpretation and verification of the final reports, and provided feedback on the penultimate drafts of the discipline specific reports.

Distribution approaches

Surveys were initially distributed through the reference groups, the professional associations and Department of Health and Human Services contact lists. In addition, a communications database was developed comprising employers, professional networks and associations, individual professionals and relevant contacts for each profession. This database evolved during the project and continues to evolve.

The survey was circulated between 11 November 2016 and 7 April 2017.

Other methods of distribution and marketing included Department of Health and Human Services newsletters, marketing on social media (e.g. Facebook), a presentation at the Victorian Allied Health Research Conference, regional conference presentations, and presentations to individual professions.

Analyses

The Qualtrics survey tool generates descriptive statistics (frequencies, means, standard deviations, etc.) for all questions which are downloadable in Microsoft Word and Microsoft Excel formats. Further

analyses were undertaken using cross tabulations of specific questions results, and comparisons with other available data from the Australian Bureau of Statistics (ABS) Census, Health Workforce Australia, Australian Institute of Health and Welfare (AIHW), Department of Health and Human Services, and profession specific associations.

Data limitations

- The challenge of distributing and marketing a survey commissioned by a single government department to distributed health services, non-government services and private providers means that the data may not be representative of the profession.
- It was difficult to engage with the NFP and private occupational therapy providers. As a result, it is not possible to determine the representativeness of the data for these groups.
- The focus group participants were invited from the AHWQ2 respondents who agreed to be followed-up. This may have resulted in selection bias as only 29% of all survey respondents agreed to further follow-up.

Results

The source of data in the tables and figures going forward is the AHWQ2 survey data unless otherwise stated.

Responses and respondents

Respondent numbers for each of the different data collection methods are presented in Table 1 below.

Table 1: Respondent numbers by data collection approach

AHWQ2 (individual respondents)	AHWQ2 (organisational respondents)	Focus groups
1,223	261	Group 1 – 3 participants Group 2 – 2 participants (early career) Group 3 – 2 participants Group 4 – 3 participants Group 5 – 1 participant

Allied Health Workforce Questionnaire 2

The AHWQ2 survey was completed at both the organisational and individual practitioner level. The respondents to the managerial level questions were presented with seven questions, and the individual clinicians were presented with 53 questions. Completion of the survey was voluntary and respondents, both organisational and individual, had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

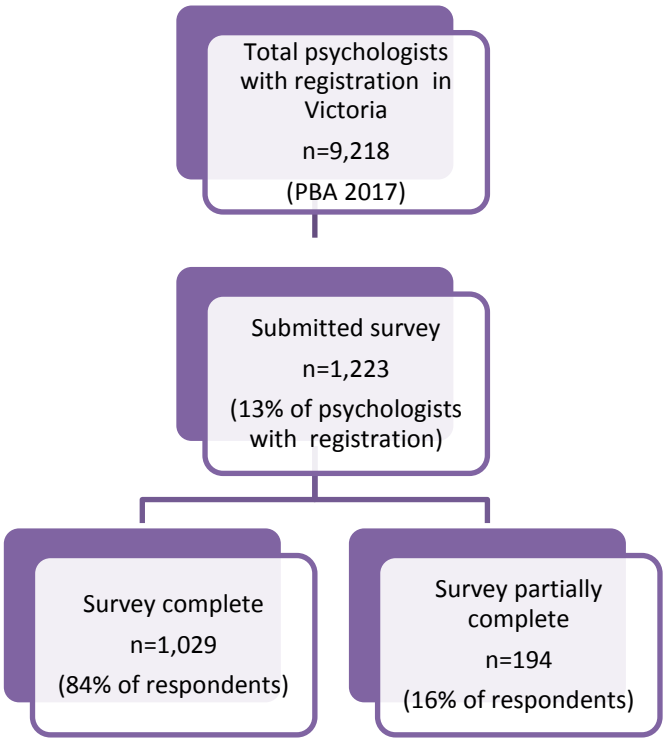
In December 2016, there were 9,218 psychologists registered in Victoria (PBA, 2017). Of the 1,223 psychologists who submitted the AHWQ2 (13% response rate based on December 2016 PBA data), 94% were employed in the psychology workforce at the time of completing the survey. The survey was completed[1] by 1,029 individual psychologists. The range of responses to an individual question was from 539 to 3,597[2]. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not (Figure 2).

A total of 261 employers or managers of psychologists completed the AHWQ2. The organisations they represented employed a total of 574 full time equivalent psychologists and provided services at 1,112 different locations or sites in Victoria. (See Appendix Table 1 for breakdown of number of different sites organisations provided services from).

[1] A survey was considered complete if the respondent answered the last survey question and submitted the survey, even if they did not provide answers to every survey question.

[2] Some questions allowed for multiple responses

Figure 2: Survey responses



Capacity

Capacity refers to the ability of the profession to meet the needs of the community in terms of workforce numbers and allocation of staff, skill mix, ratios, geographic distribution, organisation of the workforce, and their ability to influence these factors at a political, professional and organisational level (Figure 3).

Figure 3: Workforce capacity framework

Key findings

- Twenty-one per cent (21%) of respondents were under 35 years of age, with the age range being from 24 years and to over 75 years.
- The majority of respondents (70%) worked in the inner or outer metropolitan areas of Melbourne
- Most participants were employed in the state public sector (50%), were permanently employed (66%), and worked Monday to Friday during the day (88%).
- Forty–seven per cent (47%) of respondents were employed at grade 3 or below. Grade 2 (26%) was the most common employment level.
- Adults and older adults were the age group supported by the greatest proportion of respondents (74% and 38% respectively). Fourteen per cent (14%) worked across all age groups.
- On average, respondent caseloads included 5% of people from Aboriginal and / or Torres Strait Islander backgrounds and 25% from culturally and linguistically diverse backgrounds.
- The most common service delivery settings were community (54%), hospital outpatient (13%), and schools (10%).
- Mental health counselling and chronic disease management were the most frequently reported areas of practice.
- Across their careers, the setting of care showed a trend away from hospital inpatient towards community and hospital outpatients. This may reflect changes in funding models.
- Most respondents (82%) intend to stay in the psychology profession for six years or more.
- There was limited evidence of vacancies for psychologists with the majority of organisations stating that they had no unfilled positions and had not advertised for psychologists in the previous twelve months. Organisations that did advertise positions had limited responses with the majority receiving fewer than 10 applications for positions advertised across all grades.
- There was evidence of unmet demand for psychology services within the community resulting in long waiting lists, service rationing, and an inability to deliver the most appropriate evidence-based practice, however this may be the result of funding models for psychologists that affect workforce distribution and accessibility, rather than the supply of psychologists.
- Eight per cent (8%) of respondents reported that their work involved advanced scope of practice. The Australian Psychology Society (APS) does not formally recognise advanced practice roles in psychology, however a number of advanced practice roles have been recognised through Victorian Department of Health and Human Services advanced practice grants.
- Fifteen per cent (15%) of respondents reported their work involved delegation to an allied health assistant. However, focus group participants suggested that psychology does not lends itself easily to delegation to assistants, due to the fee-for-service model of funding and specific nature of therapeutic interventions used.
- Ten per cent (10%) of respondents reported using telehealth. The most common application of telehealth technology was video-conferencing with clients, including the use of telephone and skype to communicate with clients and providing phone counselling.

Workforce distribution

Demographics

Based on the most recently available data, in December 2016 there were 7,669 psychologists with general registration, 1,166 with provisional registration, and 383 non-practising (total of 9,218 psychologists) (PBA, 2017). According to the most recently available AIHW workforce data there were 7100 psychologists working in Victoria in 2015 (AIHW, 2016)[3].

Of the total cohort of 1,233 AHWQ2 respondents, 94% (n=1,154) were employed in the psychology workforce in Victoria at the time of completing the survey. (See Appendix Table 2 for reasons why respondents were not working as a psychologist).

As detailed in Table 2, the majority of AHWQ2 survey respondents were female (81%), corresponding closely with the PBA figure of 80%. There is evidence that the psychology workforce is becoming increasingly feminised. In contrast to 1996, when females made up two thirds of the psychology workforce (HWA, 2014a), currently females constitute 80% of the workforce (PBA, 2017).

One third (33%) of the AHWQ2 respondents were aged 55 and older, while only 21% of respondents were 35 years and under (Table 2, Figure 4). In comparison, 28% of registered psychologists were aged 35 years and under in December 2016 (PBA, 2017). Therefore the survey has an overrepresentation of older survey respondents than the general population of psychologists practising in Victoria. The median age of psychology survey respondents was 47 years (range 24 to >75 years).

The psychology workforce is ageing. Between 1996 and 2011 there was a substantial increase in psychologists aged 55 years and over from 9.9% to 24.4%. This increase was particularly significant for males (12.9 to 35.5%), and slightly less for women (8.4 to 21.1%) (HWA, 2014a). In comparison to other AH professions, the psychology workforce had only 11% of registrants under 30 years of age in 2012 (AIHW, 2013).

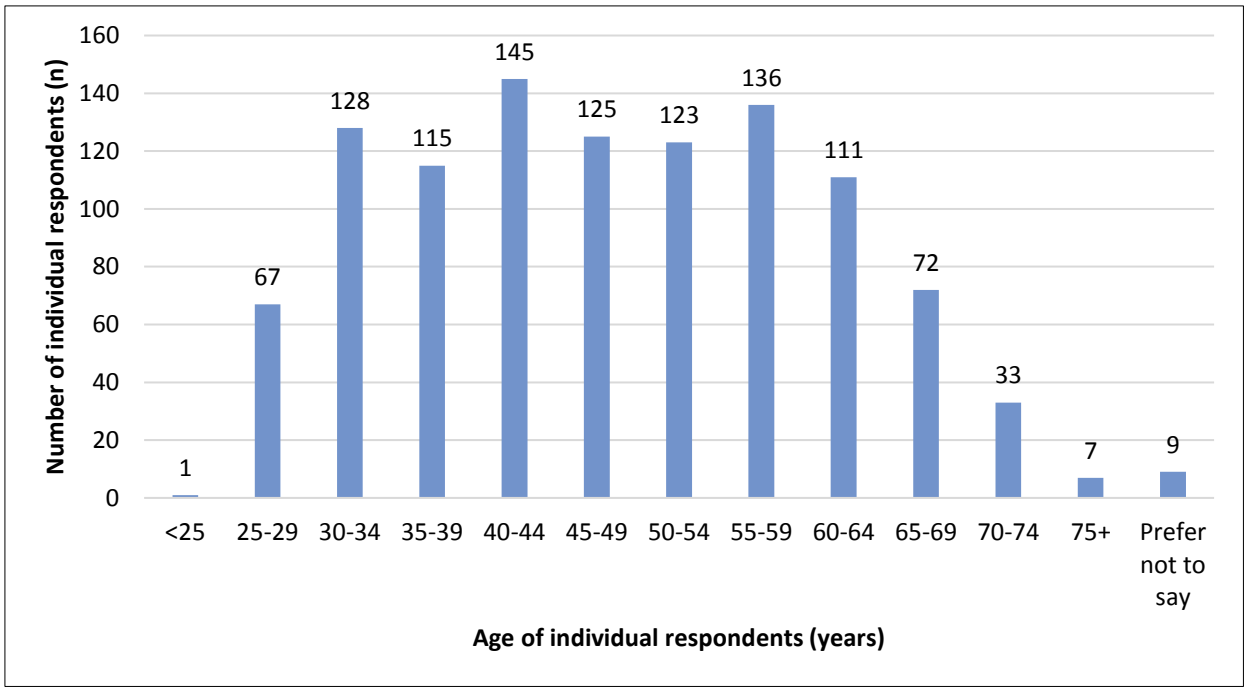
The survey respondents were predominantly female (81%); consistent with the 2017 PBA data which has 80.3% of the profession as female.

Table 2: Demographics (n=1,085) compared with AIHW 2015 data

Demographics	AHWQ2		AIHW 2015	
	n	%	n	%
Female	881	81	7,059	80
Aboriginal and / or Torres Strait Islander	0	0	27	0.003
Australian citizen / permanent resident	1,085	100	-	-
Age 55 and over	346	33	2,166	25
Age 35 and under	228	21	2,528	29
Median age (years)	47	-	-	-

[3] The AIHW national workforce dataset is constructed from the annual *Workforce Survey* carried out as part of the registration renewal process undertaken by AHPRA on behalf of the PBA. While the survey is attached to the required registration renewal documentation, completion is voluntary. Only registrants who are renewing their registration can complete it. The survey focuses on whether a registrant is employed or looking for work, and the type of work they are undertaking. The psychology version consists of 20 questions, some of which are conditional on the response to previous questions. Registrants can complete all, some or none of the questions; as a result, the number of responses to each question will vary. AIHW data in this report is from the 2015 workforce survey, unless otherwise stated.

Figure 4: Age in 2016/ 2017(n=1,072)



Psychology area of practice endorsements

In total, 319 psychologists reported that they had an endorsement in at least one area of practice[4]. Sixteen (16) psychologists reported two endorsements, while two psychologists had three endorsements. In comparison to registration data (PBA, 2017), clinical psychology endorsements were over-represented in the AHWQ2 respondents, while practitioners with other endorsements were slightly under-represented (Table 3).

Table 3: Psychologists holding area of practice endorsements

Area of practice endorsements	AHWQ2		PBA Dec 2016 (Victoria)	
	n	%	n	%
Clinical neuropsychology	64	19	289	8
Clinical psychology	216	64	1,942	56
Community psychology	0	0	35	1
Counselling psychology	32	10	481	14
Educational and developmental psychology	3	1	219	6
Forensic psychology	10	3	159	5
Health psychology	5	1	150	4
Organisational psychology	5	1	141	4
Sport and exercise psychology	0	0	22	1
Total	**335**	**99** [a]	**3,438**	**99** [a]

[a] *Due to rounding*

[4] See Who are psychologists (p.11) for description of area of practice endorsements

Geography

The AHWQ2 respondents were largely metro-centric with 70% reporting they undertook their primary role in inner or outer metropolitan areas of Melbourne (Table 4).

Table 4: Region of work (n=1,079)

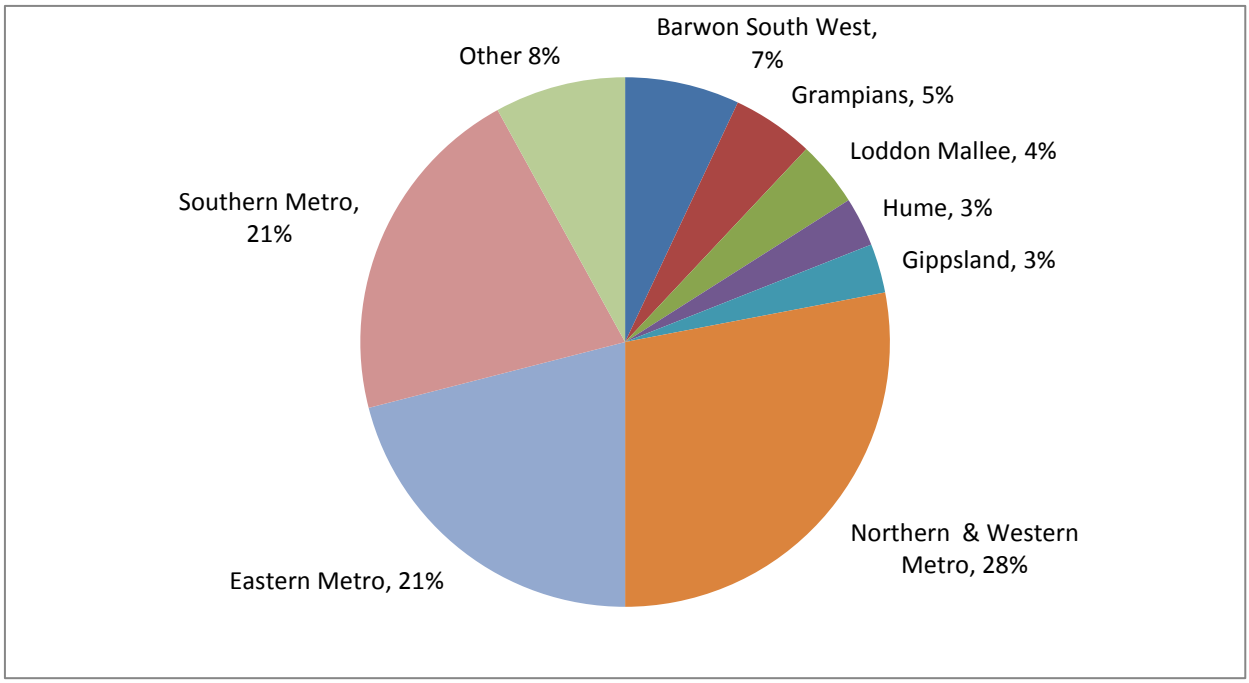
AHWQ2			AIHW 2015		
Region	**%**	**Count**	**Region**	**%**	**Count**
Inner-metro	53	572	Major city	89	7,818
Outer-metro	17	188			
Inner-regional	20	220	Inner-regional	10	892
Outer-regional	5	49	Outer-regional	1	104
Rural	4	46	-	-	-
Remote	<1	4	Remote	0	0
			Very remote	0	0
Total	100%	1,079		100%	8,814

According to the ABS Census of Population and Dwellings 2011, the greatest concentration of psychologists was in North and Western Metropolitan Melbourne (0.94/1000 population), followed by Eastern Metropolitan Melbourne (0.78/1000 population) and Southern Metropolitan Melbourne (0.68/1000). Regional areas reported rates ranging from 0.33/1000 (Loddon Mallee and Hume) to 0.56 and 0.57/1000 (Barwon-South Western and Grampians respectively), with Gippsland reporting 0.33/1000. The AHWQ2 survey results only report the number of responses per regional area, which cannot be directly compared to the ABS findings; however, responses were received from psychologists working in each Department of Health and Human Services region. (Table 5 and Figure 5)

Table 5: Primary geographic location of AHWQ2 respondents (n=1,093) compared to AIHW 2015 geographic locations

	Barwon south West	Grampians	Loddon Mallee	Hume	Gippsland	Northern and Western metro	Eastern Metro	Southern Metro	Other state	Total
Primary location	75	54	39	37	34	307	230	226	91	1,093
%	7	5	4	3	3	28	21	21	8	100
AIHW location (% of respondents)	5	3	2	3	2	44	19	21	NA	100

Figure 5: Main place of work by Department of Health and Human Services' regions (n=1,093)

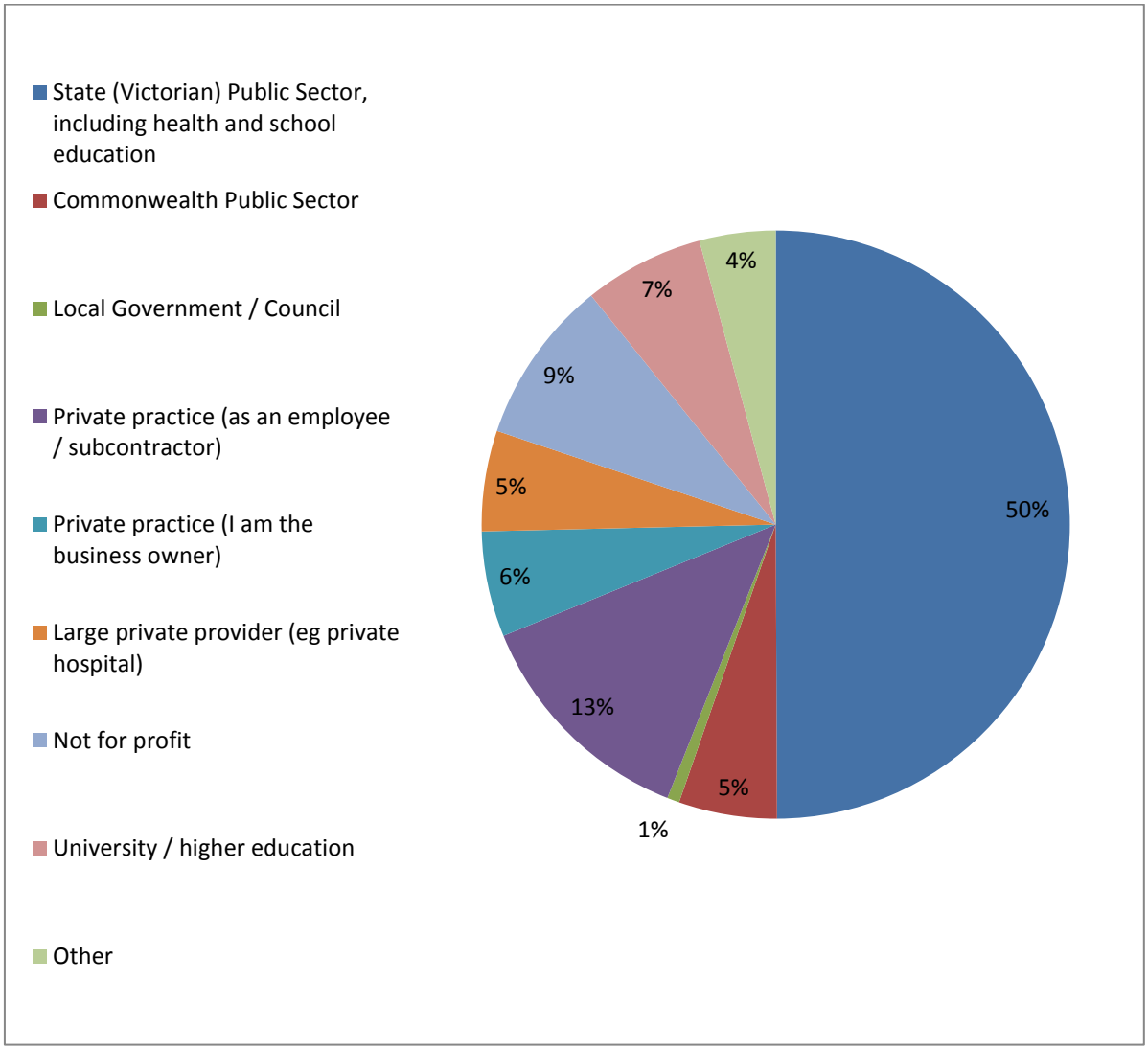


Sector

Half of all respondents (50%) reported that their main employment sector was the Victorian public sector. Private practice, both as employers and employees, accounted for 19% of respondents, the NFP sector 9%, and 7% of respondents were from universities / higher education (Figure 6). It is likely that the AHWQ2 respondent cohort included an over-representation of individuals working in the state public sector due to a greater capacity to distribute the AHWQ2 survey to employees within this sector.

In contrast, AIHW 2015 data showed that 28% of psychologists were working in the public sector whereas 51% were employed in the private sector (based on ratios of full time equivalent numbers).

