Access and attitude of rural allied health professionals to CPD and training

Karen Stagnitti, Adrian Schoo, Catherine Reid, James Dunbar

Continuing professional development (CPD) activities for allied health professionals are becoming mandatory as a means for professionals to maintain accreditation or skills. To access CPD activities, rural allied health professionals have the added costs of travel, accommodation and information technology access. It is assumed that health professionals in rural areas want access to training and CPD.

In 2003, a survey of allied health professionals was carried out in Southwest Victoria, Australia, with the aim of identifying access and attitudes to CPD. Results showed that allied health professionals in Southwest Victoria were highly qualified, wished to access CPD more than four times a year and were prepared to spend a mean rate of $1000 (£300) per annum on CPD activities.

Key words: access, attitude, continuing professional development, allied health professionals, rural


The move by allied health professions towards mandatory professional development and accreditation emphasizes the need for appropriate continuing education that complies with mandatory standards and that is at the same time, accessible for rural health professionals (Mills and Millsteed, 2002; Shillitoe et al, 2002; Cusick and Adamson, 2004). Since mandatory professional education and accreditation both include continuing professional development (CPD), the term CPD will be used throughout this article to include educational activities undertaken for professional development and training.

CPD is a process of lifelong learning and development for health-care professionals, whereby they maintain and improve their competencies and safeguard high standards of care (Hunter and Nicol, 2002; Shillitoe et al, 2002). Maintaining high standards of care for clients involves using the current best evidence for practice, together with individual clinical expertise, so that the most efficacious intervention is given to clients to maximize their quality of life (Sackett et al, 1996).

Providing best practice for client care is an important aim of CPD. A study involving 50 GPs and 50 consultants found that education was involved in one third of changes made to clinical practice to improve patient care (Allery et al, 1997). Validating the effectiveness of CPD to improve client care has only occurred since the introduction of mandatory registration or accreditation (Cantillon and Jones, 1999; Graham et al, 2001).

Accessibility to CPD programmes can be limited for allied health professionals who work in rural and remote areas, owing to professional isolation, lack of peer support and lack of opportunities to attend activities, because they either do not exist or are too difficult to access as a result of distance (Sheppard and Mackintosh, 1998). Accessibility to programmes can be further complicated by the cost of attending CPD programmes, time away from practice and scarcity of locums (Sheppard and Mackintosh, 1998).

To increase access to education for health professionals, a range of innovative technologies such as teleconferencing, videoconferencing, virtual conferencing, CD-ROM, the internet, electronic mail, videotapes and print materials offer the potential to overcome the barriers of time and distance to the rural or remote allied health professional (Hughes, 1998; Sheppard and Mackintosh, 1998).

The increasing expectation that allied health professionals participate in CPD and have access to these activities assumes that allied health staff have a positive attitude towards CPD and that health services provide the means for them to undertake such activities. To test these assumptions, a survey of allied health professionals was carried out in Southwest Victoria, Australia, which aimed to identify the access and attitude of rural allied health professionals to CPD. This study was part of a larger study, which examined recruitment and retention issues of allied health professionals living in Southwest Victoria.

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The Southwest region of Victoria is bounded by the Southern Ocean to the south, the South Australian border to the west and large farming properties and hilly landscapes to the north and east. The area is classified as accessible and moderately accessible on the Accessibility/Remoteness Index of Australia (ARIA) (Hugo, 2002).

**METHOD**

**Participants**

The target group for the survey included allied health professionals working in Southwest Victoria who met the criteria of 'university trained health professionals (other than medical practitioners or nurses) involved in direct patient care and/or services to the community' (Services for Australian Rural and Remote Allied Health (SARRAH), 1999).

As this survey was supported by the Department of Human Services in Victoria, it was important to include allied health professions that were employed by public health institutions in the region in 2003. Based on this definition, the following professional groups were included: psychologists; physiotherapists; occupational therapists; speech pathologists; social workers; pharmacists; dieticians; podiatrists; dentists; radiographers; orthoptists; optometrists; medical imagers; audiologists; psychotherapists; medical scientists.

In total, 184 out of 491 professionals returned their survey. Of these, 138 professionals completed the survey and met the criteria for allied health.