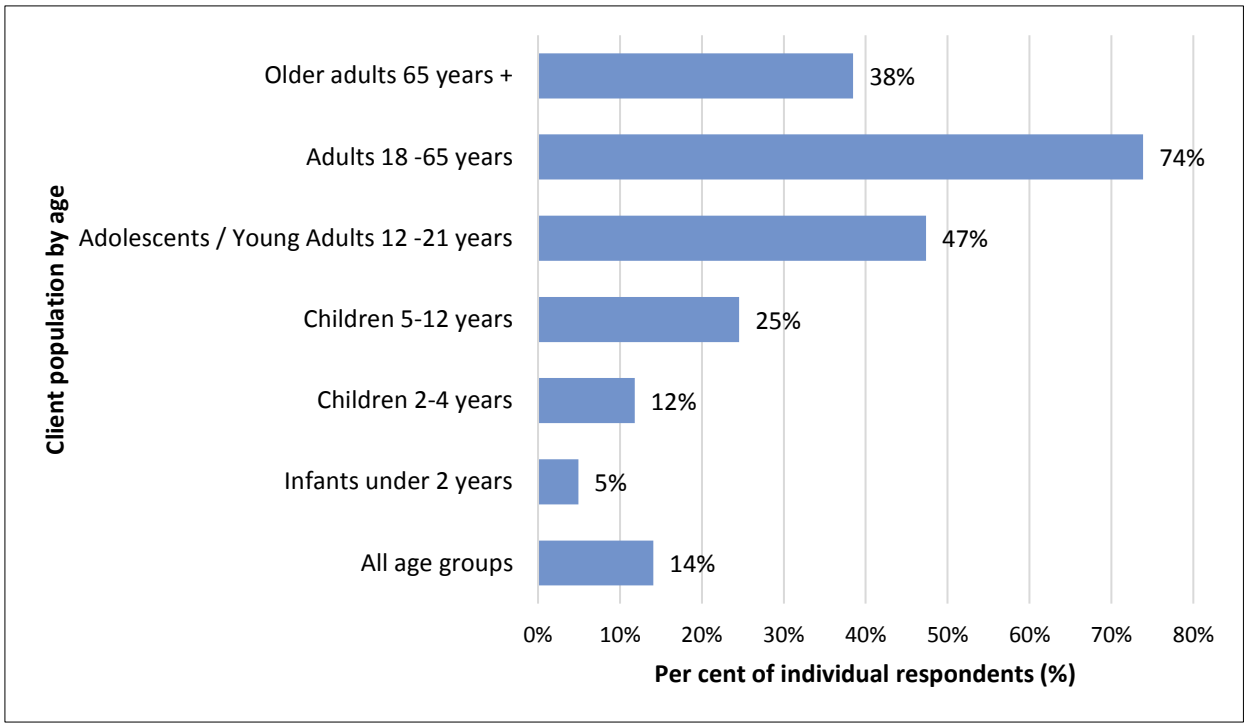
Figure 6: Employment sector of current main employer (n=741)



Clients

Psychologists' main client groups were adults (74%) and older adults (38%). Over one third of psychologists (37%) reported working with pre-school or primary school aged children while nearly half (47%) worked with adolescents (Figure 7).

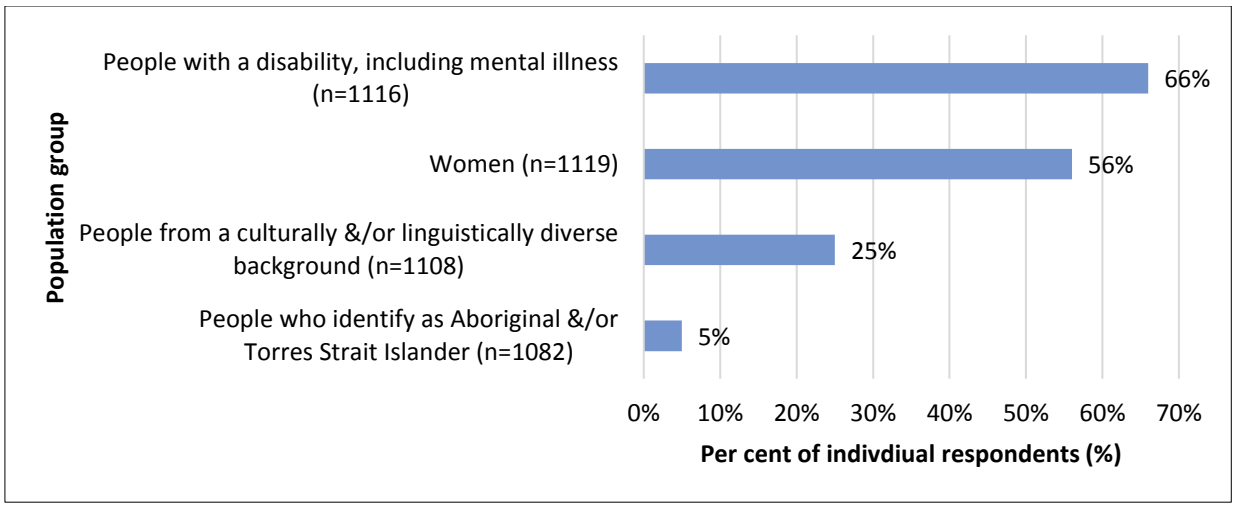
Figure 7: Clients by age (n=1,136) [a]



[a] *Respondents could select more than one response.*

In terms of specific population groups, psychologists reported that around 66% of their caseload comprised clients with a disability, including mental illness, and around 56% of their clients were women (Figure 8). Clients from culturally and linguistically diverse backgrounds made up, on average, 25% of the client load, while Aboriginal and Torres Strait Islander clients comprised approximately 5% of the client caseload.

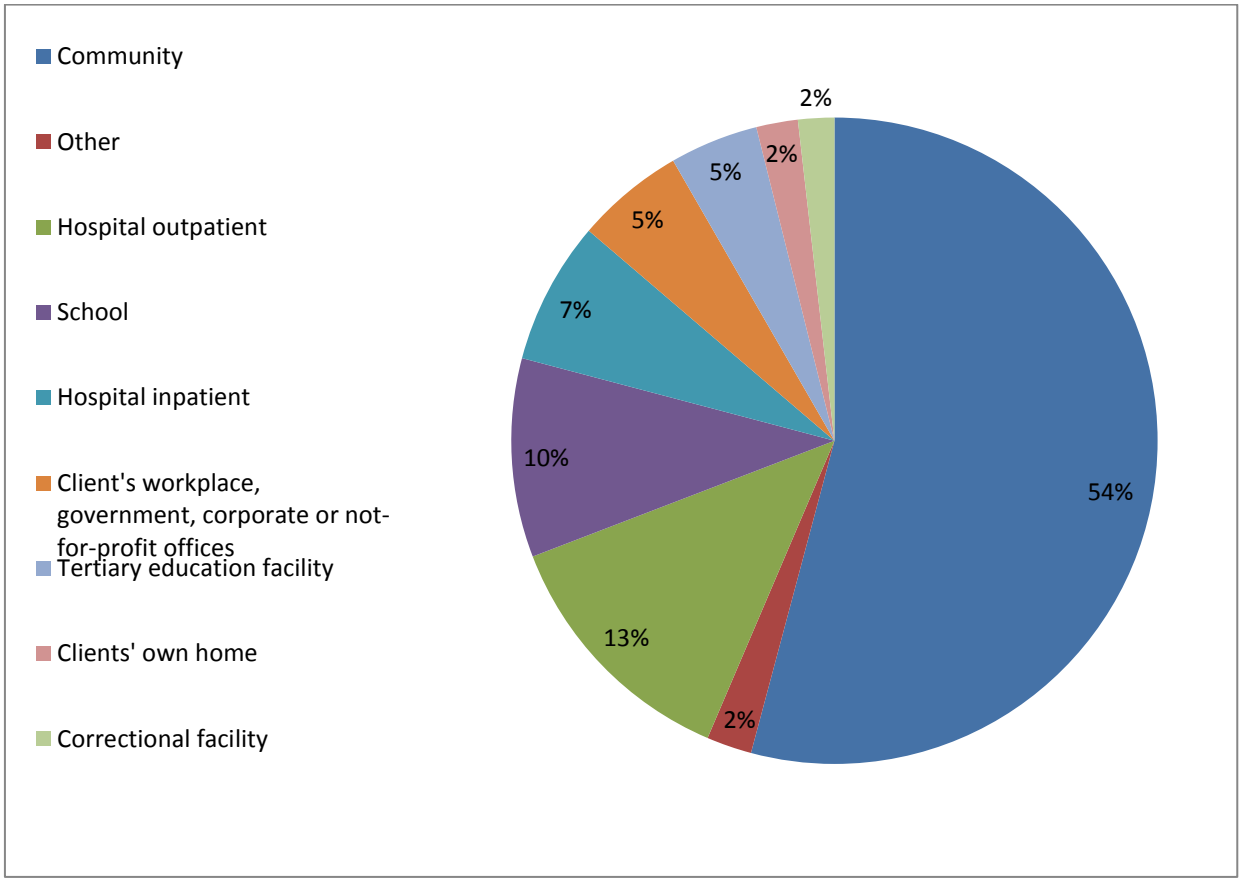
Figure 8: Average per cent of population groups represented within caseload



Settings

The community was the most common primary setting of employment for psychologists (54%), with hospital outpatient facilities (13%) and schools (10%) the next most prevalent location (Figure 9). Hospital inpatient (7%), office and workplace settings (5%) and universities (5%) comprised a relatively small proportion of the locations where services were delivered.

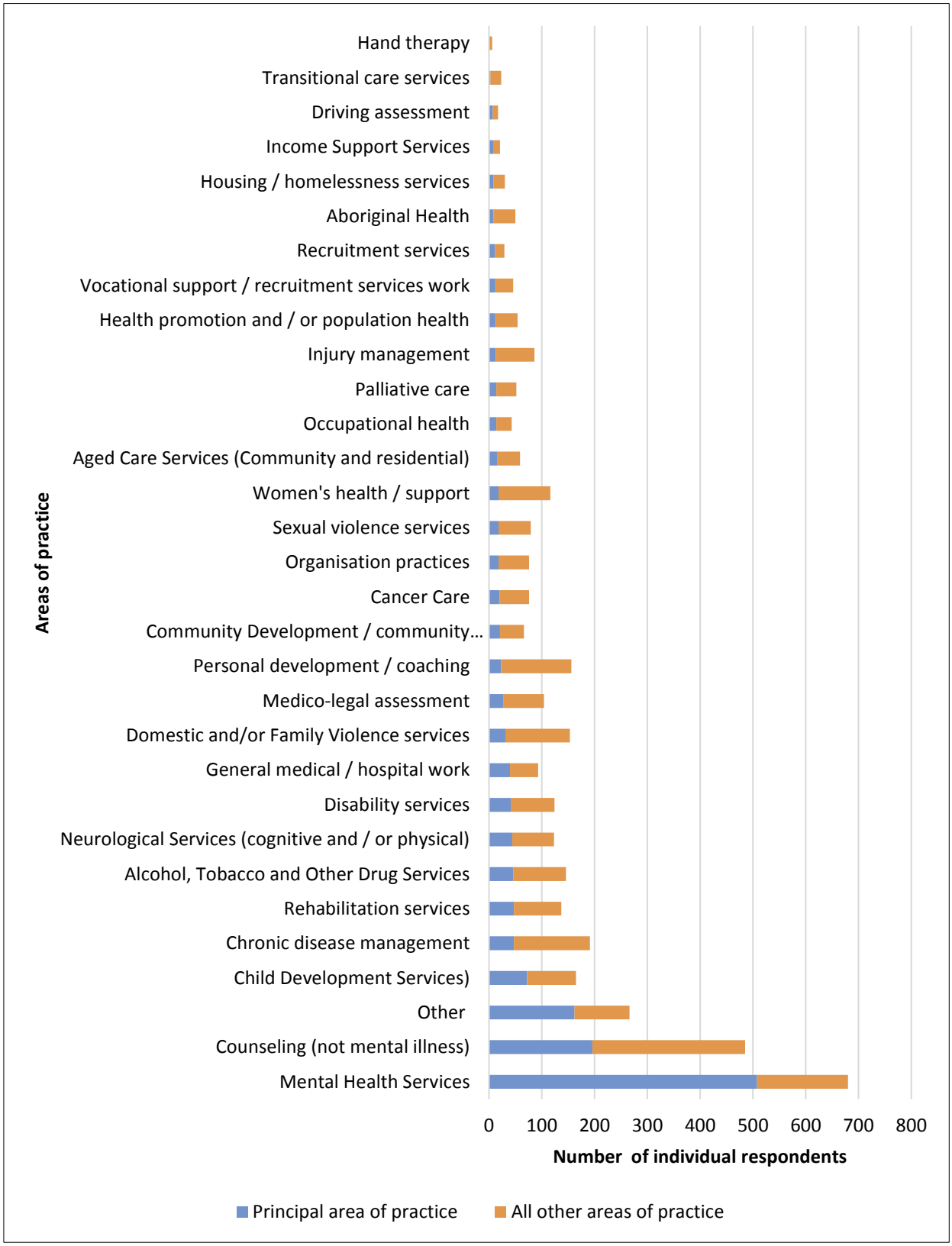
Figure 9.Setting for service delivery of current main employer (n=1,106)



Area of practice

Mental health services, counselling and 'other' were the most common areas of practice (Figure 10). Many items coded as 'others' were actually settings (such as education (n=40) and private practice (n=21)) or other types of roles (e.g. supervision). Areas of practice not otherwise listed included forensic psychology (n=10), fertility (n=3), relationships and relationship counselling, trauma (n=10) and pain management. (See Appendix Table 3 for detailed numbers of respondents per area of practice). Please note per cent is not able to be provided in Figure 10 due respondents providing more than one answer to 'primary area of practice'.

Figure 10: Areas of practice [a]



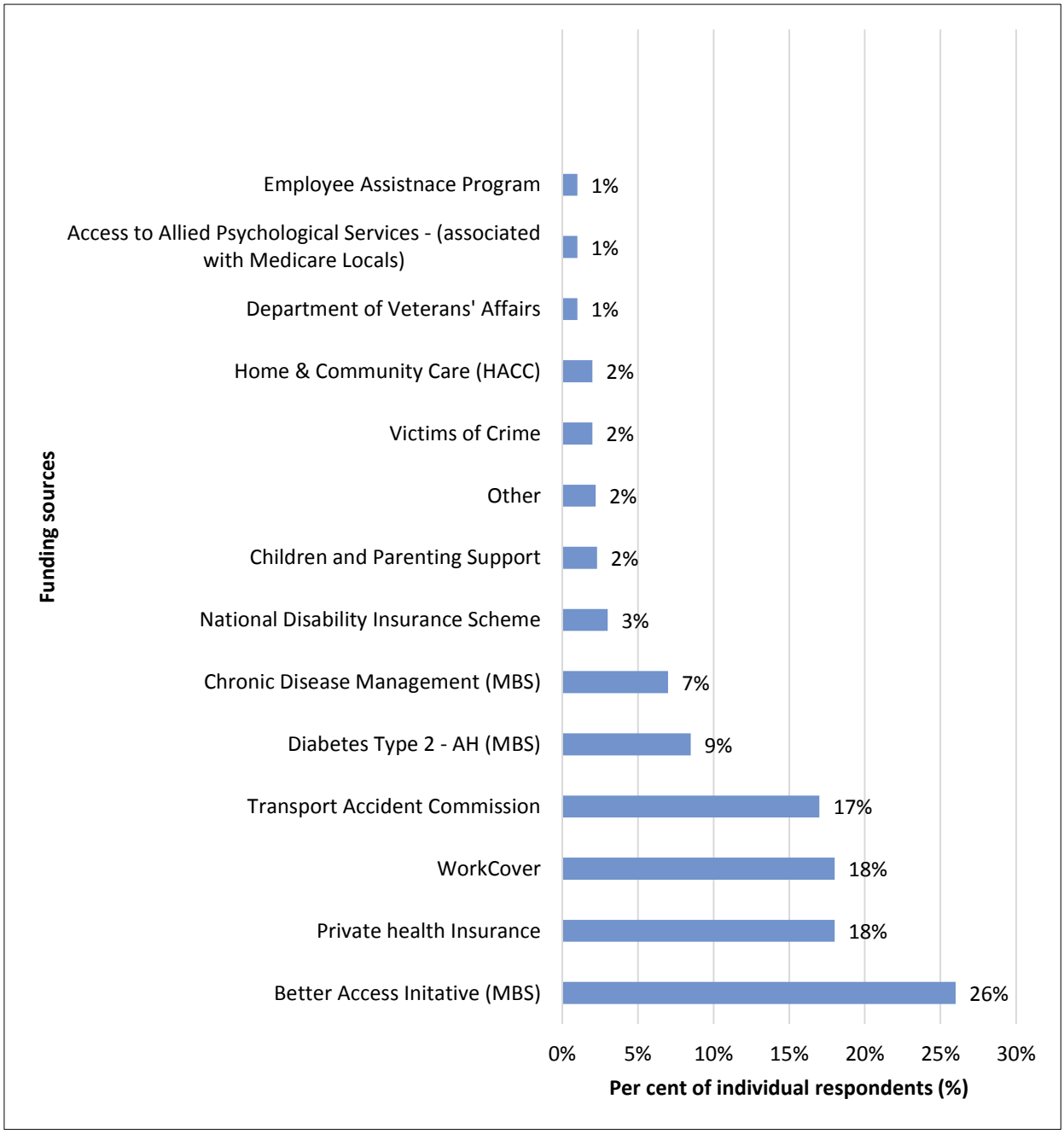
[a] *Respondents could select more than one response.*

Funding sources

Funding options for accessing psychology services have increased over recent years through a range of initiatives aimed at responding to demand for mental health services. These options include the availability of Medicare (Medicare Benefits Scheme (MBS)) benefits for a range of psychology services for people with specific conditions referred by a general practitioner. These conditions include people who have an assessed mental disorder, and people who have a chronic medical condition with complex care needs (HWA 2014a).

The most commonly accessed funding models were the MBS Better Access Initiative (26%), followed by private health insurance (18%), WorkCover (18%) and the Transport Accident Commission (17%) (Figure 11).

Figure 11: Per cent of respondents providing services funded by specific packages (n=701) [a]



[a] *Respondents could select more than one response.*

A number of survey respondents expressed dissatisfaction with the limit of 10 appointments per calendar year under the MBS Better Access Initiative. Specifically, the limit of 10 appointments was seen as insufficient for clients with complex needs, but also restricted access to services for low income clients if they required ongoing appointments.

"Under Better Access, psychologists, social workers and occupational therapists can offer only a limited number of sessions per year, often not adequate for clients with complex presentations."

"Better access to psychological services for those in high need but with restricted access to funds. Ten sessions per year under the Better Access Initiative is not enough for the majority of our clients and there's a big gap between high need, high resources clients (who are eligible for public health services) and those who are struggling but not bad enough to get into public health. It's ridiculous that we have nowhere for those people to go until they get so bad they need hospitalisation."

Demand

It was not possible to quantify the demand for psychology services from the organisational and individual survey data. However, respondents provided several anecdotal indicators of demand, such as waiting lists, client waiting times, ability to meet the psychological needs of clients with specific issues, and the need to do unpaid work to respond to client needs.

The Australian Government, Department of Employment's *Job Outlook* initiative provides data on employment characteristics, trends and prospects for some occupations. Data from this initiative shows that psychology is expected to experience very high employment growth in the years to 2022. (Australian Government, 2017) (Table 6).

The *Job Outlook* data provides an analysis of future job prospects using national statistics on job openings and employment. According to *Job Outlook*:

- Over the seven years to May 2022, the number of job openings for psychologists are expected to be above average nationally (around 24,000). Job openings count both employment growth and turnover (defined as workers leaving their occupation for other employment or leaving the workforce).
- Employment for psychologists rose strongly (in per cent terms) in the past five years and rose very strongly in the long-term (ten years).
- Looking forward, employment for psychology to 2022 is expected to grow very strongly compared to other occupations (Australian Government, 2017).

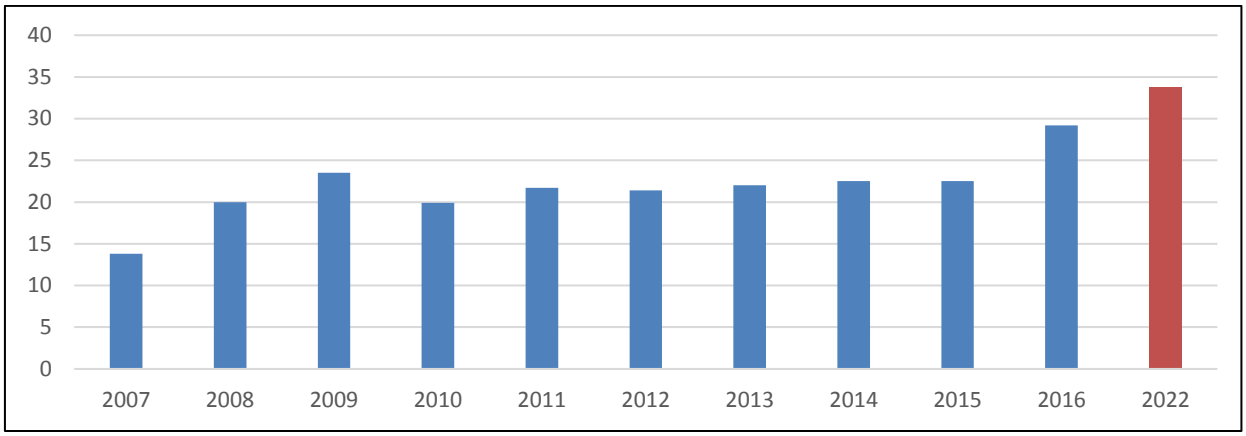
Table 6: Employment growth for psychologists (nationally)

Key indicators	n
Workers employed as psychologist	29,200
Unemployment compared to other occupations	Below average
Long term employment growth – 10 years (%)	111.6
Medium term employment growth – 5 years (%)	34.6
Likely future employment growth – 5 years	Very strong
Level of future job openings	Above average

Source: Australian Government, 2017, Job Outlook for psychology

Figure 12 shows the past, current and projected employment levels of psychologists nationally. It indicates solid growth over 15 years, with a more than doubling of psychology employment during that time.

Figure 12: National psychology employment levels 2007-2022 (thousands)



Source: ABS Labour Force Survey, Department of Employment trend data to December 2016 and Department of Employment projections to 2022.

Supply

There are a number of factors that interact with and influence the supply of psychologists. These include the size of the psychology workforce, the number of graduating psychologists, the profession's age and gender profile, employment grades, remoteness, remuneration, and local approaches to recruitment.