Professionals who did not meet the inclusion criteria were nurses working in non-traditional nursing roles or non-university-trained health workers.

The gender breakdown of the sample was 69.6% female (n=96) and 30.4% male (n=42). In total, 30% of the respondents (n=41) were aged under 30 years and 50% (n=69) were aged 40 years or over. Figure 1 presents the breakdown of the respondents by profession.

Some respondents nominated health promotion work above their original qualification (Figure 1). A total of 98 respondents (71.0%) were employed full-time, for ≥70 hours a fortnight, and 39 (28.3%) worked part-time, with a mean of 41.3 hours worked a fortnight. In total, 95 respondents (68.8%) were solely employed in the public sector and 33 (23.9%) were solely employed in the private sector, with 10 (7.2%) employed in both areas.

**Instrument**

The survey was designed based on the SARRAH (1999) workforce survey. It consisted of 78 questions, three of which were open and 75 of which were closed. A total of 25 questions were related to educational qualifications and attitudes to education. Other questions related to demographic and service delivery information (23 questions), recruitment and retention (27 questions) and attitudes to working in indigenous communities (three questions). Figure 2 gives examples of the survey questions and presentation.

**Procedure**

Ethical approval for the survey was granted by Deakin University. Consent by respondents was assumed if the surveys were returned. Because of privacy laws in Victoria, surveys and reply paid envelopes were sent to those allied health professionals listed in the phone book for the geographical region covered. For public health professionals, managers at each health service were identified by the research assistant and the surveys with reply paid envelopes were posted to managers to distribute to staff. A follow-up reminder letter was sent out 6 weeks after the initial posting. Surveys were returned to the research assistant.

**Data analysis**

Data were analysed using the Excel Statistics package (Carr, 2002). Descriptive statistics such as frequency distribution, proportion, mean, median and range were used to show trends in the data. For cross tabulations, SPSS version 11.5 (SPSS Inc, Chicago) was used.

**RESULTS**

**Description of educational qualifications**

The majority of respondents held an undergraduate degree. Some older respondents held diplomas and postgraduate qualifications, thus meeting the inclusion criteria of being members of the specific professions outlined. More than half of the respondents...
(54.3%, n=75) held qualifications higher than an undergraduate degree. Figure 2 presents the frequency with which qualifications were held.

In total, 50 respondents (36.2%) reported to have completed their postgraduate qualifications before commencing their current position and 72 respondents (52.2%) completed their postgraduate courses while in their current location. Of these, 33 (45.8%) courses were completed by full-time study, 27 (37.5%) by part-time study and 12 (16.7%) by a mix of both full- and part-time study.

Most postgraduate study was completed at a large metropolitan campus (54%, n=39). Respondents also studied externally from a metropolitan campus (14%, n=10), rural campus internally (17%, n=12) or rural campus externally (10%, n=7). A small number (6%, n=4) also completed their studies via a mix of both internal and external programmes.

The median distance travelled to complete postgraduate studies was 200 kms (mean=414 kms), with one student being required to travel 4000 kms to complete postgraduate studies. It cannot be concluded from the data whether respondents had elected to travel because of the university they had decided to attend or the availability of the course that they had elected. The frequency of travel varied enormously, with some respondents required to travel once a week while others were required to travel only once a year.

Respondents were asked about their preferred method of postgraduate training, with 39% (n=55) of respondents preferring to study in their current location rather than travel to a metropolitan campus (13%, n=18). Combined research and course work (33%, n=45) was preferred to pure research (2%, n=3).

Of the respondents, 56% (n=24) of the males and 45% (n=44) of the females had higher degrees. There was no significant difference between marital status and level of education attained ($\chi^2(25, n_{total}=138)=18.7, P>0.05$). Proportionally more professionals aged in their 20s had postgraduate qualifications (34%, n=14) than older groups, whereas more professionals aged in their 30s had a master's degree (24%, n=7) than the other groups. Higher degrees were held by 47% (n=45) of professionals working in the public sector and 56% (n=19) of professionals working in the private sector. Those with doctorates all worked in the private sector. There was no significant difference between private and public employment and level of education attained ($\chi^2(10, n_{total}=138)=11.5, P>0.05$).

**Access to continuing professional development**

A small number of respondents (8.7%, n=12) reported that they did not have access to CPD. Of those respondents who did have access, the top three
preferred types of CPD were training on request (29%, n=37), followed by formal in-service (19%, n=24) and ad hoc training as required (18%, n=23). The amount of CPD wanted by participants was answered by 131 (95%) of respondents. Of these, 78 (60%) wanted CPD four or more times a year, 25 (19%) wanted CPD three times a year, and 28 (21%) wanted it twice (n=24) or once (n=4) a year.

Continuing professional development costs
CPD costs to employers included course fees, travel and accommodation for staff. Respondents reported that the mean cost to employers per person of CPD per annum was $2135.27, with a median of $1000. The mean cost of professional development to employers was skewed by two respondents who received professional supervision at a cost of $10,000 each per annum. The mean personal cost of CPD was $1000.28, with a range of $0-5000. The costs to employers and individuals of the last professional development session attended were generally much lower than the mean costs. Figure 4 presents the cost to the individual and to the employer of the last professional development session attended.

The mean amount that respondents were prepared to spend personally on professional development per annum was $1050.88, the maximum amount being $5000. The majority of public sector professionals were prepared to spend up to $500 per annum for CPD, whereas the majority of private sector professionals were prepared to spend between $1000 and $3000 per annum.

The amount that respondents felt the employer should bear varied greatly, with 38 respondents (27.5%) reporting that they thought the employer should bear 100% of the costs of professional development. Two respondents (1.4%), both in private practice, felt the employer should bear none of the cost of professional development. The majority of respondents (92.8%, n=128) reported that the employer should bear 50% or greater of the costs of professional development. Figure 5 shows the annual amount that respondents were prepared to spend on professional development.

Salary range
Salary range for both full- and part-time employees was similar, with most employees earning the hourly rate of $20-29 per hour. There was a difference between the salaries of professionals employed in the public sector and those in private practice, with private practice professionals earning more per hour. Figure 6 presents data on salaries of private and public sector professionals. Professionals who worked in both sectors were not considered in this figure.

Preferred type of continuing professional development
Hands on training using face-to-face learning was found to be the preferred method of educational delivery by health professionals (42%, n=55).

Time spent on continuing professional development activities
The mean number of hours of CPD preferred per year by respondents was 48.45 hours (median 40), with a maximum of 300 hours per annum preferred by one respondent and a minimum of 5 hours per annum preferred by two respondents.
Access to information technology
Most respondents were supported in the workplace with access to information technology \((n=129, 92.8\%)\), with only 9 (6.5\%) respondents indicating they had no access. Access to computers was high \((n=129, 92.8\%)\), as was access to the internet \((n=120, 87.0\%)\) and email \((n=113, 81.9\%)\). Half of the respondents had access to electronic journals \((n=69, 50.0\%)\).

Continuing professional development access and intention to stay
There was no significant relationship between the amount of CPD and intention to stay \((\chi^2(20, n_{total}=138)=18.2=P>0.05)\). There was also no significant relationship between intention to stay and the CPD provided \((\chi^2(15, n_{total}=138)=15.5=P>0.05)\).

DISCUSSION
Educational qualifications
Allied health professionals in Southwest Victoria are well educated, with over half of the respondents indicating that they had postgraduate qualifications. At the time of the survey, graduate entry into an allied health profession was not common in Australia. There was a trend for younger professionals to have postgraduate qualifications. A survey of nurses in Hong Kong also found a trend for health professionals to continue education, with the majority of graduate nurses surveyed intending to continue their study (Simsen et al, 1996).

The benefits in undertaking postgraduate study have been found to include:
- Enhanced career progression, opportunities and options
- Development of clinical practice
- Enhancement of one’s life from obtaining a higher level of skill and knowledge, increased confidence and the likelihood of adopting a positive attitude towards change (Stathopoulos and Harrison, 2003).

Simsen et al (1996) found a significant relationship between marital status and educational level, with married nurses more likely to continue their study and choose generalist courses than single nurses. No relationship was found between marital status and educational qualification in this study. Further study is needed to explain the different findings.