Psychology workforce

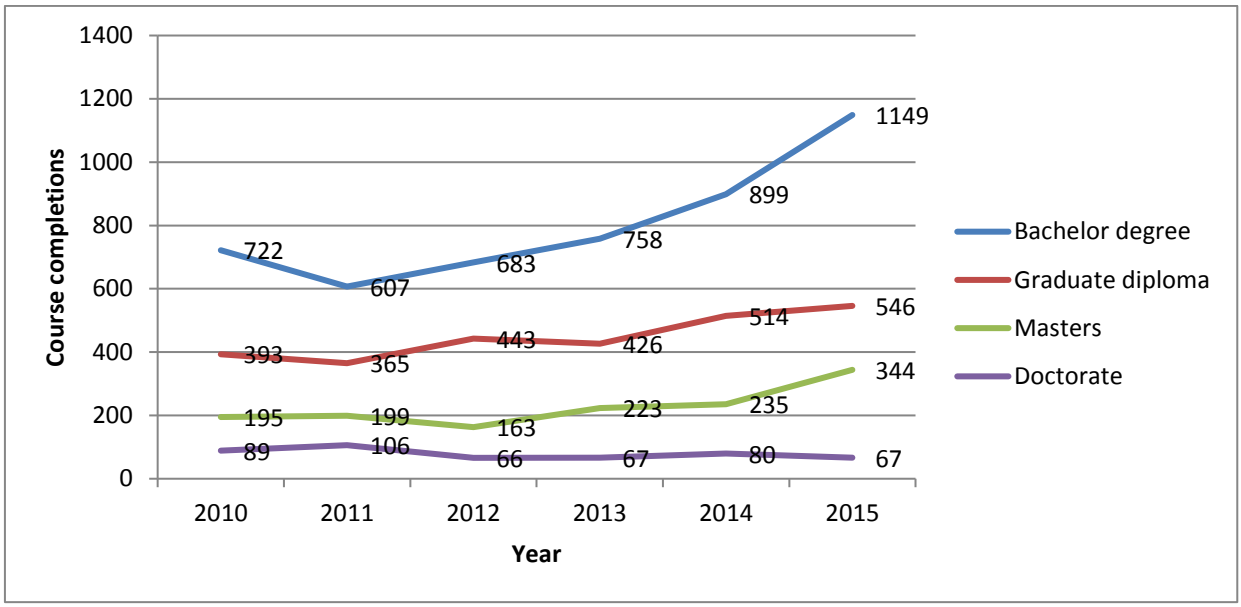
In December 2016, there were 9,218 psychologists registered in Victoria, this included 7,669 general, 1,166 provisional and 383 non-practising (PBA, 2017).

Student completions

Since 2010, the number of students completing an undergraduate (bachelor) degree in psychology has increased by approximately 100%, or around 600 students. This may be a direct response to the deregulation (uncapping) of undergraduate university places in Australia beginning in 2010. At the same time, the number of students completing the graduate diploma and master's degrees in psychology has increased by 43% and 28% respectively. The number of students enrolled in a doctoral program has declined over the same period, from a peak of 101 students in 2011, to 69 students enrolled in 2015 (Figure 13) (unpublished data, Department of Education and Training[5]).

[5] The Department of Education and Training (DET) conducts the Higher Education Statistics Collection, which provides information on the number of student commencements and completions in higher education courses. While DET data does not identify those courses that lead to professional-entry for most disciplines, using information supplied by DET (in a particular field of education and course name), the Victorian Department of Health and Human Services has estimated the number of domestic students commencing and completing professional-entry courses for selected disciplines. Given this is an estimate; caution should be used in interpreting these data.

Figure 13: Victoria university domestic course completions 2010 – 2015



Source: Department of Education and Training

Workforce supply / job shortages

One hundred and thirty (130) employers of psychologists responded to the open ended question in the survey *Do you have any quantifiable evidence of workforce shortages for psychologists?* Of these, 37 respondents stated that they had no evidence of workforce shortages; however 90 respondents indicated there was evidence of unmet service need due to a lack of funded psychology positions, rather than a shortage of psychologists.

Responses to this question included:

- Long waiting times for services (from one month to 12 months)
- Long waiting lists of clients requiring psychology services
- Unable to fill a psychology position in a low socio-economic area
- Demand for specific services which cannot be provided (e.g. memory and outpatient clinics)
- Psychologists unable to review reports / long backlog of reviews
- Services using stringent referral criteria to manage waitlists, reducing access to people who may benefit from the services
- Psychologists feeling overworked
- Clients having to travel long distances to access services

"The shortage of psychologists is mainly due to limited EFT [equivalent full time] provided by the service (noting it is a large area mental health service). Despite years of discussions with the service, psychology roles have remained limited. The EFT and role in the service does not even cover the bare minimum and fails to address service needs."

"We have a three month wait-time for OP [out-patient] neuropsychology services. There is substantial unmet demand."

"Waiting times are up to six months. There are only two psychologists on our team with expertise in formal psychological assessment of trauma and personality, which means a wait time for these services as well as more general therapy services."

The education system, specifically the state school system was identified as a specific area of shortage.

Individual psychologists were asked to describe the impact and consequences of shortages in workforce numbers. Their responses included:

- Lack of access to services for clients
- Inability to engage clients in the type of therapy needed to treat them
- Impact on the quality of services, and an inability to provide 'meaningful therapeutic intervention'
- Increasing pressure on the psychologists who currently provide services
- Fewer psychologists providing bulk-billing services, which further reduces service accessibility
- Difficulty discharging clients, leading to increased length of stay
- Recruiting people from other disciplines such as nursing and social work to provide mental health services

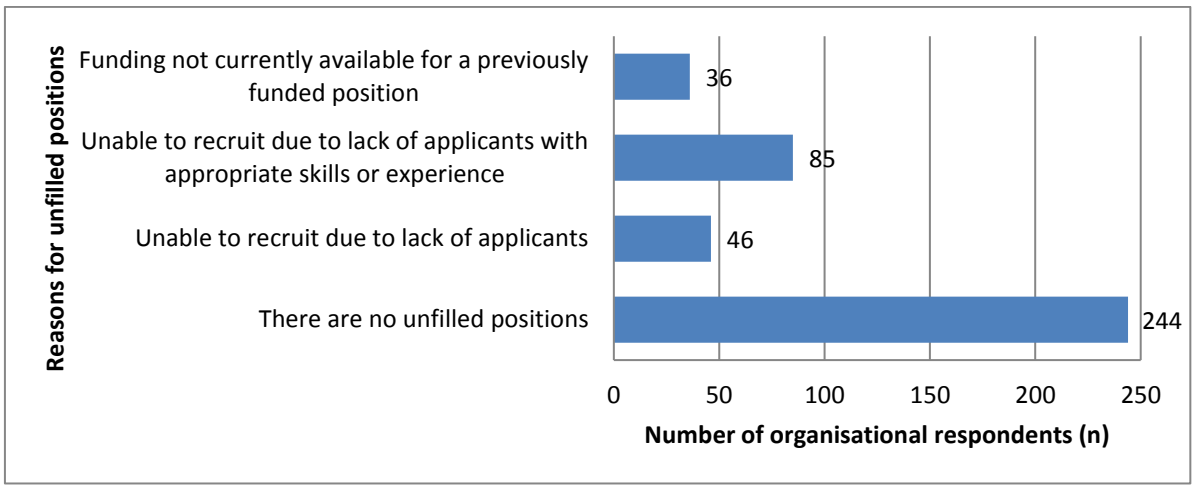
The lower rebate doesn't cover the cost of doing business. When you work in a low socio economic area the clients can't afford to pay a gap fee. The psych's getting the higher rebate are picking and choosing where they work and it isn't with low socio-economic people.

We hire people with other qualifications, we train people up and we provide additional support to them but this means more complex presentations may not be offered the optimum treatment experience and opportunities are lost.

Unfilled positions

Less than half of the organisational respondents reported having any unfilled positions. Of those with shortages, only 12% reported an inability to recruit due to a lack of applicants. The main reasons for unfilled positions included lack of funding for previously filled positions (14%) and lack of applicants with appropriate skills (30%) (Figure 14).

Figure 14: Reasons for unfilled positions (n=411) [a]



[a] *Respondents could select more than one response.*

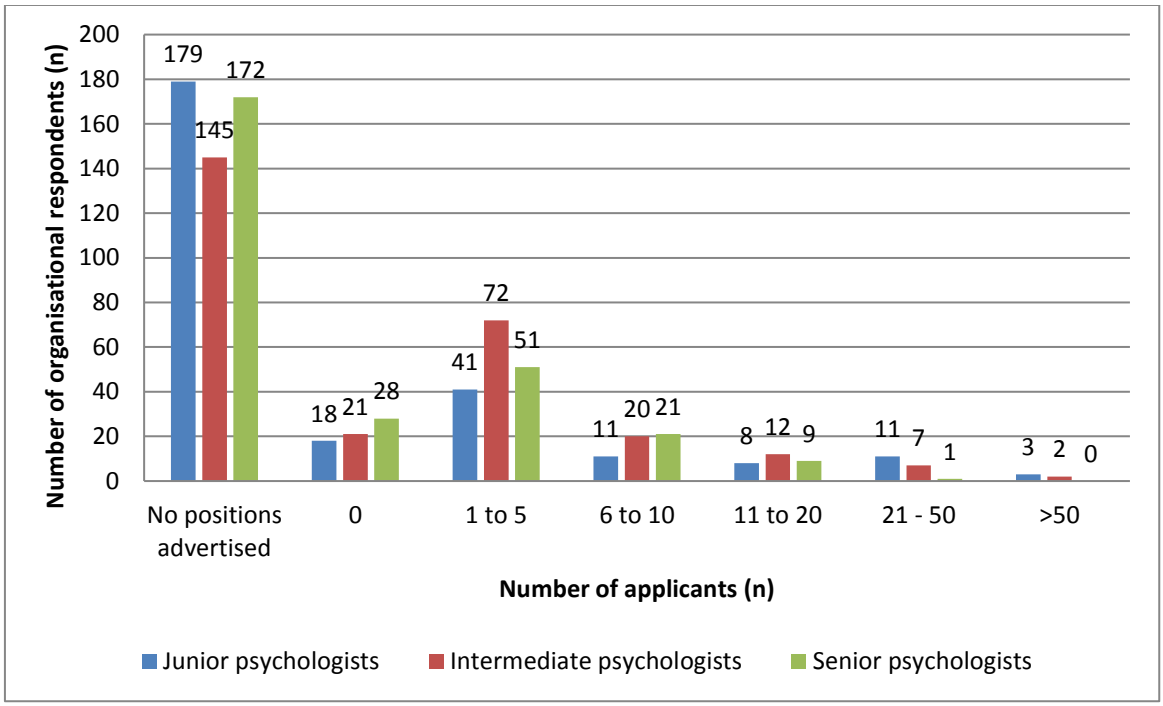
Recruitment

Number of applicants

Organisational respondents were asked to report on the number of applications they received for positions advertised within the previous 12 months. The majority of respondents reported they had not

advertised any positions. Of the organisations that had advertised positions, the number of applicants was relatively modest, with most organisations receiving fewer than five applications for positions advertised across all grades. The largest numbers of applications were reported for intermediate grade positions (Figure 15).

Figure 15: Number of applications for positions advertised in the past year by grade [a]

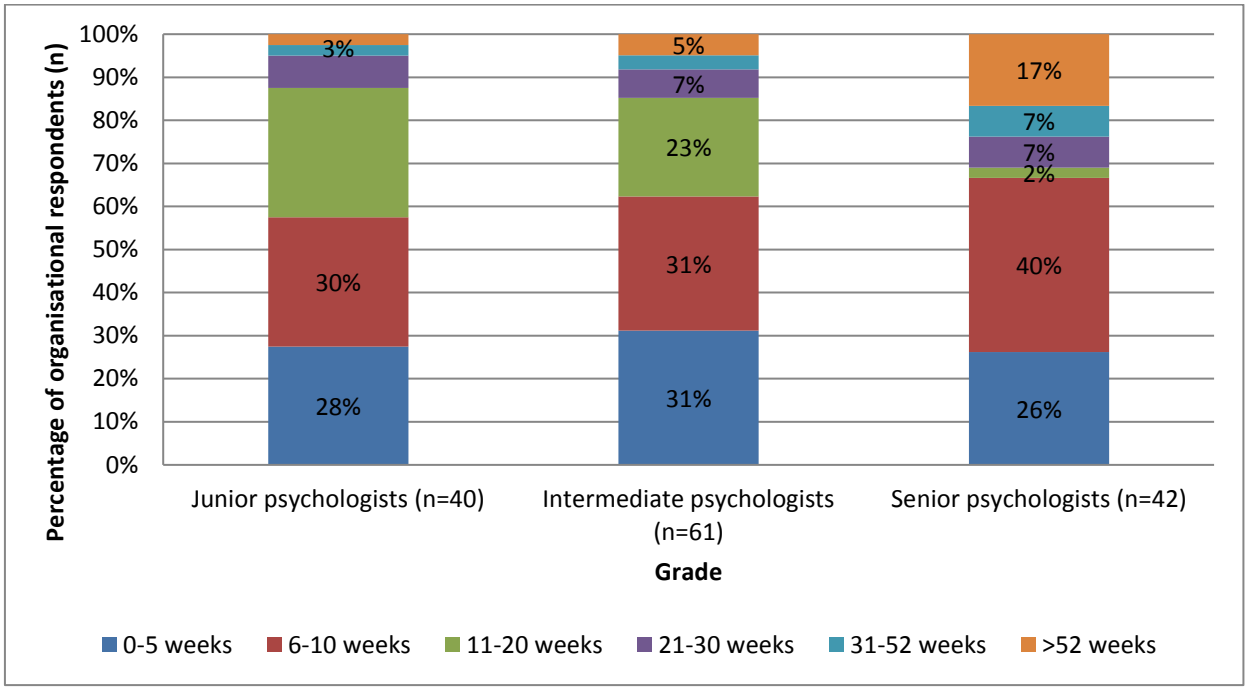


[a] *Respondents could select more than one response.*

Time to recruit

There was little evidence of difficulty recruiting psychologists. Less than half of all services reported having any vacancies for psychologists in the preceding 12 months, and of those that did, the majority were able to recruit within 10 weeks. Intermediate grades were more likely to have vacancies than senior or junior grades, but the time to recruitment was still relatively short (Figure 16).

Figure 16: Time to fill vacancies [a]



[a] *Although 120 organisational representatives responded to this question, data is only included for organisations that indicated they had vacancies in the prior 12 months.*

Respondents were asked to identify barriers to recruitment. There was a mixed response to this question, 37 organisational respondents specifically said that they experienced no barriers to recruitment.

"No, there is very strong competition for positions (limited openings due to long term retention of current staff) in my organisation."

However, 90 other organisational respondents identified barriers to recruitment which included:

- Pay inequities across sectors, making some jobs uncompetitive compared to others
- Unattractive pay in the public sector compared to the private sector
- Pay and grading offered inappropriate for the level of work required
- Remoteness of location (regional / rural areas)
- Less desirable / accessible suburbs more difficult to recruit
- Employment of psychologists in generic roles (e.g. mental health and case management)
- Lack of career pathways
- Difficulty attracting staff to specialised areas

"In our service, employment of psychologists in non-specific roles such as full-time mental health case-management is a significant barrier to recruitment and retention. Psychologists who have been trained for specific mental health interventions are unable to utilise their skills under case-management roles. Community mental health structure is a failure when psychologists are not integrated into care; care remains limited to medication treatment and community follow-up of patients within the case-management role. This issue continues despite significant evidence-base on good effect of medication and psychological therapy on mental illness, including severe mental illness."

"Salaries are not sufficiently high in NFP to encourage long term employment for young psychologists. Most work for a few years and then move to private practice."

"Positions being advertised at a lower grade than the reality of the required clinical work."

"Educational psychology doesn't seem to be a desirable area of clinical practice for many psychologists."

"Rural location often necessitates relocation."

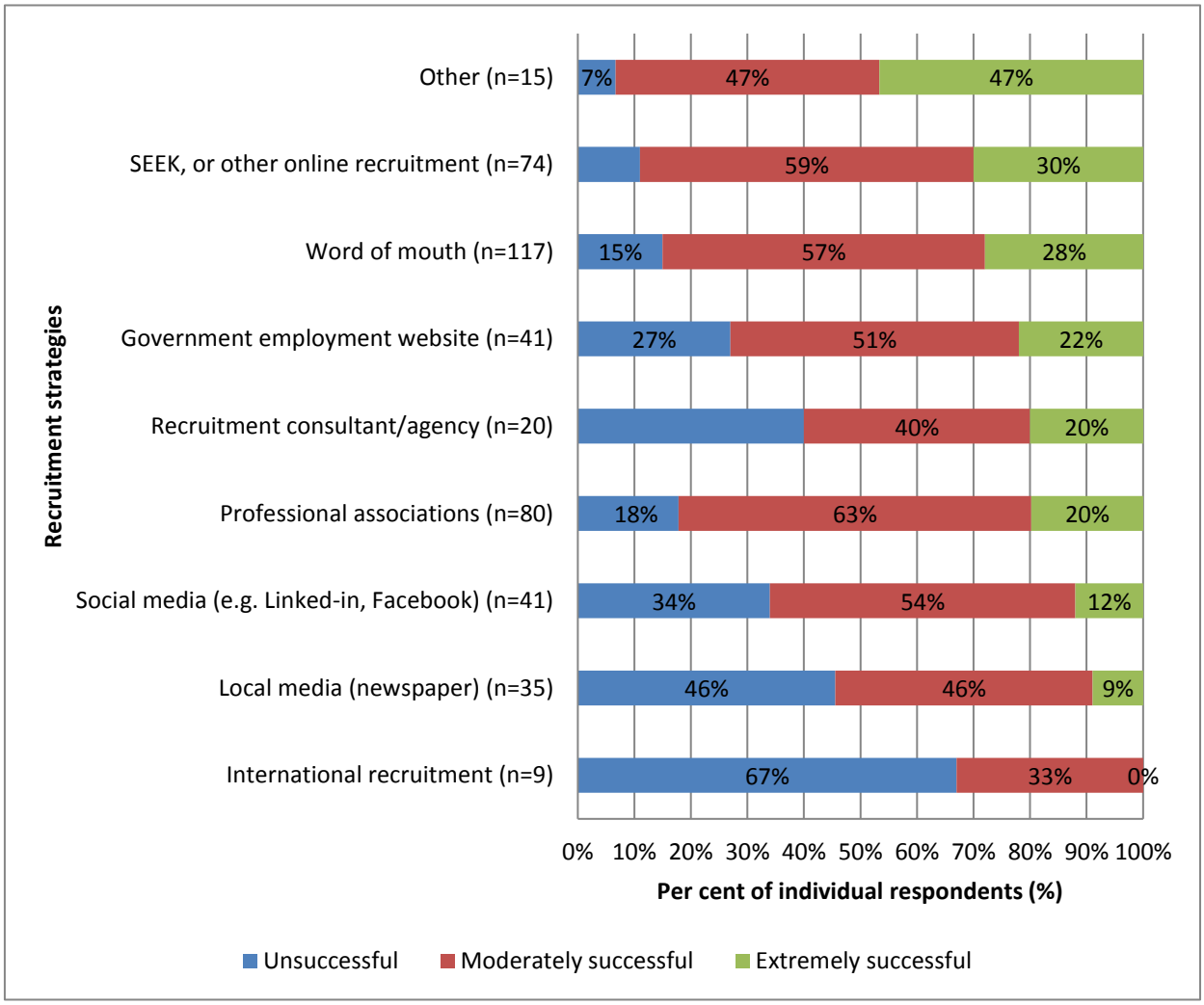
"Our entry level is grade 2 with 4 years' experience. Most master's and D Psychs [doctoral level graduates] are not interested as they seem to feel that they should enter our particularly specialised field direct from graduating."

"Ours is a specialised field: sexual abuse trauma of children; it has a high VT [victim therapy] rate and requires significant skills in reflective practice, not to mention developmental psychology, counselling psychology, forensic psychology and clinical psychology."

Recruitment strategies

Organisations reported using a range of different strategies to recruit. The most effective strategies were word of mouth, professional associations and the SEEK employment website (Figure 17).

Figure 17: Relative success of strategies used to recruit psychologists (n=140)



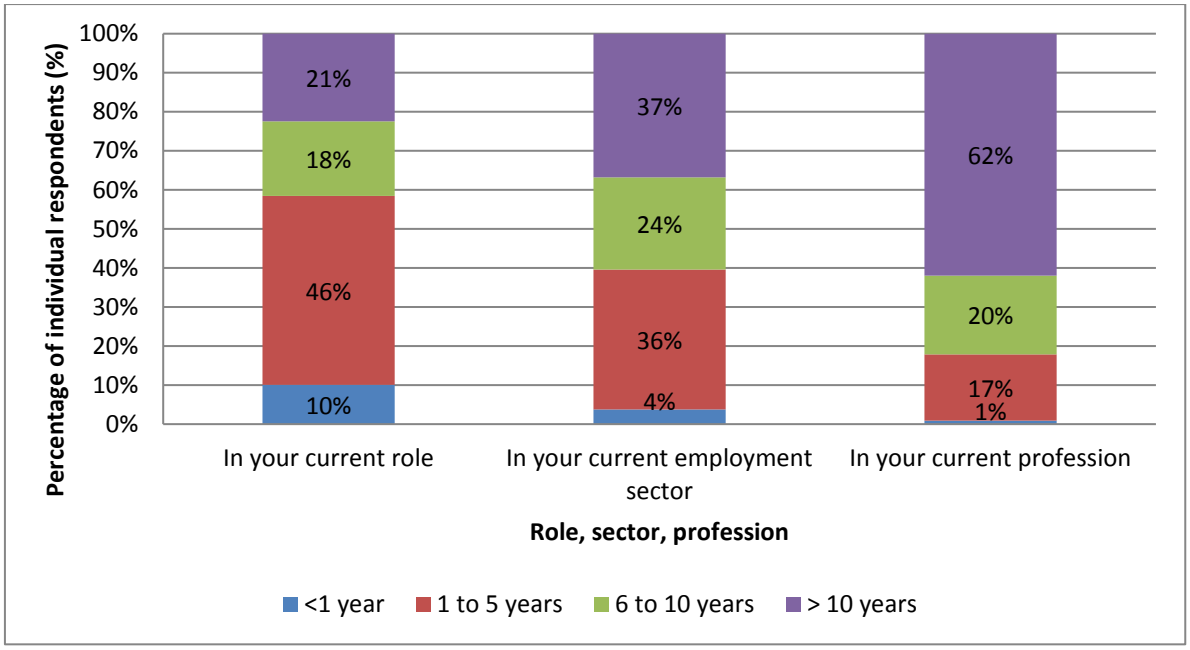
[a] *Although 140 organisations responded to this question, for each recruitment strategy data is presented based on the number of organisations that reported that they used the strategy. For some strategies, such as international recruitment, a high proportion of respondents indicated they 'do not use' the strategy.*

Retention

Psychology respondents to the AHWQ2 were asked about their intention to remain in their current work situation, 10% indicated an intention to remain in their current role for less than one year; 4% indicated an intention to remain in their current sector for less than one year; and 1% indicated an intention to remain in their current profession for less than one year. Although these results suggested a degree of intended mobility in the roles respondents were employed in, the proportion that indicated an intention to leave the profession in the short term was very low (Figure 18).

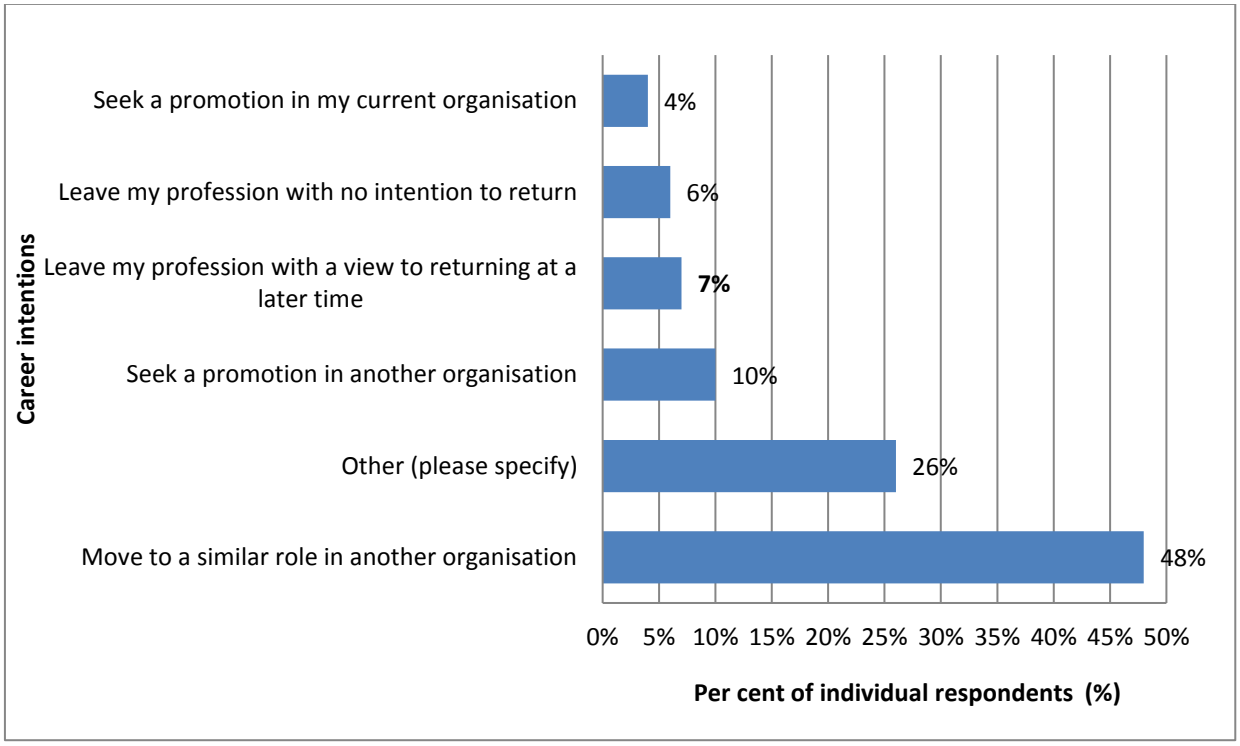
The retention rate across the profession is relatively high, with only 18% of respondents stating that they intend to change their profession in the next five years; however there is a high degree of movement across employers and sectors. Forty per cent (40%) of psychologists proposed to change their employment sector within the next five years and 56% planned to change their role.

Figure 18: Intention to stay in current role, sector and profession (n=1,073)



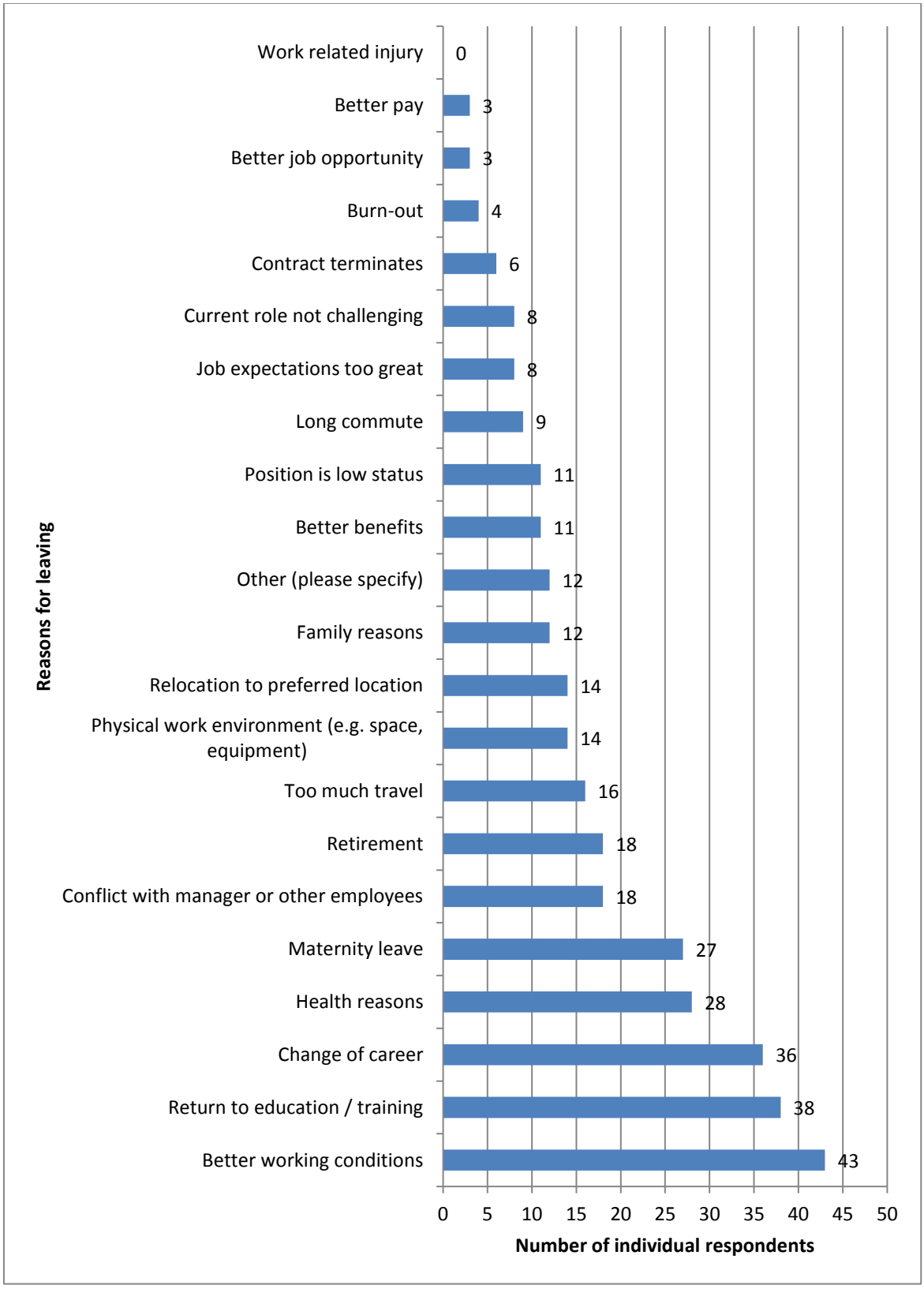
Of those who intended to change their career within the next twelve months (n=105), the majority proposed to move into a similar role in another organisation (n=50) (Figure 19).

Figure 19: Career intentions of respondents indicating an intention to stay in their current role for 12 months or less (n=105)



Respondents were asked to identify the main reason for changing roles within the next 12 months. The most prevalent reason was to achieve better working conditions (n=43), other reasons were better job opportunities (n=38), better pay (n=36) and because of burn-out (n=28) (Figure 20).

Figure 20: Reason for leaving (for respondents intending to change roles within 12 months) (n=105) [a]



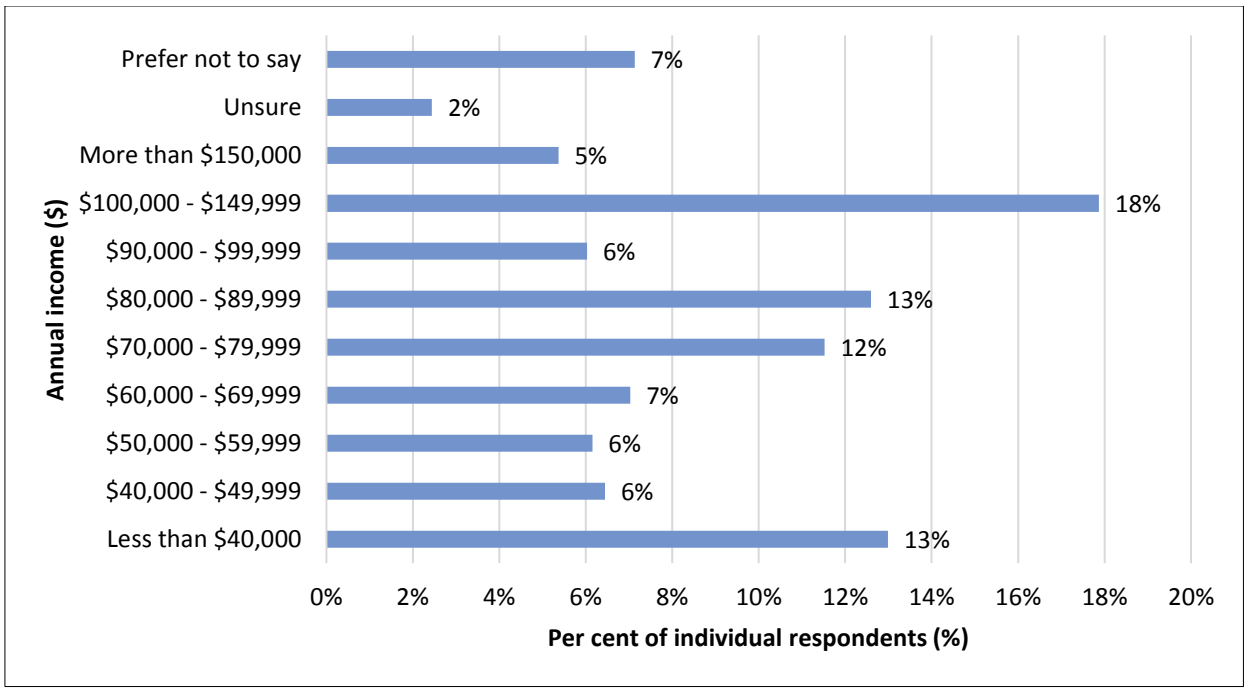
[a] *Respondents could select more than one response.*

Organisation of the workforce

Pay level

The median annual income before tax for psychologists responding to the AHWQ2 was between $70,000 and $79,999, although the largest proportion of respondents reported earnings of between $100,000 and $149,999 last year (Figure 21).

Figure 21: Total annual income last year, before tax (n=1,024)



Pay was an important issue for psychologists with perceptions of pay inequity between sectors and disciplines which were highlighted in the qualitative data.

"We need better financial remuneration for psychological services. The gap between current charged rates of psychological services and those provided by general practitioners (GP) and psychiatrists is substantial."

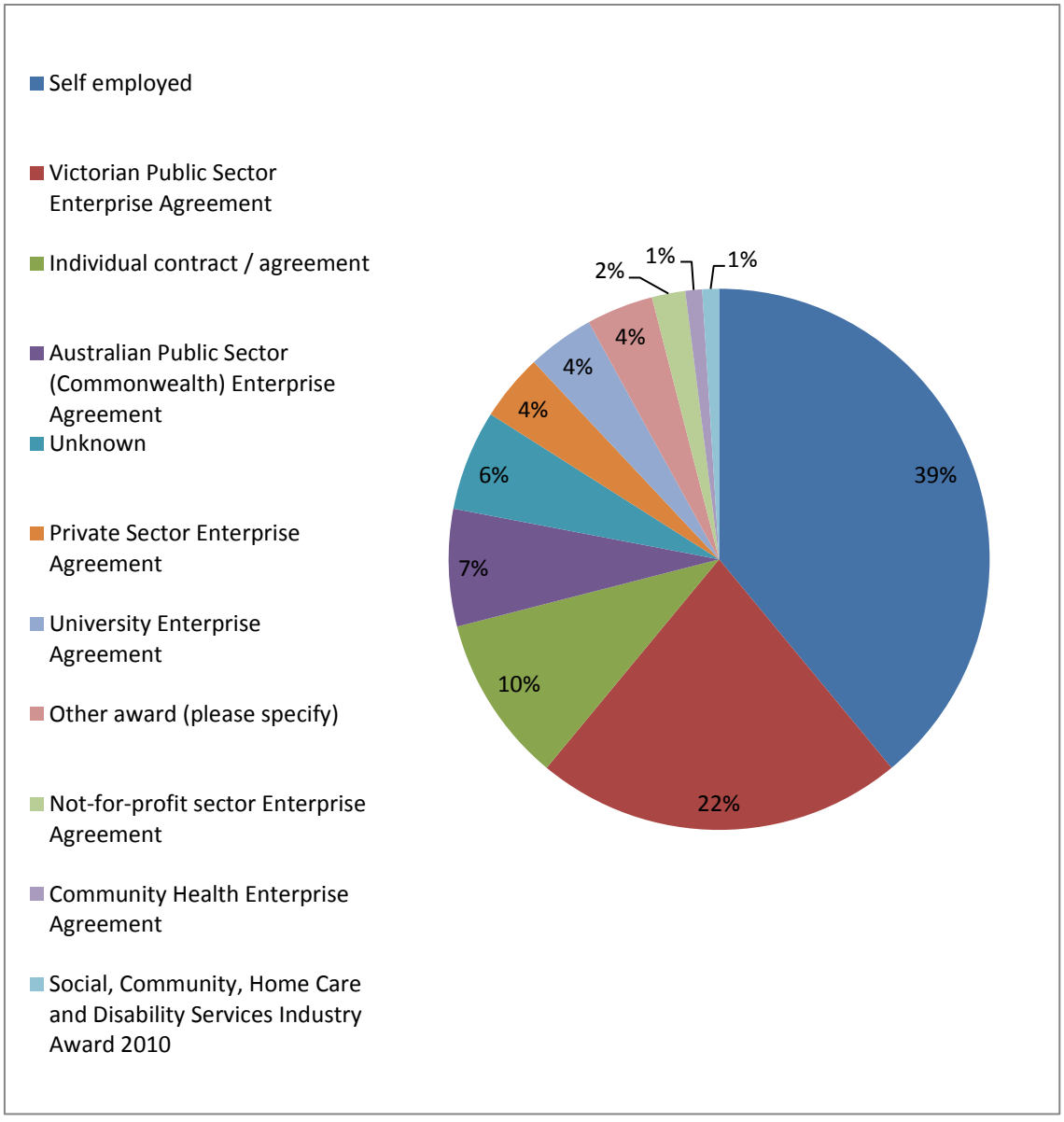
The pay differential between clinical and general psychologists was a particular issue.

"Closure of the gap in pay between clinical and general psychologists working in the private sector."

Awards

The largest per cent of participants were self-employed (39%), with a further 10% employed under an individual contract or agreement. Only 22% were employed under the Victorian Public Sector Enterprise Agreement, despite this being the most common workplace setting (Figure 22).

Figure 22: Current award or employment agreement (n=1,089)



Employment grade / level

Of those respondents who were employed on an award, 47% were employed at grade 3 or below, with grade 2 (26%) being the most common level (Figure 23). Forty six (46) respondents were on academic grades, the majority of these were Level B academics (Figure 24).

Figure 23: Current grade (non-academic) (n=493)

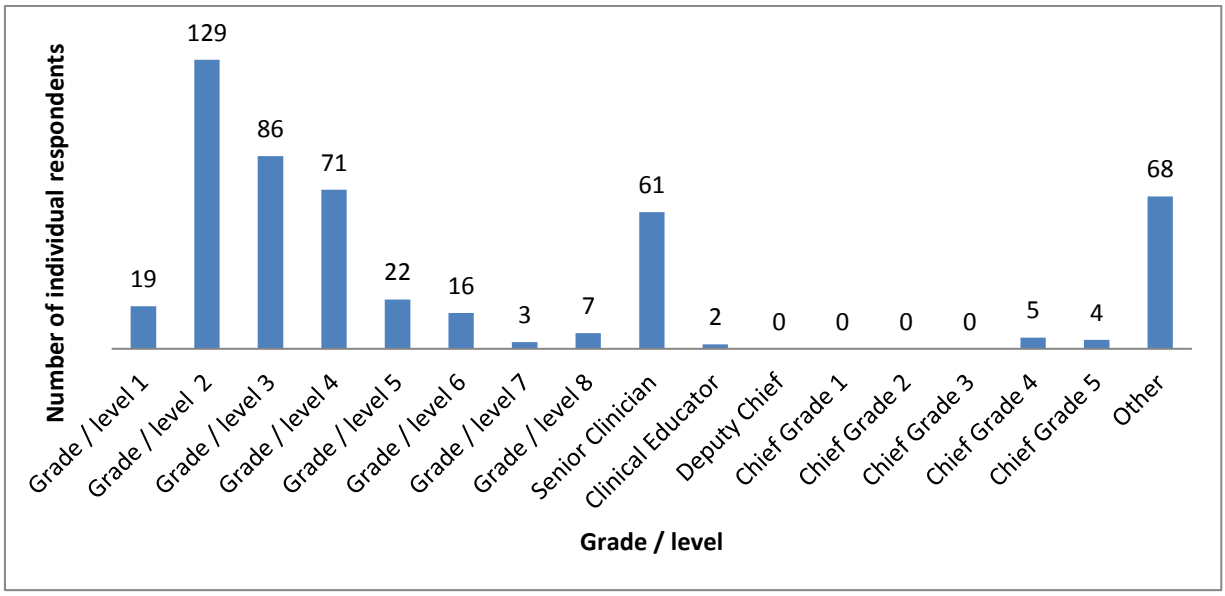
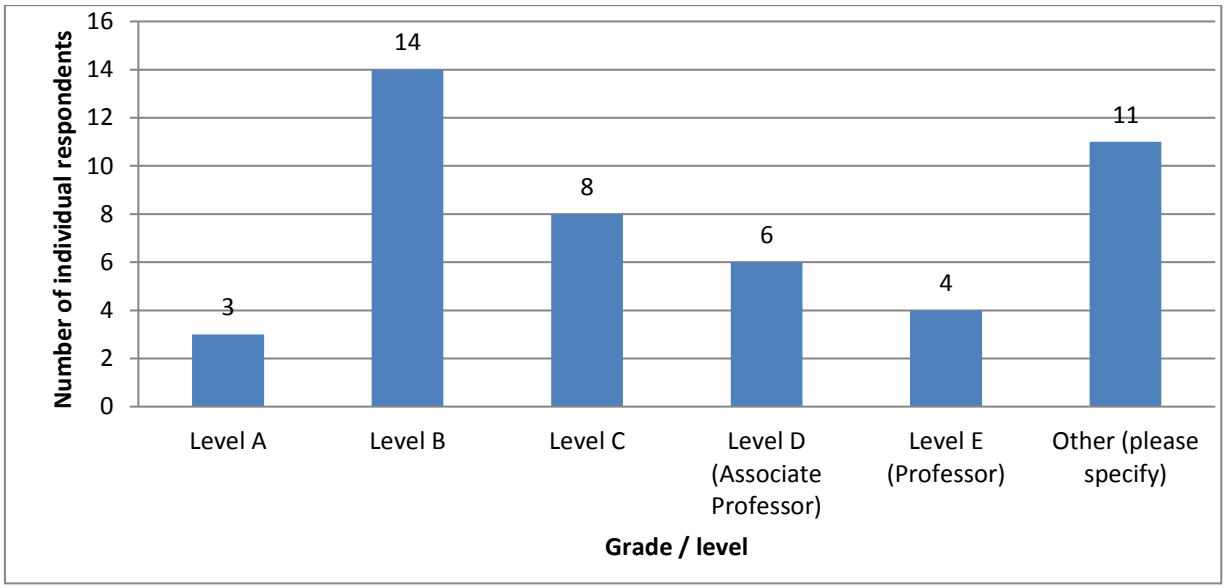


Figure 24: Current grade (academic) (n=46)



Psychologists in the higher education sector (n=46) reported the highest salaries, with more than half of all respondents reporting a total annual income in excess of $100,000. Private practice business owners (n=39) were the second most likely to report an income of above $100,000.

Employment status

The majority of psychologists responding indicated they were currently employed in a permanent role (66%, n=492), however it should be noted that only 60% of potential respondents answered this question (Table 7).

Table 7: Nature of employment with current main employer (n=741)

Employment status	%	Count
Permanent	66	492
Temporary	3	23
Self-employed	7	51
Contract	20	145
Voluntary	1	4
Casual	2	15
Other	1	11
Total	**100**	**741**

Number of employers

The majority of respondents were either fully self-employed or worked for a single employer (78%, n=875). Of the remaining 22%, the majority worked for two employers with a small number (50) working for three or more employers. (Table 8)

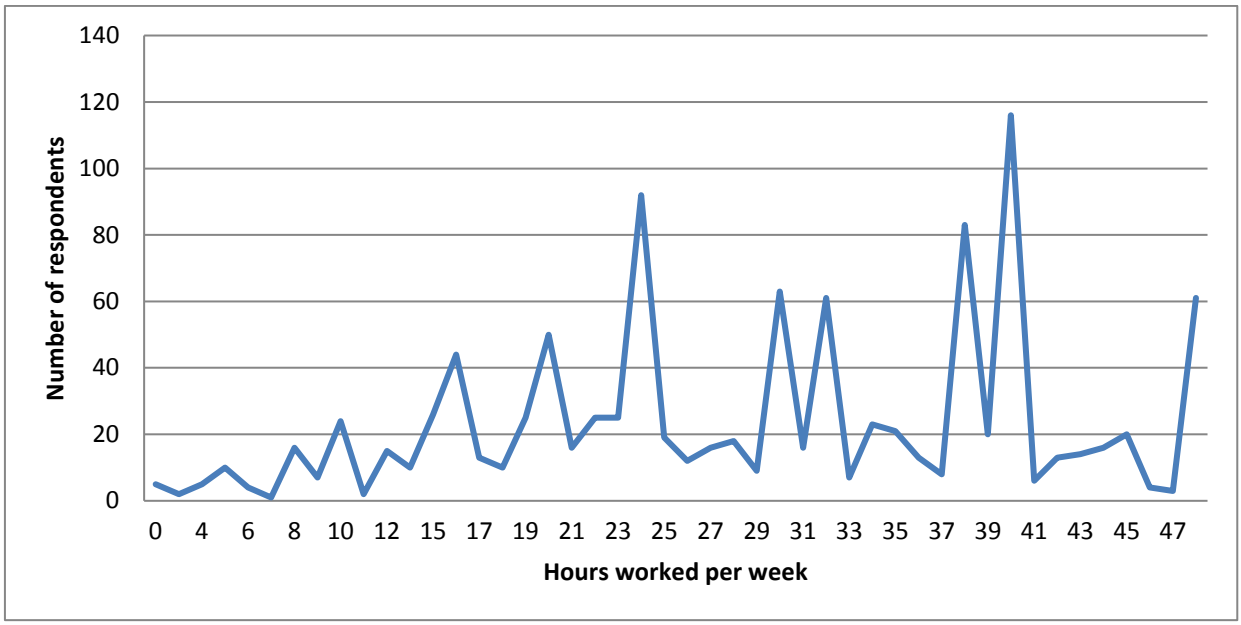
Table 8: Current number of employers (n=1,113)

Number of employers	%	Count
1	46	508
2	17	188
3	4	40
4	0	4
5 or more	1	6
I am fully self-employed	33	367
Total	**100**	**1,113**

Hours of work

On average, psychologists reported working 29 hours per week, with a range of zero to 48 hours (Figure 25). This is slightly less than the 32.7 hours reported by the AIHW in 2014. Figure 25 also shows the wide distribution of the hours worked by psychologists, with a large number of psychologists working part time. The largest number of respondents (n=116) worked 40 hours per week, with the second largest number (n=92) working 24 hours per week, and 38% (n=406) worked more than 33 per week. The total average hours of paid work may be a little higher than 29 per week as 22% (n=228) of respondents reported being employed by more than one employer (Table 8).

Figure 25: Number of hours worked per week (n=1,064)



However, there is evidence that the number of hours worked by psychologists per week is falling. Until 1998 the full-time equivalent rate was closely aligned with the headcount of psychologists employed, the two figures then began to diverge (HWA 2014a). Available data does not shed light on whether psychologists are working fewer hours by choice or as a result of available employment opportunities.