Respondents completed their postgraduate degrees through a variety of course options, with half of the respondents completing their postgraduate degrees through a metropolitan university campus. This necessitated travel by many of the respondents to access further training. It has been suggested that rural and remote health professionals wishing to pursue professional education may face three hurdles:
- Choosing a suitable education programme that meets their professional needs
- Accessing such programmes without having to relocate to a major centre with disruptions to their family support systems
- Staying in the programme (Aoun and Johnson, 2002).

Delivery of continuing professional development
If given a preference for course delivery, the majority of allied health professionals nominated locally accessible courses. The Simsen et al (1996) Hong Kong study also found a preference for course work that was offered locally. Flexible course delivery, then, becomes an imperative to tertiary institutions servicing rural allied health professionals.

Face-to-face learning was found to be the preferred method of delivery by most health professionals. This has the added important benefit of providing valuable opportunities for networking (Sheppard and Mackintosh, 1998; Aoun and Johnson, 2002).

The primary aim of CPD is to help the health professional to maintain and improve clinical competence, which should be of direct benefit to clients. In medicine, the most effective CPD courses for improving client care were courses that were linked

<table>
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<th>Cost per annum</th>
<th>Public (n)</th>
<th>Private (n)</th>
<th>Public and private (n)</th>
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<tbody>
<tr>
<td>$0</td>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>$1-500</td>
<td>46</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>$501-1000</td>
<td>19</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>$1001-3000</td>
<td>7</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>$3001-5000</td>
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<td>0</td>
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<tr>
<td>Total</td>
<td>79</td>
<td>26</td>
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Figure 6. A comparison of salaries of private and public sector employees.

TABLE 1. Annual amount that respondents were prepared to spend on professional development by private and public sector

<table>
<thead>
<tr>
<th>Salary range</th>
<th>Public sector employees</th>
<th>Private sector employees</th>
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<tbody>
<tr>
<td>&lt;$20</td>
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to clinical practice and were based on work that doctors did (Cantillon and Jones, 1999).

The current study had similar findings, with health professionals preferring hands on training using face-to-face learning. For example, the current face-to-face CPD programme for physiotherapists in Southwest Victoria was composed on the basis of results of a needs survey, with requested topics that were directly related to the clinical work of physiotherapists in the region. The CPD presentation and workshop series in 2004 and 2005 included topics such as ‘assessment and treatment of soft-tissue injuries’, ‘taping techniques in sports and general physiotherapy practice’ and ‘incontinence and exercise therapy’. Courses included ‘myofascial dry needling’ and ‘stabilization exercises for people with back problems’ (Schoo, personal communication, 2005).

There is mounting evidence that CPD could improve clinical practice and client care, although the results have been mixed (Cantillon and Jones, 1999). For example, a study on the effectiveness of a course to help GPs manage depression and thus reduce suicide rates in Gotland, near Sweden, showed initial success in reduction of suicide rates (Rutz et al, 1989); but a follow-up study 3 years later showed management of depression had deteriorated and suicide rates had again risen (Rutz et al, 1991). Although management of depression had deteriorated between 1989 and 1991 in Gotland, the results of the 1991 study do suggest that continuing education was needed to maintain standards in health care for clients with depression.

Access to information technology
Professionals in the Southwest of Victoria are supported with information technology. Computer, internet and email access was high. Electronic journal access was only 50% and since that is an essential source of evidence on which to base practice, rural practitioners are disadvantaged in this area. It is not evident from the data if those professionals with no access to information technology in the workplace had private access at their home.

Attitude to continuing professional development
The majority of respondents could access CPD and most respondents reported that CPD four times or more a year was desirable. This level of CPD per annum is possibly a reflection of the change in clinical practice. Professional registration and accreditation programmes linked with the move towards evidence-based practice are probably the driving forces behind the desire to access CPD four or more times a year. Clinicians want to remain up to date, increase their knowledge, provide the highest quality care for their clients and maintain accreditation.