The majority of psychology respondents performed their work between Monday and Friday, during the daytime (88%, n=940). Only 14% of psychologists reported that they regularly work on weekends (Table 9).

Table 9: Working pattern during a normal working week (n=1,072) [a]

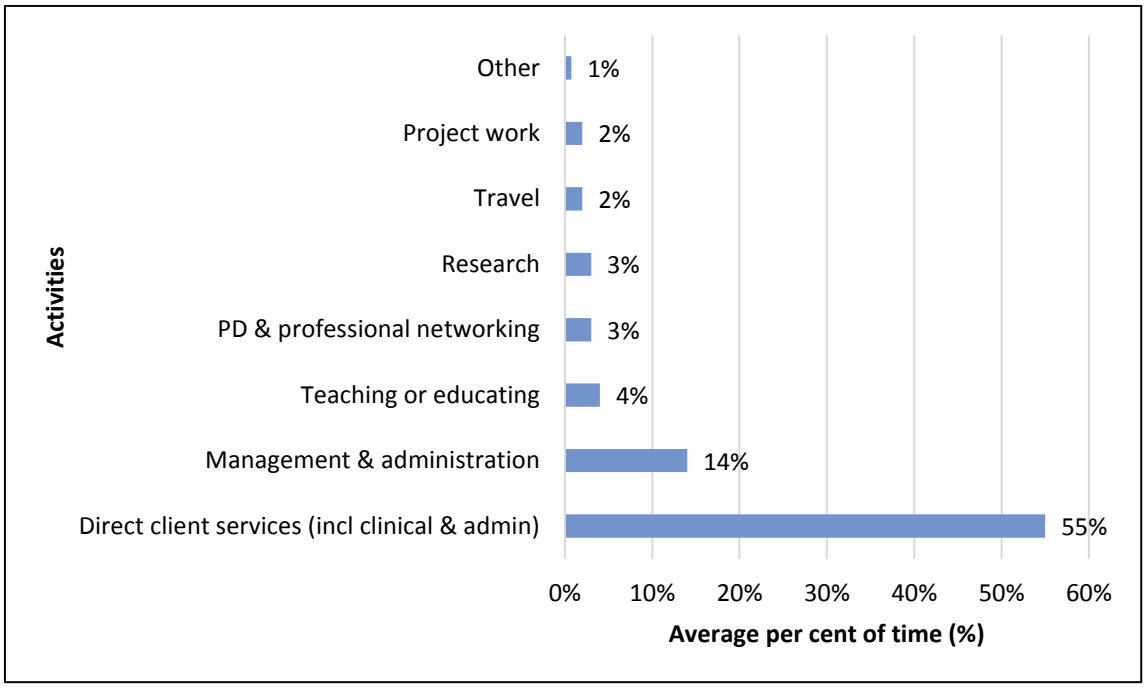
Working pattern	%	Count
Monday to Friday (mostly day time)	72	940
Monday to Friday (mostly night time)	5	60
Saturday	9	120
Sunday	2	32
Shifts that change from day to day, or week to week	3	35
Other working pattern (please specify)	9	112
Total	**100**	**1,299**

[a] *Respondents could select more than one response.*

Roles

On average, respondents spent a little over half their time (55%) on client related activities. The average time spent on management and administration was substantially less than this at 14%. When averaged across the psychology workforce, teaching, research, project work, professional development and travel accounted for only a small proportion of time (15% combined) (Figure 26).

Figure 26: Average per cent of time spent on work activities (n=1,072)



Scope of practice

Psychologists worked across a wide range of sectors and in diverse roles. This was illustrated in the responses to the open ended question where respondents were asked to provide their actual job title (Table 10). The highlighted titles are areas of practice endorsement (as per Table 3, page 20).

One of the areas of growth of practice for psychologists is the generic mental health clinician.

Table 10: Actual job title (n=1,059)

Academic psychologist	32
Assessment clinician	5
Case manager	5
Clinical neuropsychologist	67
Clinical psychologist	226
Consultant psychologist	8
Counselling psychologist	27
Counsellor	35
Director / manager / CEO	51
Educational and developmental psychologist	4
Forensic psychologist	8
Mental health clinician	27
Organisational psychologist	3
Principal psychologist	20
Professional practice lead	4

Provisional psychologist	9
Psychologist	416
School psychologist	21
Student support officer	7
Team leader	7
Youth justice / family clinician	5
Other	54

Prevention and early intervention

There were no specific questions asked of the respondents relating to their role in prevention and early intervention. Unlike other professions, this area did not emerge as a theme in either the open ended questions in the survey or the discussion in the focus groups. Further investigation would have to be undertaken to determine the importance and perspective of members of the profession in relation to this area.

Generic roles

Role substitution is facilitated by a number of the different enterprise bargaining awards (EBA) that exist across professions. Psychologists can be employed in a range of generic roles including mental health and case management. They also believed that they could play an important function in multidisciplinary settings. However, they felt they were seen as an expensive workforce so their role was often substituted with other types of practitioners, specifically nursing, social work, occupational therapy, and in some cases physiotherapists, psychotherapists and counsellors.

"The AH workforce is divided across two EBAs within hospital public sectors - some opportunities do not exist with our EBA. Mental health and public health networks are separate - poor integration of mental health services (insular to the rest of public health). Psychologists are also viewed as an 'expensive' workforce."

Additionally, psychologists reported challenges to accessing jobs in mental health services due to a lack of understanding by management of the value that psychologists can bring, and few opportunities to be involved in multidisciplinary team work.

"Few psychologists work on the multidisciplinary teams. [There is a] lack of understanding from management / executive of the skills and requirements of working as a psychologist in the public mental health workforce."

A further challenge to employing psychologists in generic roles is the supervision requirements of more junior psychologists. This further reduces the capacity of services to employ and support psychologists within multidisciplinary teams.

"Lack senior psychology staff – we only have only two staff in senior positions. This creates challenges for the supervision of more junior staff – issues for placements and being able to employ other staff."

However, services that offered generic case management roles were seen to prefer psychologists over other disciplines. Case management was described as the process of overseeing client care through collaborative assessment, planning, facilitation, care coordination, evaluation, and advocacy for services and options to meet an individual's and family's health needs. This may include the delivery of direct clinical services, but is generally distinct from direct clinical care. Psychologists were preferred in these roles due to their post-graduate qualifications, and because these positions were often labelled as 'clinician positions' rather than case management.

"In our early life mental health service we employ 45 psychologists. The reason is that these positions are called 'clinician positions' not case management positions. While other allied health professionals (AHPs) can apply for these (e.g. occupational therapists etc.), psychologists will normally get them because of their post graduate qualifications."

At a more general level, there was a perception from focus group respondents that generic roles erode the skills base of specific AH professions and dilute the recognition of their contribution to a multidisciplinary team.

"Genericisation of positions – this is a problem for AHPs. It has led to the erosion of the skills base to demonstrate the value of a profession. This means that management don't understand the value of different professions in terms of individual skill base and what they bring to the team."

Advanced practice

The following definition of advanced scope of practice was used and respondents were asked to describe their advanced scope of practice role.

> *Work that is currently within the scope of practice for your profession, but that through custom and practice has been performed by other professions. The advanced role requires additional training, competency development as well as significant clinical experience. Examples include non-medical prescribing (e.g. pharmacy, podiatry), physiotherapy led post-operative review clinics; occupational therapy led spasticity and intervention clinics.*

The Australian Psychology Society (APS) does not formally recognise advanced practice roles in psychology. Advanced practice in psychology has been recognised through a number of Department of Health and Human Services advanced practice grants such as advanced practice behaviour management in subacute at Alfred Health. Two practitioners said that they performed non-medical prescribing (no details were provided as to what treatments or medications were involved) and focus group participants perceived that prescribing will be an important workforce issue for psychology over the next five years.

Few respondents (n=83, 8%) reported that their work involved advanced practice. Several respondents said that they did not understand the question. The responses were varied and included where they held a dual professional role and undertook specific activities as summarised below:

Dual professional role as an:

- Occupational therapist
- Medical practitioner - Bachelor of Medicine, Bachelor of Surgery
- Nursing practice
- Audiometry

Other roles included broad interpretations of the roles of psychologists, but probably would not be described as advanced practice, specifically:

- Supervision
- Hypnotherapy
- Victims of crime work
- Working with sleep disorders
- Medico-legal work
- Multidisciplinary team work
- Mental health practice
- Clinical governance
- Business and recruitment
- Complex case management
- Supporting parents of children with autism spectrum conditions
- Alcohol and other drugs

Allied health assistants (AHA)

Fifteen per cent (15%, n=162) of respondents reported their work involved delegation to an AHA. However, feedback from focus group participants suggested that psychologists do not work in a way that lends itself easily to delegation to assistants. This was particularly true in the fee-for-service model of funding, but the specific nature of psychology's therapeutic interventions also meant that it was difficult for psychologists to see how they could delegate work to another practitioner.

Telehealth

Ten per cent (10%, n=105) of respondents reported using telehealth. The most common application of telehealth technology was video-conferencing with clients, including the use of telephone and skype to communicate with clients and providing phone counselling. One respondent specified that they provided telehealth services to clients who are not MBS telehealth (presumably meaning that these clients do not receive reimbursement).

"I provide Skype services to some clients which are not 'MBS telehealth' which is quite unfortunate for clients."

Other telehealth applications included case conferencing, to access professional development, and to access supervision sessions.

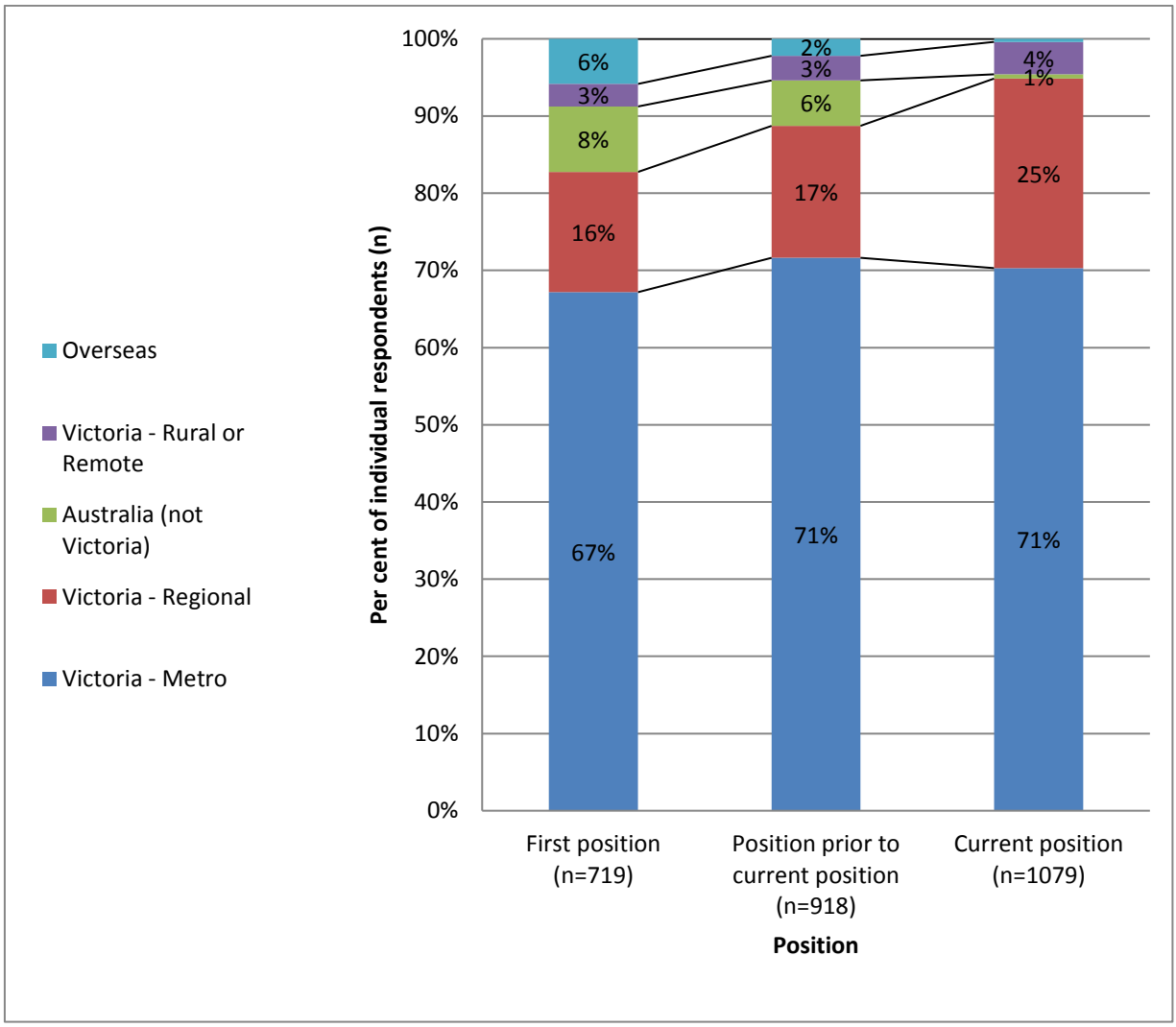
Workforce movement

To identify patterns in the career pathway of psychologists, participants were asked to provide details regarding their first position, their position prior to their current position, and their current position/s. Questions focussed on position locations, roles, settings, and sectors. They were also asked about the number of years they had worked in each role. The results are presented as percentages as not all respondents had worked in three roles. The numbers of respondents for each position and each question are presented in the relevant figures, which illustrate the broad trends across respondents' careers to date.

Changes in location

The data showed a slight increasing trend towards metropolitan areas, but relative stability of regional, rural and remote work locations between the individual's first, immediately prior and current role. The proportion of respondents working in metropolitan areas increased from 67% (483/719 respondents) to 70% (760/1,079 respondents) between their first role and the role they were in immediately prior to their current role. This proportion remained stable (71% (645/918)) between their prior and current position. Regional area employment increased slightly from 16% (n=112/719), to 17% (n=156/918) and then to 25% (n=269/1079) between the first, previous and current positions. The rural and remote proportion remained steady at three to four percent. Relatively few respondents (fewer than 6%) reported ever having worked overseas (Figure 27).

Figure 27: Changes in location across the career path (n=719 – 1,079)

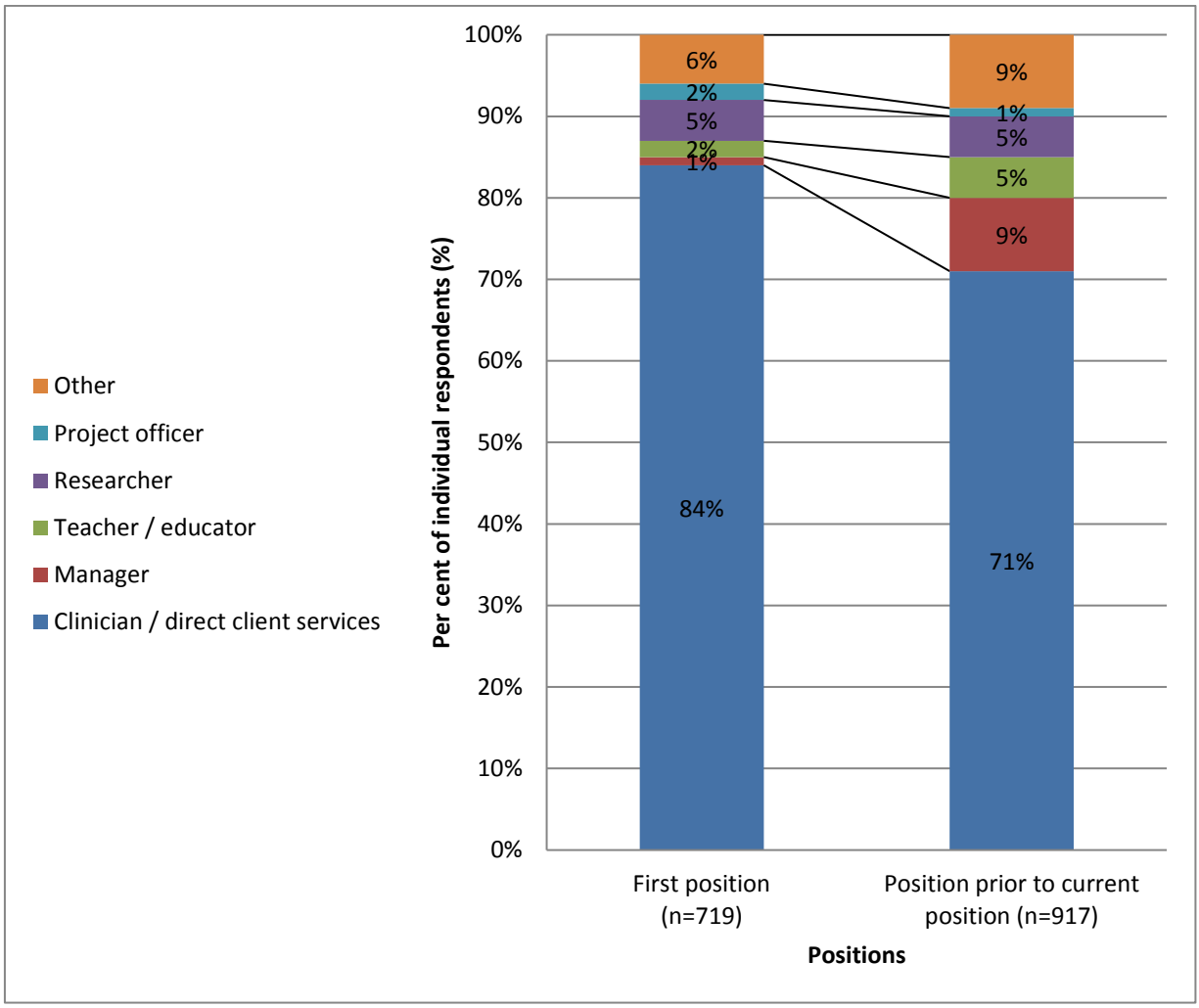


Changes in role

The trends across the career pathway for psychologists suggest a shift away from direct client / clinical care, an increasing proportion of management work, a decline in research, and a slight increase in teaching / education roles as careers' progressed (Figure 28).

Psychologists reported that in their current role, on average 55% of their time is spent in direct clinical care; 14% of their time is spent in management or administration; 4% of their time is spent teaching or educating and only 3% of their time is spent on research. Please note due to the wording of these questions relating to current role this data was not able to be included in the same manner as the prior roles in Figure 28.

Figure 28: Changes in role across career path (n=719 – 917)

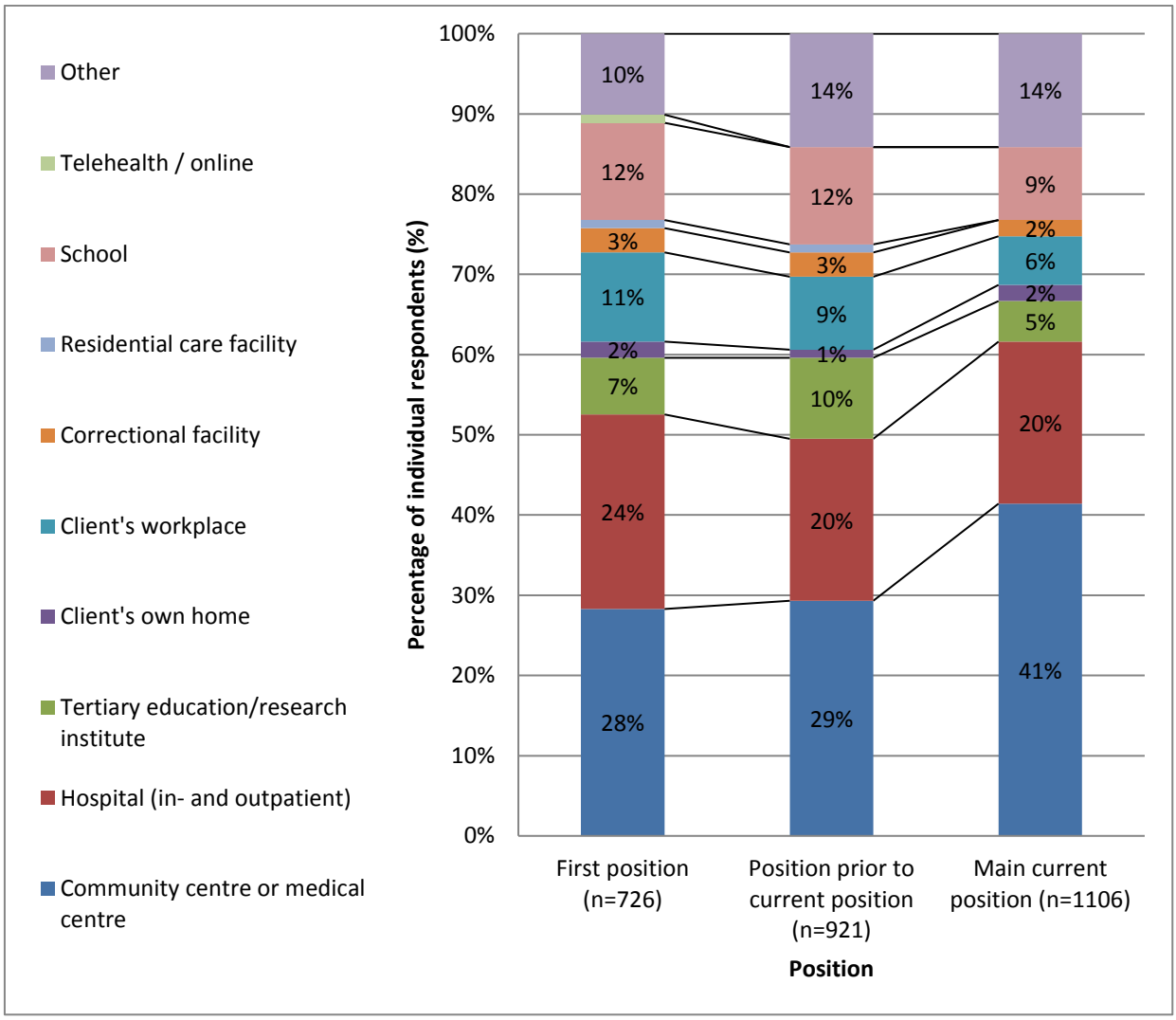


Changes in setting

Figure 29 shows noteworthy changes in the work setting of psychologists across their first, immediate prior and current positions. The data show a trend towards increasing delivery of psychology services in the community with a slight shift away from hospital inpatient care and provision of services in the workplace or corporate / office based environments .

These findings were supported by the focus group data, which suggested that psychologists are shifting towards community based private practice due to MBS incentives.

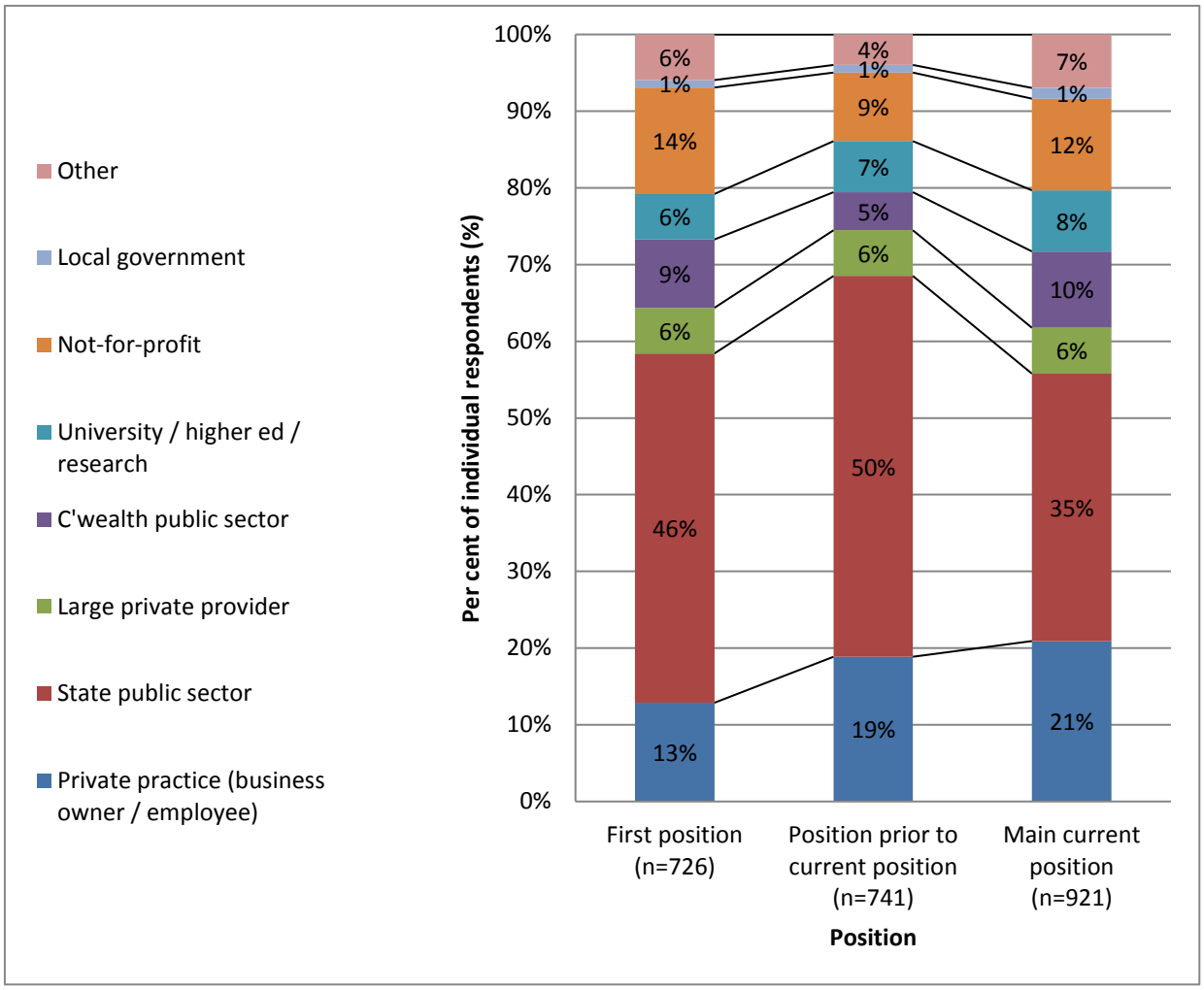
Figure 29: Changes in the setting of care across career path (n=726 – 1106)



Changes in sector

As noted previously, the cohort that responded to the AHWQ2 most likely included an over-representation of individuals working in the state public sector due to greater ease of distribution of the survey within this sector. Despite this, Figure 30 illustrates a decreasing proportion in the public sector and an increase in the proportion in the private sector across an individual's career.

Figure 30: Changes in sector over the career path (n=726 - 921)



Years in role

Over time, the number of years that respondents work in a role was shown to increase. Fifty per cent (50%) of respondents reported that they had stayed for three or less years in their starting position, while 40% of respondents reported that they had been in their most recent position for 10 or more years (Table 11)

Table 11: Years in each role over career path

	Mean	Range	Count
Years in current role	10	<1 - 40	1,084
Years in prior role	6	<1 - 40	894
Years in first role	4	<1 - 40	686

Capability

Capability refers to the strength of the evidence underpinning relevant occupational therapy activities, access to training and continuing professional development (CPD) to develop the appropriate skills, the standard of skills practitioners have to deliver evidence-based services, the contextual supports available (supervision, mentoring, dedicated time and appropriate funding models), and opportunities for change in practice to occur (i.e. knowledge translation and implementation) (Figure 31).

Figure 31: Workforce capability framework

Key findings

- The psychology workforce has a strong tradition of evidence-based practice which is implemented through a rigorous training regime. The majority of survey respondents (83%) had a post-graduate qualification, including masters and doctorates as their first qualification to practise.
- Sixty-nine per cent (69%, n=733) of all respondents had worked in at least one previous profession, most commonly teaching (n=110) or another health profession (n=80).
- The training requirements for psychologists, while seen as important to maintain professional standards, come at a high cost in terms of the individual's investment in education.
- The high cost of training was seen as a barrier to accessing clinical endorsement for many practising psychologists as well as a potential barrier to employers recruiting psychologists and providing services in regional / rural areas.
- There appeared to be confusion over the requirements for 'supervision' versus peer consultation, further investigation into this area is warranted
- While the majority of psychologists reported access to clinical supervision (83%), lack of access to qualified supervisors was a key recurrent theme by psychologists because of its impact on career development opportunities and service and training capacity, particularly in regional / rural areas.
- Despite the strength of the evidence underpinning professional practice, psychologists perceived that more outcomes based evidence is required by services to help argue for and justify the provision of more clinical services.
- There were few strong trends regarding skills gaps for psychologists, and a perception that most of these could be met through localised training.
- Most respondents (95%) said they have the skills needed to complete their work, but only two thirds agreed they have access to adequate training to progress their career (63%), and access to mentorship and mentoring to support their career growth (57%).
- Key facilitators of career progression included life experience, high quality supervision, training and education, access to mentorship and support and personal networks.
- Psychologists tend to work within formal multi-disciplinary team structures (38%), as part of a co-located team without a formal team structure (21%), or as a sole practitioner (20%).
- Psychologists who have a clinical supervisor were most likely to be supervised by another psychologist (81%). Five per cent (5%) had no clinical supervisor despite working in a clinical role.

Evidence / knowledge base

The psychology profession has a strong academic tradition and demanding educational requirements for entry. Eighty three per cent (83%) of survey respondents reported that a post-graduate or honours qualification was the first qualification that enabled them to practise as a psychologist. More than half of all respondents held a masters (n=617) degree and nearly one third (n=303) a professional doctorate or PhD.

The high level of education required to enter the profession was seen as an advantage, however this does come at a cost to the individual. Individuals entering the profession through the 4+2 or 5+1 pathways (as described on page 11) are required to have supervision from a PBA approved supervisor until they have completed their training and internship, and have obtained *General Registration* with the PBA (Leonard, 2015). The cost of this supervision may be borne by the student /trainee or their employer.

After obtaining general registration, peer supervision and mentoring, helps to maintain high standards of evidence and knowledge within the profession (Leonard, 2015). While the PBA's mandatory CPD requirements to maintain registration (e.g. 30 hours per year) are the same as for many of the other AHPRA registered AH professions and nursing /midwifery, psychologists are expected to have 10 of these 30 hours of CPD through peer supervision. To meet this requirement "Many psychologist arrange to exchange peer consultation with one another" (Leonard, 2015), and some do it through paid consultation which may place a higher cost on individual psychologists.

"My own drive to succeed. This is a tough profession, with high costs to remain registered, and time commitments to stay versed in current research and evidence-based practice."

However, the emphasis on an established evidence and knowledge base in psychology was also perceived to limit flexibility of clinical judgement and professional innovation.

"We like innovation, but only with an evidence-base and critical review, we don't follow the latest fad."

"Psychologists are often trained to adhere so rigidly to certain practices that they feel they are not permitted to adapt their practice to suit their referral base or service."

The opportunity to perform research and work with academics was seen to enhance career development opportunities.

At a service level, focus group respondents reported that they thought it was important that clinical and outcomes data were used more appropriately to help drive evidence-based demand for psychology services. There was a perception that psychology services were being overlooked in areas that they could provide efficacious services for patients because the service was unaware of the potential offered by the profession (and AH in general).

"AHPs need to prove that they have value to the health service because it doesn't feel like there's any funding for them. What is the minimum amount we need to make the service run?"

"There is a trade-off between maintaining a high quality profession and maintaining a profession."

Training and continuing professional development

Prior work experiences

The majority of survey respondents had worked in at least one (n=495, 47%), if not several previous professions (n=238, 22%) prior to becoming a psychologist. The most common previous professions were teaching (n=110) and other health professions (n=80) predominantly nursing, but also occupational therapy and speech pathology. Other common previous roles included, but were not limited to

administration, academic work, banking, creative arts, counselling, hospitality industry, human resources, management, disability services, welfare work and youth work.

The time spent in these previous roles was 10 years on average, with a range of 1 to 40 year.

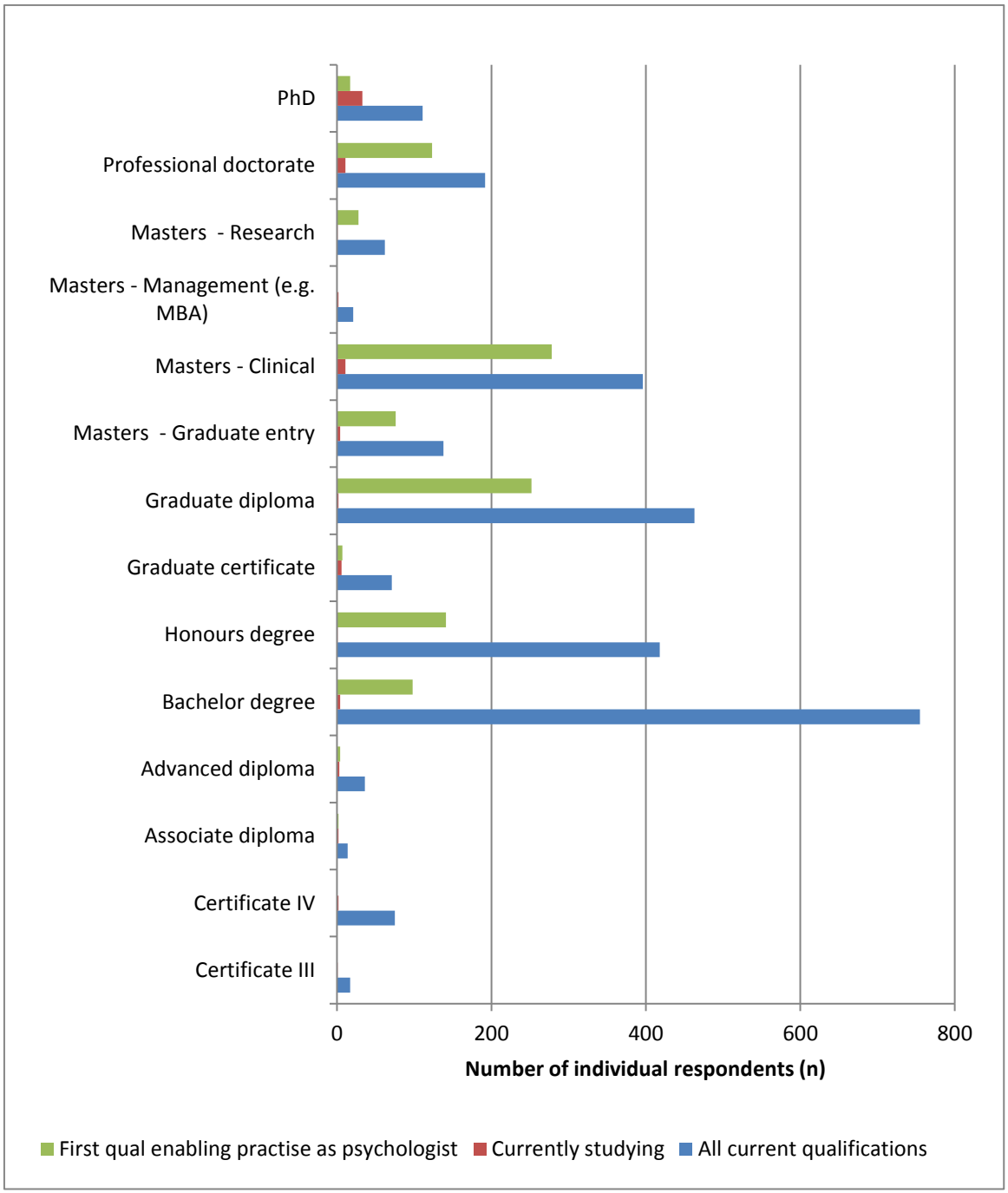
Qualifications

The predominant qualification held by respondents was a bachelor degree (n=755), followed by a graduate diploma (n=463) and an honours degree (n=418).

The main qualifications used as entry to practise as a psychologist were graduate diplomas (n=252), clinical masters degrees (n=278), honours degree (n=141), and professional doctorate (n=123). Of the 755 respondents who held a bachelor degree, it was the primary qualification to practise for only 13% (n=98) of these.

Respondents also reported having a range of other post-graduate qualifications including graduate certificates (n=71), clinical masters (n=396), management masters (n=21), research masters (n=62), professional doctorates (n=192), and PhD (n=111). See Figure 32 and Appendix Table 5 for detailed breakdown by respondent numbers to different qualifications.

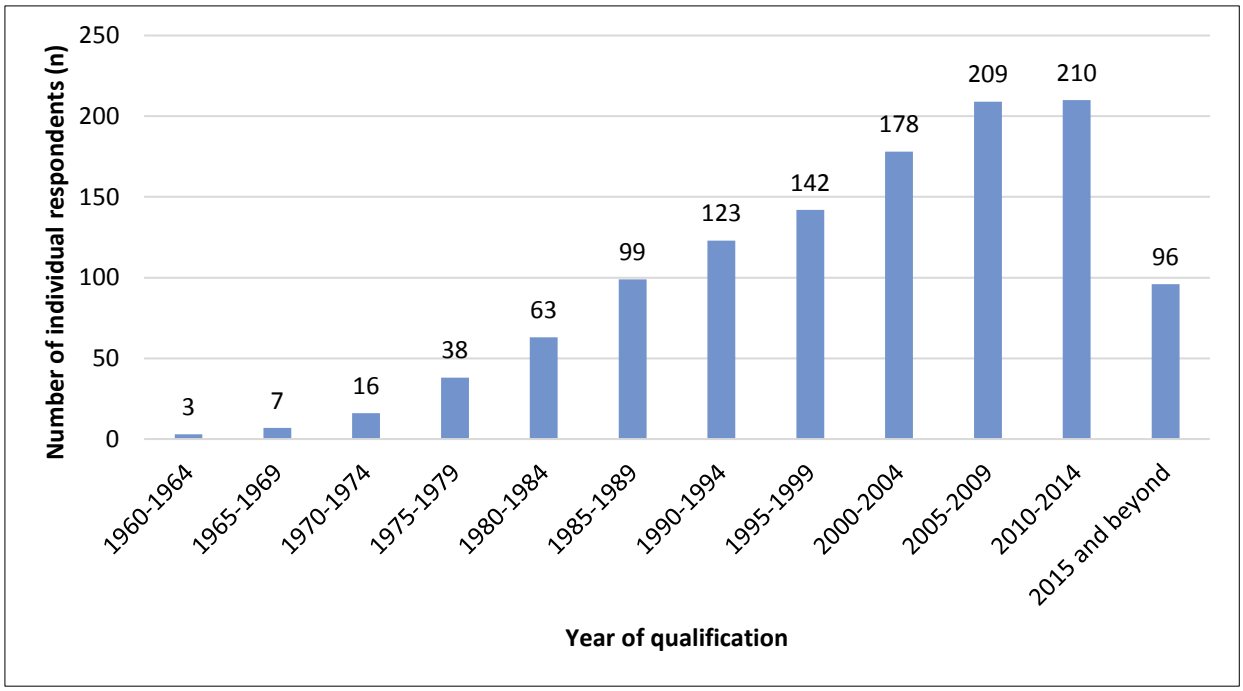
Figure 32: Qualifications held or currently studying (n=1,116) [a]



[a] *Respondents could select more than one response for 'all current qualification' and 'currently studying'*

Half of all respondents received their qualification to practise as a psychologist in 2004 or later (Figure 33).

Figure 33: Year of qualification (n=1,184)



The majority of respondents (84%) trained as a psychologist in Victoria; 11% trained in another Australian state (predominantly NSW (n=44) and Queensland (n=32)), while 5% were overseas trained (New Zealand, United Kingdom, United States and others).

Continuing professional development

The high level of training of psychologists was largely valued by the profession, but was also seen as a barrier to accessing certain aspects of the profession.

A number of psychologists expressed that they were unable to access the training pathway for clinical psychology due to cost, personal circumstances, or that the pathways to entry into the various career pathways in psychology were not clear.

"I trained as a psychologist many years ago and have undergone a lot of professional development. Then Medicare brought in a system where clinical psychologists get reimbursed substantially more for doing ostensibly the same work. When I looked into doing a clinical master's it is the case that despite the fact that I have a psych master's degree and teach some areas that would be covered in a clinical master's I would get no acknowledgement and would have to start a master's from scratch. At that point in my career I could not take out the time from work in order to accomplish that."

Psychologists who trained more than 10 years ago found that their first qualification was not always recognised as an entry pathway into the clinical psychology program.

"I was not accepted into a master's program because it had been more than 10 years since I had acquired my post graduate degree even though I had undertaken continuous training CPD and awarded certificates in chosen areas of further specialisation. Also there was no bridging program for me to obtain an endorsement in clinical psychology even though my area of expertise was in the area of clinical practice."

In addition, the high training requirements of psychologists were seen to hinder career progression due to the high cost of the training, and relatively higher cost of employing psychologists compared with other AHPs. For existing practitioners, the time to attend the programs would detract from their current income earning capacity.

"The catch 22 that we're highly trained which attracts a relatively high salary compared to other AH clinicians but too 'expensive' to employ in senior positions. There are less and less opportunities to develop into senior positions with growing organisation level of decisions to have less qualified practitioners do a version of the work we do."

"I investigated doing master's, but it costs $18,000. I can't justify that given that it won't give me any higher remuneration."

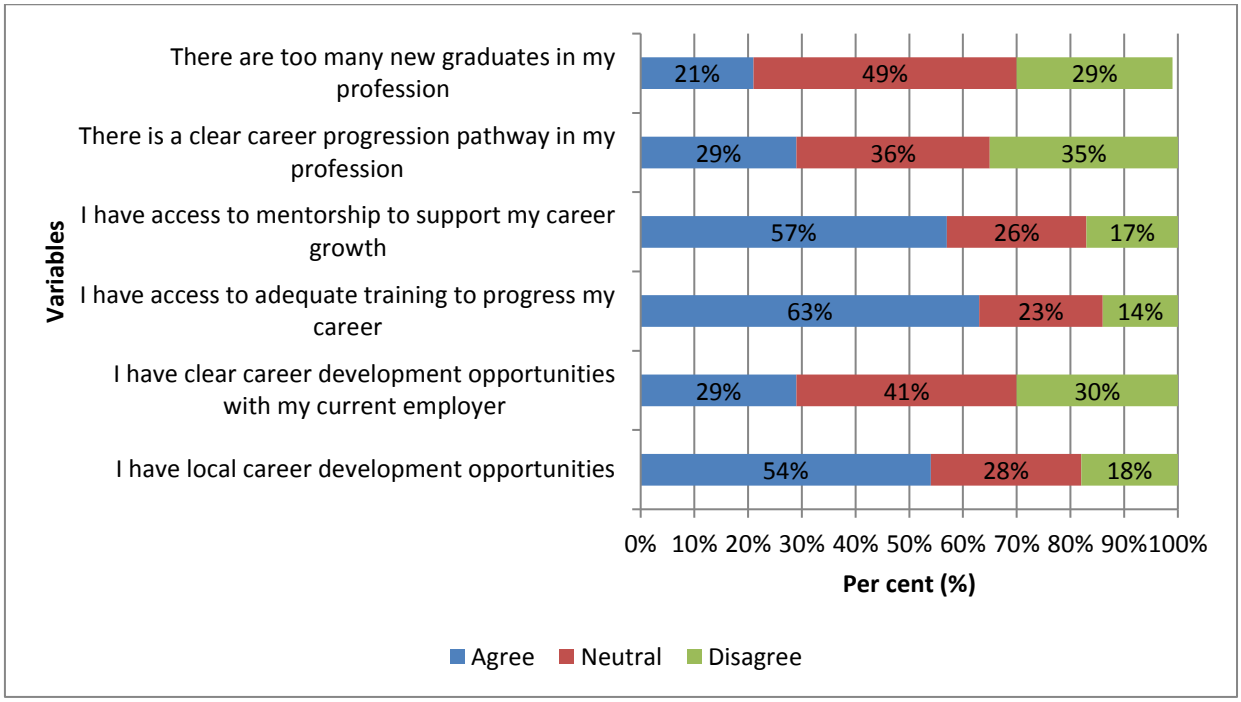
Access to training was seen as particularly problematic in regional / rural areas.

"Further training and supervision is expensive and is unrealistic if you are living remotely. It is hard to access professional development of good quality without the expense of travelling."

Career development opportunities

With respect to career development and progression, 54% (n=550) agreed they had local career development opportunities however less than one third (29%, n=297) agreed that they had a clear career progression pathway in their profession (Figure 34). This theme was also expressed very strongly within the qualitative survey responses and focus groups.

Figure 34: Career development opportunities (n=1,028)



When asked about the factors that had supported their career progression, respondents provided the following responses:

- Opportunities for a variety of clinical placements at university and / or different types of roles in their local area
- Building relationships with referrers
- Mentorship
- Access to CPD and distance education
- The variety of non-psych roles performed before training as a psychologist, as well as breadth of life experience, and previous experience as a psychologist

"Good quality and frequency of clinical supervision; placements during master's in local multidisciplinary teams; current employment in well supported workplace that encourages professional development."

The training associated with student supervision was seen as a career development opportunity for some survey respondents. However, a large proportion of respondents (over 70%) reported that the career development opportunities available to them in their profession were either unclear or they gave a neutral response to this question (Figure 34). A similar proportion of respondents were also dissatisfied with this element of their current position. These findings were supported by the qualitative data where psychologists overwhelmingly reported a lack of career development opportunities.

This was attributed to a number of factors:

- Lack of employment opportunities in regional areas due to few positions being available
- Limited access to psychology positions with government employers and lack of growth or reductions in funding in public psychology services and lack of employee turnover in these roles

"Ceiling on career advancement created by the hospital funding and role structure."

- Lack of access to professional development opportunities; the high cost of accessing training and supervision
- Lack of recognition of certain psychology skills to practise in specific fields

"Being a counselling psychologist has prevented me from applying for hospital jobs where my skills and knowledge could be used."

"Being a counselling psychologist may also preclude me from writing reports for different government bodies, although so far I have not had any reports rejected, I have heard this can be a problem."

"Being a generalist psychologist has limited my opportunities. As it cost me a lot of money to retain in another profession [i.e. psychology], it wasn't viable for me to spend the extra time studying to be a clinical psychologist."