A study of burnout in occupational therapists and physiotherapists found that CPD activities were strongly associated with feelings of accomplishment, and even though the therapists were emotionally exhausted, they did not feel depersonalized (Schlenz et al, 1995). Health professionals’ positive attitudes to CPD could also be a reflection that they view their work as a career, and not as a short-term job (Brown et al, 2003).

Continuing professional development costs
The cost of rural allied health professionals accessing CPD is increased by the costs of travel, accommodation and food. Respondents spent an average of $1000 per annum on CPD, which was matched with employer contributions to CPD per annum. Shillitoe et al (2002) reported that in the UK, CPD was central to the government’s strategy for health services, but that despite this, CPD in allied health was unfunded and uncoordinated. The SARRAH survey of Australian rural and remote allied health professionals found that 45.6% of professionals were supported in CPD activities by their employer, which is comparable to the current study.

The majority of public sector professionals were not prepared to spend as much per annum for CPD compared to the majority of private sector professionals. This could be because private professionals earn a higher hourly rate on average than public health professionals. Private practitioners also run their own business and it is good business to provide best client care for the client’s money. Private professionals in this study were physiotherapists, dentists and pharmacists. This trend was not matched in educational level as no significant difference was found between the educational levels of private or public employees.

Recruitment and retention
The impact of CPD on health organizations is considered from the viewpoint of recruitment and retention of staff. Recruiting and retaining of competent staff ensures the delivery of constant high-quality services and the viability of individual professional departments (Smith et al, 1995). A systematic review of the role of CPD in recruitment and retention of occupational therapists working in mental health found no conclusive evidence that CPD was related to retention of staff (Hunter and Nicol, 2002). This was owing, in part, to the lack of studies addressing this specific question. However, in seven of the 13 articles analysed, CPD was considered an influence on retention (Hunter and Nicol, 2002).

Further evidence that CPD can benefit a health organization is summarized as follows:

- An Australian study of allied health professionals found that lack of access to continuing education
was a consideration of professionals intending to leave their workplace (Belcher et al, 2005)

- An American study found that CPD activities augmented feelings of personal accomplishment and minimized burnout, and was thus an issue in job retention (Schlenz et al, 1995)

- CPD activities were in the top three strategies of managers to recruit and retain occupational therapy staff (Smith et al, 1995)

- A Canadian study found that for therapists working in rural and remote areas, CPD influenced their job satisfaction but not their intention to stay (Solomon et al, 2001).

In this study, no connection was found between the amount of training offered and the respondents' intention to stay in their current position. Differing results are a reflection that retention is a multifactorial issue (Solomon et al, 2001; Stagnitti et al, 2005).

**CONCLUSION**

Despite the difficulties of rural health professionals accessing CPD, many respondents reported to have postgraduate qualifications. Those who pursued postgraduate qualifications in their current location travelled large distances. The vast majority of respondents had access to information technology.

Flexible course delivery that includes face-to-face interaction is the challenge for educational institutions and professions offering CPD to rural health professionals. Even though there was a difference between private and public employees in expenditure on CPD, most professionals were prepared to personally spend on CPD and most preferred to share costs with the employer.

Allied health professionals are not rewarded for CPD by increases in salary, yet this survey found that respondents had a positive attitude towards accessing CPD. It is suggested that maintaining registration and/or accreditation, the shift towards evidence-based practice, career development, improving clinical skills for client care and job satisfaction are all influential in shaping positive attitudes towards CPD. Although no relationship was found between CPD and intention to stay in their position, it is suggested that health professionals value CPD activities as indicated by the amount of money individuals were prepared to spend and preference for CPD activities four or more times a year. JTR

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Conflict of interest: none.


Services for Australian Rural and Remote Allied Health (1999) Survey of allied health professionals. SARRAH, Bathurst


**KEY POINTS**

- Rural allied health professionals (AHPs) had a positive attitude to continuing professional development (CPD).
- Rural AHPs preferred a mean of 48.5 hours CPD a year (i.e. four or more educational activities).
- Rural AHPs are prepared to spend money on CPD.
- Private practitioners spend more on CPD than practitioners in public institutions.
- AHPs felt that employers should contribute to the costs of CPD.
- Flexible course delivery that includes face-to-face interaction is the challenge for organizations supplying CPD.