- Challenges attaining experience in specific areas

"Being pigeon holed in terms of experience - not being considered for jobs unless you have prior direct experience in that area. It would be good if psychologists had a system like medical graduates - get rotated through a range of areas."

- Short term contracts
- Management by non-psychologists which reduces the advocacy for the profession within the organisation and limits the career opportunities

Several psychologists highlighted that they felt that being a younger member of the workforce was a disadvantage. Similarly, a number of women reported that they perceived that they were disadvantaged because of having more caring responsibilities, the challenges of balancing work with family life, and in some cases because of gender-based discrimination in the workplace.

A further barrier to career development was the need to attain accreditation and endorsement and the physical and financial challenges of accessing the training to do this if practitioners are already working as a psychologist.

"As I have been in private practice for 16 years I have to pay for my own PD and take unpaid time from work to do it. I have to organise my own career progression. I cannot do a clinical masters or a PhD without stopping work because of the practical work and supervision requirements."

Combining a clinical and academic career was seen as one way to provide career development opportunities.

"My position is rather unusual in that I have combined a clinical and academic role - I think these types of positions are excellent for the profession, and provide stimulation and variety that enable one to sustain a long career."

There was a great deal of dissatisfaction expressed regarding the two tiered funding system and preferential recognition in many cases for clinical psychologists over registered psychologists. The APS has recently undertaken a governance review to attempt to address this issue.

"Division and disharmony in the profession with preferential treatment for clinical psychologists, and unfair pay and opportunities for general psychologists under the Medicare two tier system. General psychologists are not advocated for or supported by the APS."

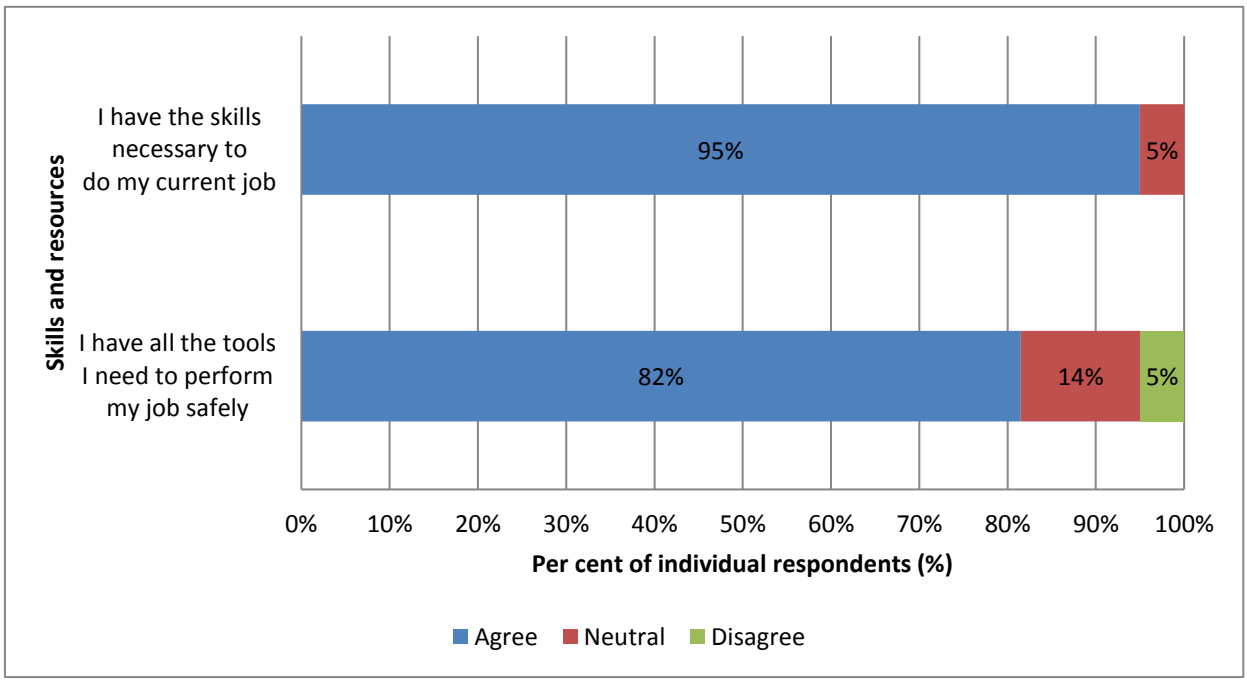
Another issue was the changing complexity of the workload and need for increasing skills and experience without appropriate recognition or remuneration.

"I am in the same role, for the same employer essentially as when I started in 2005. I have changed locations and gone from subcontracting through an intermediary to permanent staff. I am more experienced but in the same salary grade. The work I do is more complex, more difficult, more autonomous, less supported, and I am a de facto sole practitioner in my role and location, but my employer does not recognise any of these things."

Clinician knowledge and skills

The vast majority of survey respondents reported that they were well equipped to perform their job; with the overwhelming majority (95%) agreeing that they have the skills to perform their current job and they have access to the tools to perform their job safely (82%) (Figure 35).

Figure 35: Clinician skills and resources (n=980



Skill gaps

Employers and managers of psychologists (n=225) were asked to identify skills gaps in the psychology profession. Of those respondents, 115 said that there were no skills gaps, or that this question was not applicable to their role and a further 10 were unsure or unable to comment.

Of the 100 who identified skill gaps, no single area consistently emerged. Some of these respondents believed that most gaps could be addressed through ongoing professional development.

The areas listed below illustrate the spread of issues raised rather than identifying any particular priority areas.

Gaps in clinical skills

- Lack of experience working with complex clients
- Forensic training
- Treatment and management of acquired brain injury
- Managing family violence and treating children
- Autism training
- New graduates lacking a broad range of therapeutic tools other than cognitive behavioural therapy or acceptance and commitment therapy
- Skills working with clients with disabilities
- Contemporary pain management
- Specialist testing
- Wider range of counselling modalities
- Trauma therapy / high risk clients

Gaps in management, business or other professional skills

Areas where professional skill gaps were reported included:

- Cross cultural skills
- Case management / case formulation skills / care coordination
- Understanding of, and experience in the public sector
- Working with clients from low socio-economic backgrounds
- Lack of knowledge of other branches of the psychology profession and the types of work they perform
- Insufficient registered supervisors
- Management skills
- Group facilitation
- Accounting and marketing
- New graduates lacking note-taking and record keeping skills
- Leadership skills

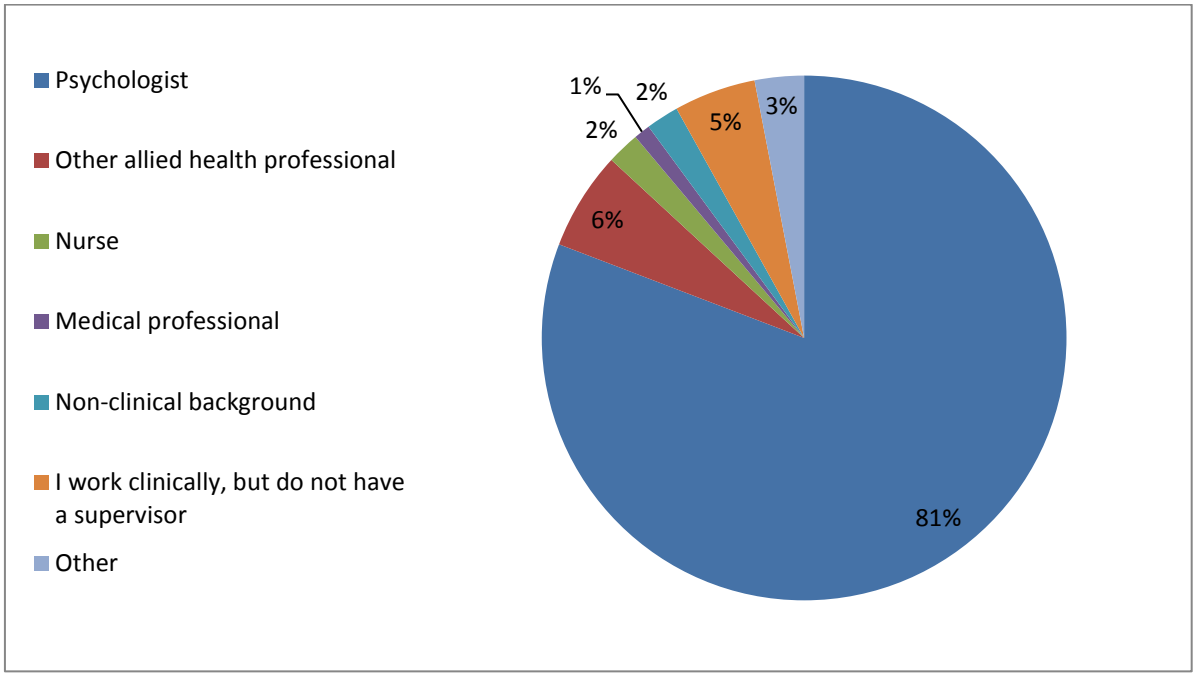
"As a result of the lack of sufficient junior psychology positions - a generation of 'under socialised' psychologists have been forced to develop their clinical practice in the small business model that has emerged. There are important skills about knowing what you don't know, knowing when not to treat and having realistic (not consumer driven) treatment goals."

Support contexts to enhance capability

Supervision and support

Access to clinical supervision was one of the key points raised by participants in the qualitative data. Eighty one per cent (81%) of individual respondents stated they were supervised by a psychologist (Figure 36).

Figure 36: Professional background of clinical supervisor (n=1,010)



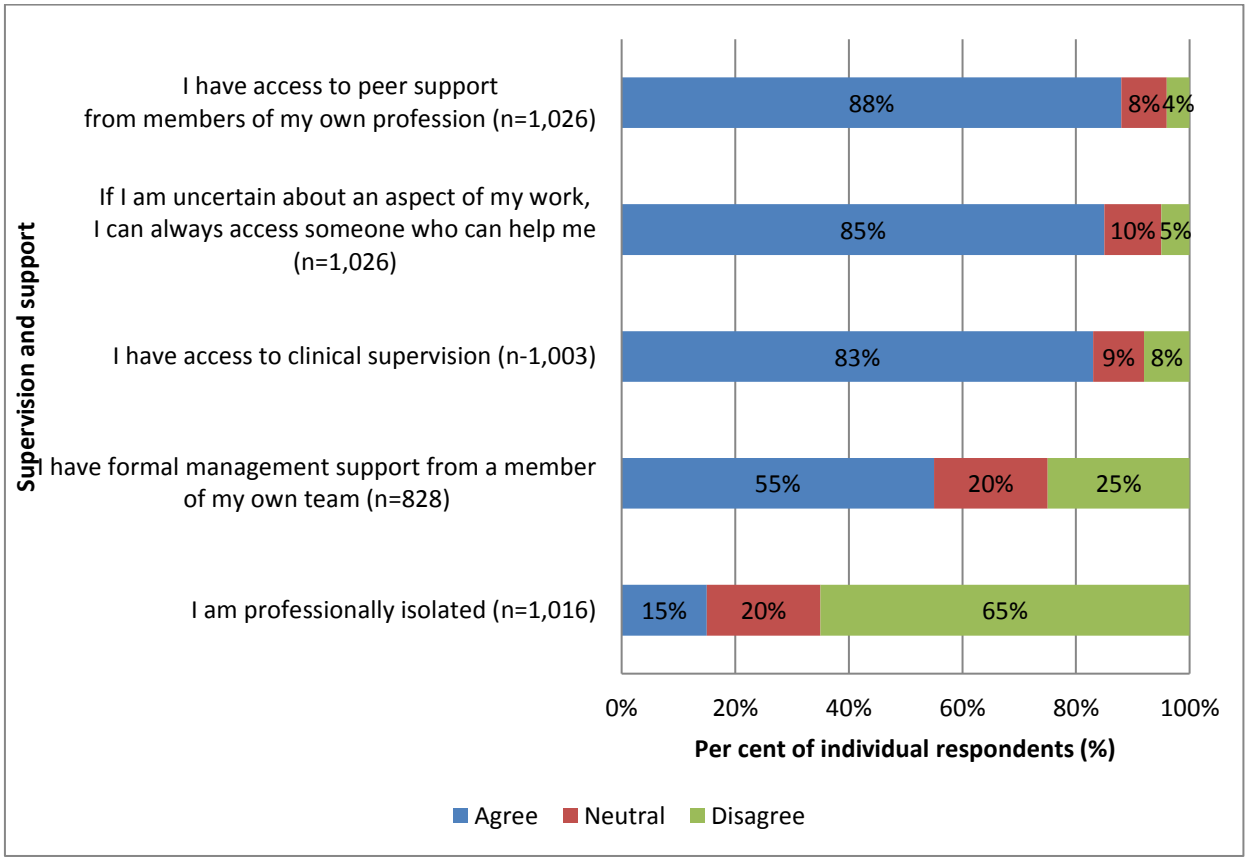
However, supervision within psychology appears to be a confusing issue. There appeared to be some challenges around distinguishing between supervision, peer consultation and mentoring. As was previously noted, supervision is a PBA requirement for students and provisional psychologists. For this type of supervision the supervisor must be a PBA approved supervisor. According to the APS (2016) there were 2,137 Board-approved supervisors in Victoria in December 2016, or 27.9% of the general psychology registrants in Victoria who were able to carry out this supervision

Once a psychologist has general registration with PBA the 'supervision' requirements change.

"Once a psychologist has completed their formal supervised training, they are still required to engage in discussion about issues arising in their practice with a colleague as part of their ongoing continuing professional development (CPD) for ten of the 30 hours per year. This is called peer consultation and has a less hierarchical relationship than that of supervision. Many psychologists arrange to exchange peer consultation with one another. The psychologist who is being consulted can count these hours towards CPD but only the hours focussed on their own practice counts as their peer consultation. The mentoring process is also different from supervision. It involves identifying a relevant senior colleague who is willing to be consulted and who can guide another less senior colleague through stages of transition in their careers" (Leonard, 2015).

Of the survey respondents, 83% of psychologists agreed that they have access to clinical supervision (Figure 37) and even more (88%) said that they have access to peer support from members of their own profession.

Figure 37: Access to supervision and support (n=828 – 1,026)



However survey respondents expressed considerable concern about 'supervision', and the 'cost / availability' of this supervision was a recurring theme in the qualitative data from both the survey and the focus groups. Respondents spoke of difficulty in accessing supervision, particularly in regional and rural areas, and concerns that only psychologists who are grade 3 or above can be supervisors.

"It is frustrating that despite completing a clinical master's I now have to spend $13,000 on registrar supervision to use the title."

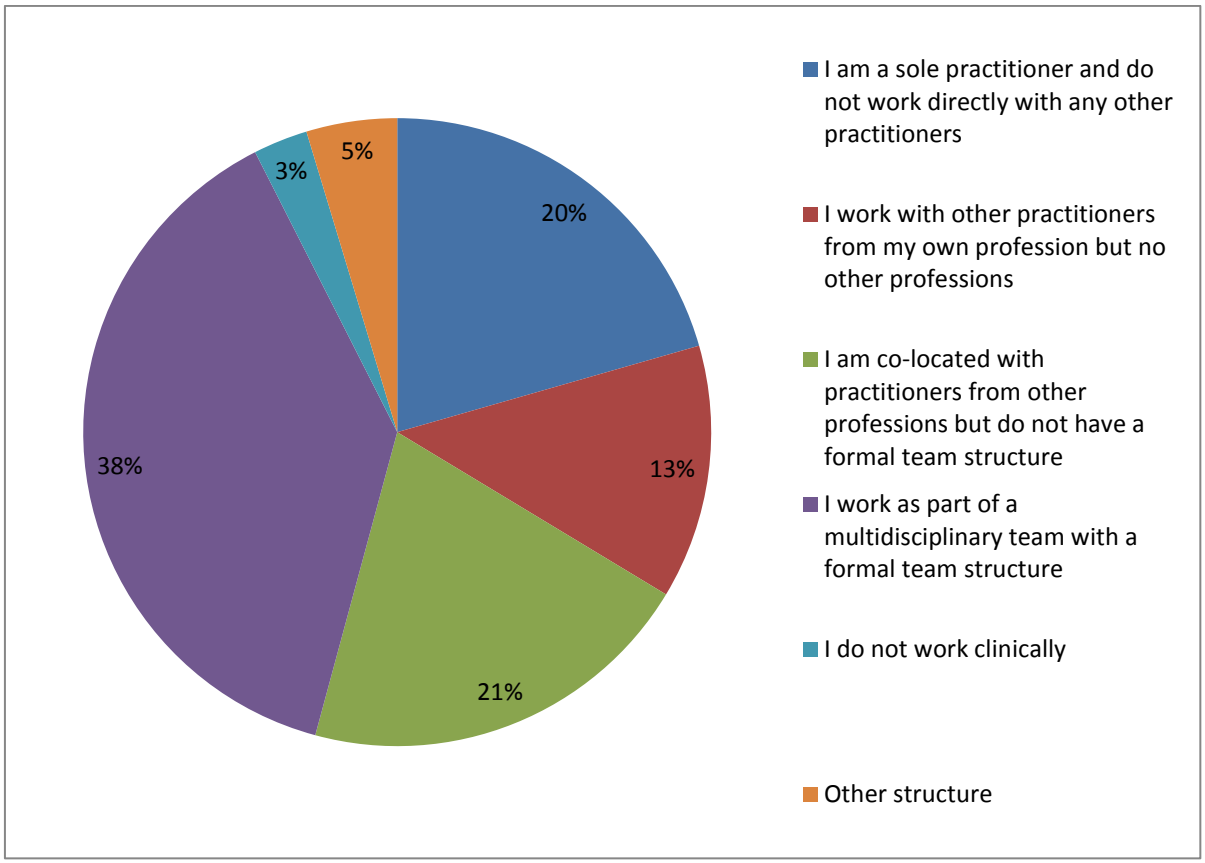
"AHPRA unfairly structuring supervision requirements. If you're not a clinically endorsed supervisor, it's extremely difficult and almost pointless to pursue accreditation as a supervisor."

Given the level of concern expressed relating to this issue, and the apparent confusion that exists relating to this area, further exploration and clarification of this issue is warranted.

Team Structure

The largest proportion of psychologists reported that they worked either in a multidisciplinary team structure (38%), or were co-located with other professionals but not within a formal team structure (21%). One fifth (20%) of respondents stated they worked as a sole practitioner, while 13% work only with other psychologists (Figure 38).

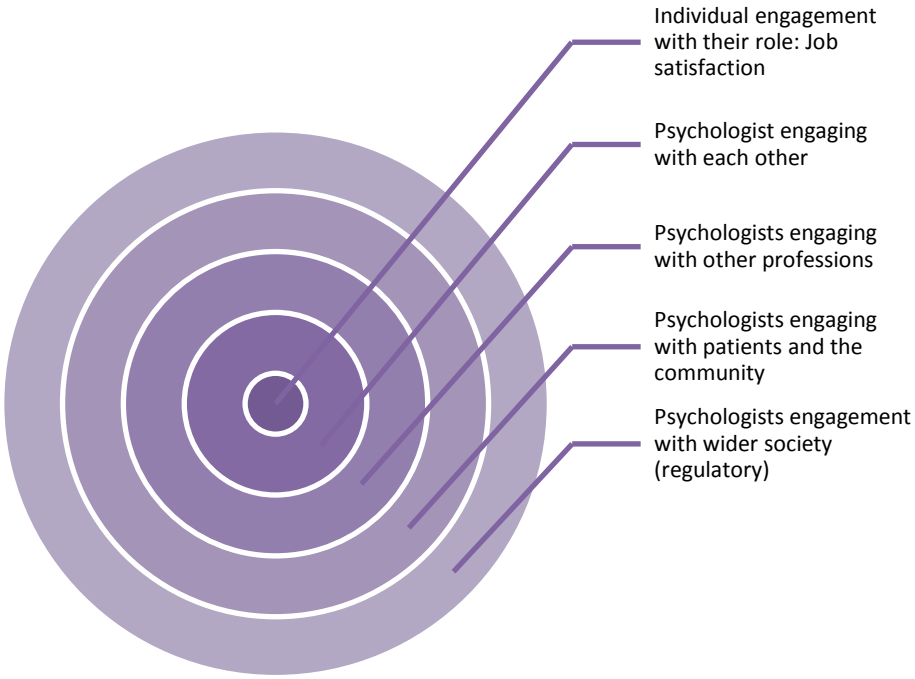
Figure 37: Practice structure (n=1,069)



Engagement

Engagement involves a continuum from the individual practitioner's engagement with their role to the wider engagement of the profession with society through regulatory mechanisms. Within this course there is engagement with the profession, engagement with other professions, and engagement with patients and the community (Figure 39).

Figure 39: Model of engagement



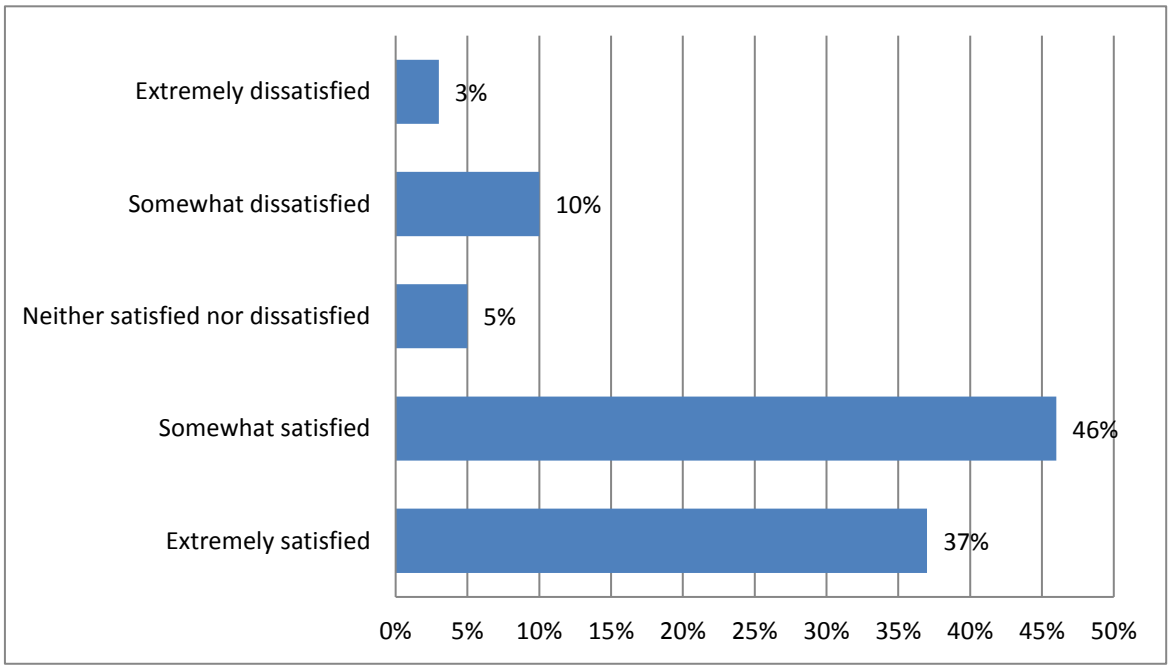
Key findings

- Psychologists were largely satisfied with their jobs with 83% expressing that they were somewhat or extremely satisfied in their role.
- The most important factors affecting employment choices for psychologists were work-life balance, the type of work / clients, flexibility of hours, and professional development opportunities.
- The single greatest point of contention expressed by more than half of respondents was the inequities created by the two-tiered system of psychology.
- Psychologists lacked good structures for intra-professional engagement which may impact on local or regional referral pathways and service integration for clients. Psychologists working in rural areas reported feeling professionally isolated.
- Psychologists perceived that generic mental health roles, when not filled by a psychologist, limited the input of psychology modalities into mental health teams.
- Respondents reported that the role of psychologists was misunderstood by other professions and the public and that there was a need to manage community expectations and stigma around psychology services.
- Interdisciplinary tensions were reported between the psychology and psychiatry professions with the psychologists sensing a privileging of psychiatry services and roles over psychology services if they are ever in competition.

Individual role engagement

Overall, respondents were satisfied with their current work situation with 83% of participants stating that they were somewhat or extremely satisfied in their current work situation (Figure 40).

Figure 40: Overall satisfaction (n=1,067)



The focus group participants suggested that while they found their clinical work rewarding and satisfying, there were a number of extrinsic factors that influenced their general satisfaction with their roles.

In response to the question *What is the single most important factor influencing the psychology profession?* more than half of all respondents (n= 640) expressed dissatisfaction with the two-tiered system of recognition in which clinical psychologists receive greater reimbursement from Medicare and access to specific services and interventions that are not available to non-clinical psychologists. This, in turn, was seen to place an additional cost onto the health system and clients, as well as limit access to specific psychology services.

"Elimination of two tier payment system for psychologists within Medicare. This is unfair. There is no evidence that clinical psychologists or endorsed psychologists provide a better service or get better results with clients. It merely serves to divide the profession and make some feel superior to others without any real justification. It creates ridiculous situations where I cannot provide an assessment for e.g. Social Security, and I have to send a client to a clinical psychologist who has far less experience than myself, and who does not know the client, and who then gets paid much more."

Focus group and survey participants also identified a perception of 'credential creep', particularly in relation to the recognition of clinical psychology skills at the expense of recognition of other skills.

"When I qualified a master's was seen as a reasonable standard, then there was a growing trend for clinically qualified people and as I don't hold a clinical qual in psychology, I moved away from the field altogether as no other types of qualifications and experience seem to be valued in psychology."

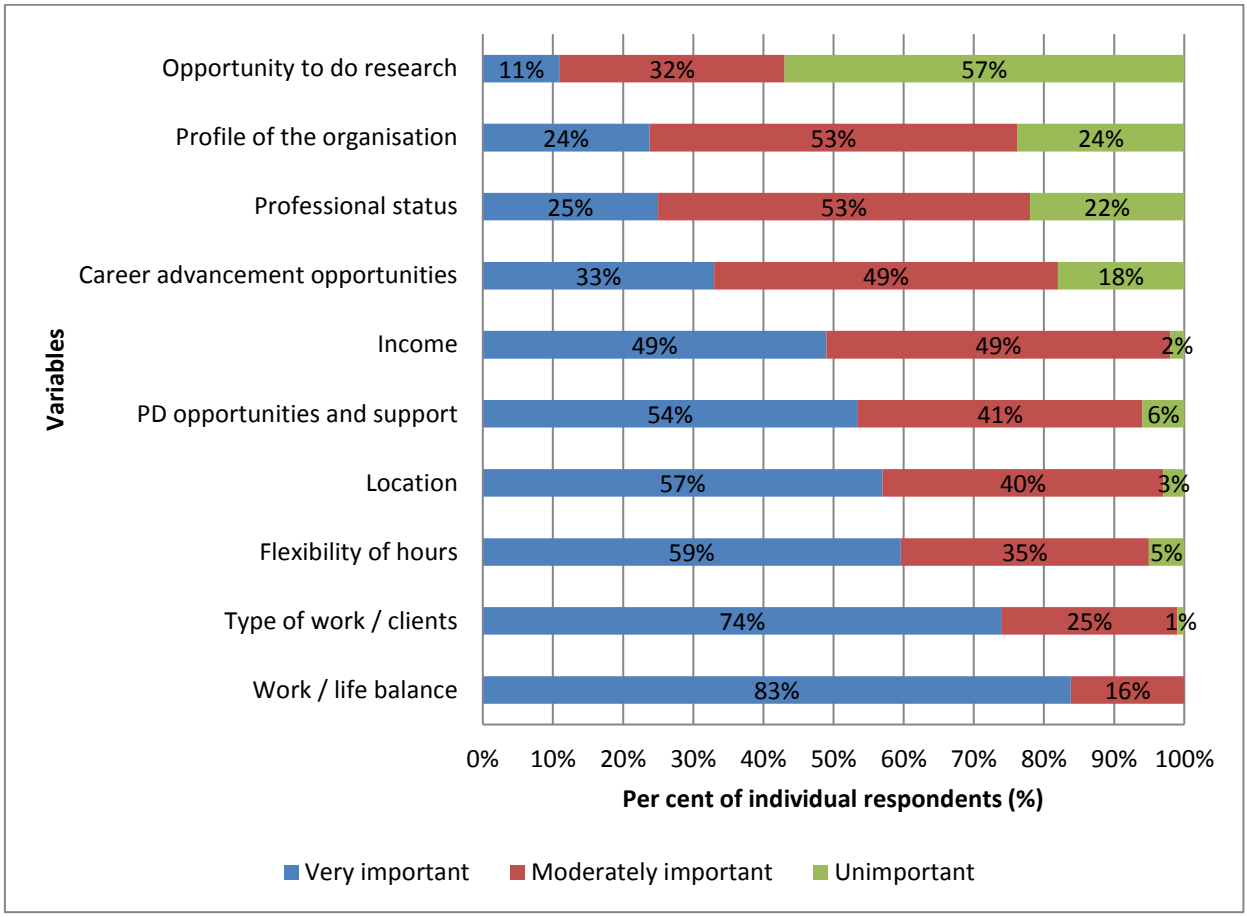
"I hold registration and membership but I simply don't identify as a psychologist even though I work with extremely marginalised and disadvantaged people. I also work with a significant number of people with violent and sexual offending histories in the context of child protection who receive minimal support and management in the community."

The limited number of psychology sessions available under the Better Access Initiative (MBS) was also a source of dissatisfaction by psychologists because of the lack of tailoring of services specifically to client needs, and the inadequacy of this amount of care for many clients.

"Better access to psychological services for those in high need but with restricted access to funds. Ten sessions per year under the Better Access Initiative is not enough for the majority of our clients and there's a big gap between high need, high resources clients (who are eligible for public health services) and those who are struggling but not bad enough to get into public health. It's ridiculous that we have nowhere for those people to go until they get so bad they need hospitalisation."

The research participants were asked about the relative importance of different features of their employment. The most important factors affecting employment choices were work-life balance, the type of work / clients, flexibility of hours and professional development opportunities (Figure 41).

Figure 41: Importance of factors in employment choices (n=1,027)

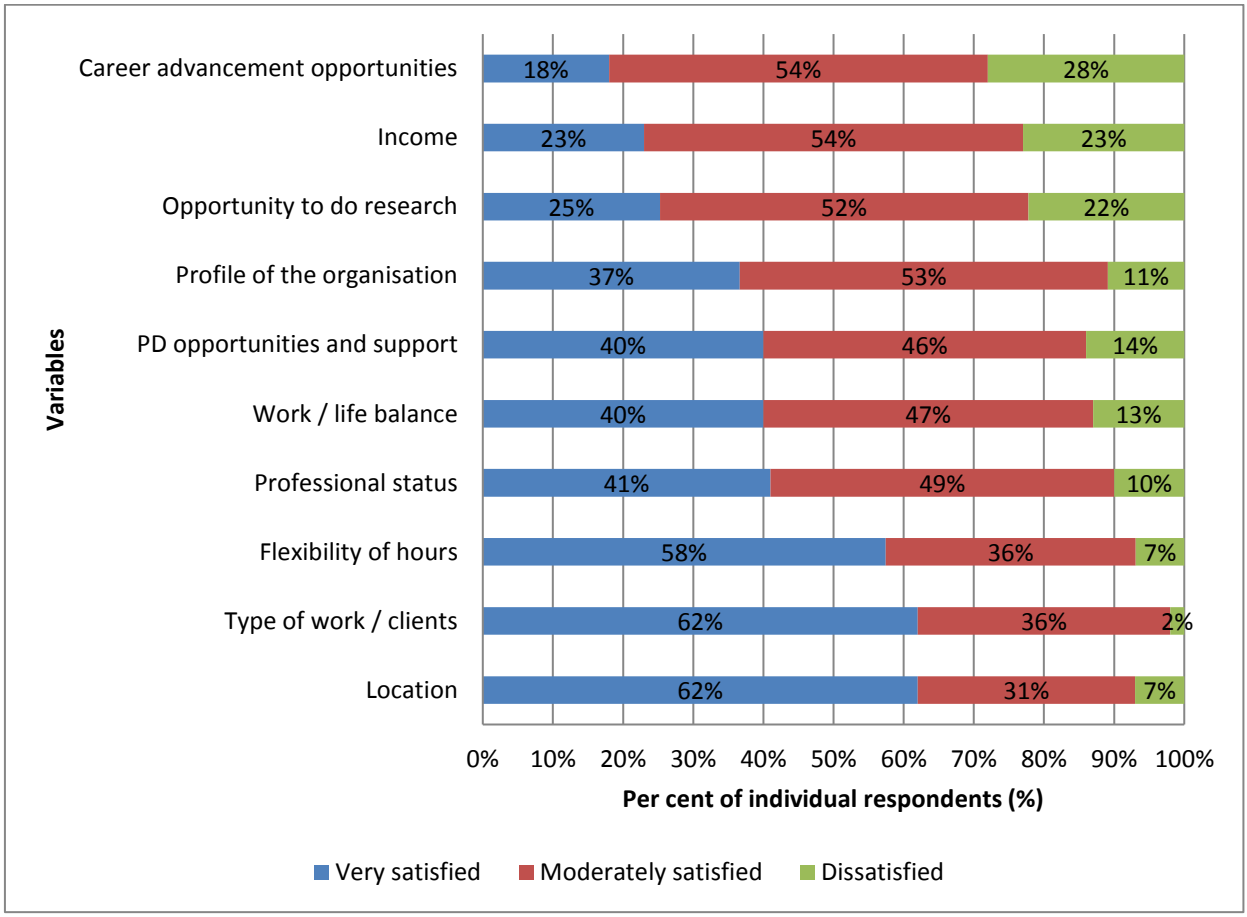


However, the proportion of those who indicated they are currently very satisfied with their work-life balance (40%, n=410) markedly lower. The other top rated importance factors fared better, 62% were very satisfied with the type of work / clients (n=634) with only 2% (n = 27) were dissatisfied. In the area of flexibility of hours approximately the same proportion who felt it was very important were very satisfied with this factor (57%, n=590) (Figure 41).

The variable that the highest proportion of respondents reported they were very satisfied with was location (62%, n=635).

Career advancement opportunities was the factor where the highest proportion of respondents (28%, n=287) reported dissatisfaction in their current working life (Figure 42).

Figure 42: Current satisfaction with factors affecting employment choices (n=1,027)



Intra-professional engagement

Despite the high level of structural organisation within the psychology profession, the heterogeneity of the various factions within psychology, as well as the variety of workplace contexts and settings, created a picture of a profession that lacked a consistent and clear culture of intra-professional engagement. The differential valuation of specific psychology endorsements created clear tensions within the profession. This issue was specifically addressed within the focus groups where psychologists from a range of settings reported challenges in establishing locality-based psychology networks. One consequence of this was a lack of local referral pathways between practitioners. This problem was particularly exacerbated by 1) the shift of psychologists into individual private practices and 2) those working in regional or rural areas. Both of these resulted in practitioners feeling professionally isolated.

"The psychology profession is not very friendly in country areas. We don't speak to each other very often and seem to come from different paradigms."

Those practitioners who reported having good support said that they had established these networks during their undergraduate and post-graduate training thus creating ongoing peer consultation. Strong networks were seen to be underpinned by a shared belief system, which was established through accessing common training pathways.

Psychologists who participated in the focus groups and worked in group private practices said that they lacked formal opportunities for networking and support, and that only accidental interaction between them took place if they were not simultaneously seeing clients. One respondent indicated that they had been part of a closed Facebook site which was used for networking and sharing of articles of interest. The Mental Health Professionals Network was seen to create valuable CPD and networking opportunities.

Inter-professional engagement

The complexity and variability of contexts in which psychologists worked meant that interprofessional engagement was a complex area to explore. One of the largest interprofessional issues raised by psychologists was the mental health role in which there were generic roles that could be filled by a range of different providers. There was a perception that psychologists were at a disadvantage in being employed in these roles because of the high cost of employing and supporting them. This, in turn limited the amount of psychology expertise and psychology specific intervention that mental health clients received as well as limiting the psychology perspective in the multidisciplinary team.

"Clinical Psychologists are not applying for generic roles in mental health services and we are losing psychologists from the public health sector very quickly into private practice. Psychologists need to be given psychology specific roles in health services. Psychologists need to be used more for diagnostic and assessment purposes as well as for psychological interventions."

Private psychologists working in the community stated they lacked access to interdisciplinary teams and support that might be required by clients, although the focus group participants also said that they rarely referred to other AH disciplines. Challenges in referrals to other disciplines included a lack of knowledge and understanding of what others' do; challenges communicating with other professionals due to incompatible technology; and lack of feedback from the practitioners they referred to.

"Everyone uses different kinds of systems; GPs are ARGOS [medical practice, client management software] enabled and AHPs are not. AHPs are always using different kinds of technology. We can't even get Medicare technology to work."

Interprofessional tensions between psychologists and psychiatrists were also highlighted, with the perception that psychiatrists were the preferred providers if they were ever in competition with a psychologist.

"I see a lot of WorkCover Rehabilitation, but often get gazumped by a psychiatrist. They might see someone for 20 minutes in a year. Any time a psychologist comes up against a psychiatrist, the psychiatrist always wins."

Community and society engagement

As with other AH professions, psychologists perceived that their role was poorly understood by both the general public and other health professionals.

"In terms of people understanding what we do, there are a bunch who assume it will be a client lying on the couch, and 'free association' – expecting psycho-analysis. We're not valued in terms of the support that can be given to clients. There is a trend with mental health GP care plans towards ticking the box for supportive counselling – they are valuing that aspect more, but I don't think that general public value that more."

Focus groups participants highlighted specific challenges associated with community engagement by psychologists including the stigma associated with seeing a psychologist, particularly from certain cultures. Psychologists were also dependent on GP referrals for clients and the way that the GP presents the idea of a psychology referral to the client influences the likelihood of the client attending psychology services. Primary Health Networks were seen to play an important role in awareness raising and brokering access to psychology services. No participants were able to identify any examples of Primary Health Network support or enablement of psychology services, and some identified delays in being able to access funding under the Access to Allied Psychological Services (ATAPS) scheme through the Primary Health Networks.

Respondents perceived that it was the responsibility of the APS to market the profession to the public and to GPs; although several focus group and survey respondents said that they engaged with local GPs. An additional problem identified by psychologists in rural / regional areas was the high number and turnover rate of international medical graduates working in these areas: this required ongoing relationship building with these new professionals.

A further consideration in community engagement was managing the public expectations of psychology services including public education about the variety of possible therapeutic interventions. Government funded mental health campaigns, such as those promoting men's mental health, were also seen as important sources of marketing and raising awareness of psychology services.

Conclusion

Psychology is one of the largest AH professional groups in Victoria. It is a complex profession because of the range of potential entry pathways and the variety of settings, sectors and areas in which psychologists can practise. The majority of psychologists have entered the profession from other careers, notably teaching and other health disciplines (nursing, other AHP and assistant type roles), as well as from the welfare and counselling space.

The psychology profession sets very high standards for entry and maintenance of practice. The minimum standard for professional registration is a post-graduate diploma followed by an internship. The majority of psychologists have some form of post-graduate qualification. The high cost and time to initially train as a psychologist, then the further expense to undertake an endorsement means it can be prohibitive for many professionals to gain a recognised endorsement. This may limit their scope of practice and career progression. However, this high investment in training may also reduce the attrition rate from the profession.

As a whole, psychologists were highly satisfied with their work and perceived that they added value to client care and the interdisciplinary management of persons with complex and or chronic illness. The introduction of generic mental health and case management roles supports input from psychology; however the absence of a psychologist in these multidisciplinary teams potentially limits the suite of psychology interventions available to be used.

Given the diversity of practice areas in psychology, it is difficult to see it as a homogenous profession; however the largest, single unifying point for the profession was the high level of dissatisfaction with the divide created by the financial recognition of psychologists who hold a clinical endorsement.

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Appendix

The following section contains additional data, figures and tables referred to in the main report relating to the data collected through the AHWQ2 psychology survey.

Responses and respondents

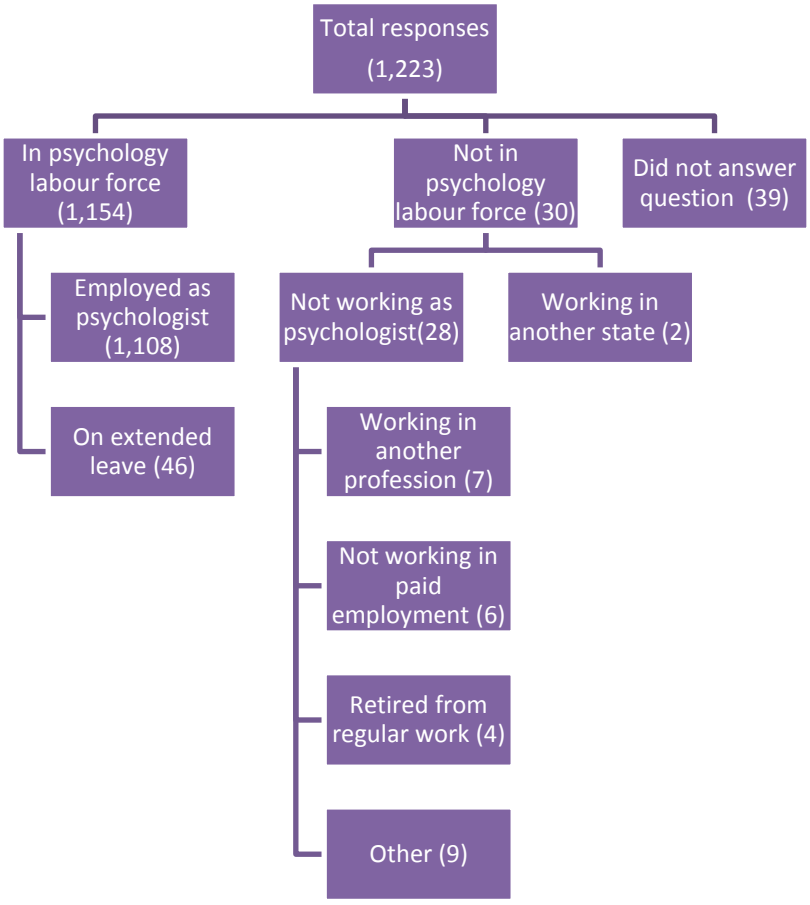
The AHWQ survey consisted of 53 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

A total of 1,223 psychologists completed at least one question on the survey and submitted their survey. The range of respondents to an individual question ranged from 539 to 3,597. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

A total of 355 respondents (29%) provided their email address and agreed to be followed up for further research.

Most respondents (94%) were employed in the psychology workforce in Victoria at the time of completing the survey.

Figure 1: Current employment status[6]



[6] All data in Figure 1 and Tables 1 – 7 comes from AHWQ2 survey

Table 1: Number of different locations or sites organisations provides psychology services from (n=204 organisational respondents)

Answer	%	Count
1	36	73
2	14	29
3	12	24
4	5	10
5	5	11
6	5	10
7	2	5
8	1	3
9	1	2
10 - 20	5	12
> 20	12	25
Total	**100%**	**204**

Table 2: Reasons for not working as a psychologist in Victoria (n=28)

Answer	%	Count
I was working in another Australian state as a psychologist	7%	2
I was working overseas as a psychologist	7%	2
I was working in another profession	25%	7
I was not working in paid employment at all	21%	6
I am retired from regular work	14%	4
Other	25%	7
Total	**100%**	**28**

Table 3: Principal area of practice and all other areas of practice in the week prior to completing the AHWQ2[a]

Areas of practice	Principal area of practice	All other areas of practice
	Count	Count
Mental Health Services	508	172
Counselling (not mental illness)	196	289
Other	162	104
Child Development Services)	72	93
Chronic disease management	47	144
Rehabilitation services	47	90
Alcohol, Tobacco and Other Drug Services	46	100
Neurological Services (cognitive and / or physical)	44	79
Disability services	41	83
General medical / hospital work	40	53
Domestic and/or Family Violence services	31	122
Medico-legal assessment	27	77
Personal development / coaching	23	133
Community Development / community engagement	21	45
Cancer Care	20	56
Organisation practices	18	58
Sexual violence services	18	61
Women's health / support	18	98
Aged Care Services (Community and residential)	16	43
Occupational health	14	29
Palliative care	14	38
Injury management	13	73
Health promotion and / or population health	12	42
Vocational support / recruitment services work	12	34
Recruitment services	11	18
Aboriginal Health	9	41
Housing / homelessness services	9	21
Income Support Services	8	13

Driving assessment	7	10
Transitional care services	3	20
Hand therapy	0	6

Table 4: Number of different jobs held during career as a psychologist (n=1,075)

Number of different jobs	%	Count
One / this is my first and only job as a psychologist	14%	146
2	18%	197
3	21%	226
4	18%	189
5	13%	137
6-10	14%	155
>10	2%	25
Total	**100%**	**1,075**

Table 5: Qualifications held or currently studying (n=1,116)

Qualification	Current qualifications	Currently studying	First qualification enabling practise as psychologist
Certificate III	17	1	0
Certificate IV	75	2	0
Associate diploma	14	2	2
Advanced diploma	36	3	4
Bachelor degree	755	4	98
Honours degree	418	1	141
Graduate certificate	71	6	7
Graduate diploma	463	2	252
Master's degree - Graduate entry	138	4	76
Master's degree - Clinical	396	11	278
Master's degree - Management (e.g. MBA)	21	2	0
Master's degree - Research	62	1	28
Professional doctorate	192	11	123
PhD	111	33	17

Table 3: Location of where psychologist grew up (n=1,089)

Location	%	Count
A capital city	56%	614
Other metropolitan area	14%	149
Large regional centre	10%	106
Small regional centre	10%	108
Other rural area	9%	102
Remote centre	1%	10
Total	**100%**	**1,089**

Table 4: Country of qualification to practise as a psychologist (n=1,190)

Country	%	Count
Victoria, Australia	84	998
Other Australian state or territory (not Victoria)	11	131
New Zealand	1	10
United Kingdom	1	11
Canada	<1	2
United States of America	1	7
South Africa	0%	4
Other overseas country	2	27
Total	**100%**	**1,190**

Table 5: For non-Victorian applicants, state / territory of first qualification to practise as a psychologist (n=128)

Location	%	Count
New South Wales	34	44
Australian Capital Territory	9	11
Tasmania	9	11
South Australia	10	13
Western Australia	13	16
Northern Territory	1	1
Queensland	25	32
Total	**100%**	**128**