I am the author of the thesis entitled: Comparison of the work of psychologists in rural and urban settings; Implications for professional training

submitted for the degree of Master of Arts

Access to this thesis is subject to the following conditions in accordance with Copyright Act 1968.

This thesis may be made available for consultation, loan and limited copying in accordance with the Copyright Act 1968.

Full Name......Thalia Dimogiannis

Signed.   Date 31-5-2000
Consultation of Thesis

Please sign this form to indicate that you have used this thesis in accordance with the Access to Thesis form signed by the author of this thesis.

<table>
<thead>
<tr>
<th>NAME (please print)</th>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COMPARISON OF THE WORK OF PSYCHOLOGISTS IN RURAL AND URBAN SETTINGS: IMPLICATIONS FOR PROFESSIONAL TRAINING

by

Thalia Dimogiannis, B. A. (Honours)

Submitted in total fulfillment of the requirements for a degree of Master of Arts.

Faculty of Health and Behavioural Sciences
August 2000.
DEAKIN UNIVERSITY
CANDIDATE DECLARATION

I certify that the thesis entitled:

submitted for the degree of:

is the result of my own research, except where otherwise acknowledged, and that this thesis in whole or in part has not been submitted for an award, including a higher degree, to any other university or institution.

Full Name  THALIA DINOCANNIS

(Please Print)
Signed  Date 25/08/2000

Signature Redacted by Library
Acknowledgments

I would like to express my gratitude to the following people and organisation without whom the completion of this degree would have been a harder and less enjoyable task.

My greatest thanks to my principal supervisor, Boris Crassini, for his invaluable input during the research process and the writing of this thesis.

John Hinchy, for his input into the design of the survey and guidance in the first stages of data analyses.

Catherine Cheyne, for her time in formatting this thesis.

The Australian Psychological Society for allowing me use of their mailing list, and their interest and endorsement of this research project.

My parents for whom enough could not be possibly said. Thank you for believing in me.
CONTENTS

1.1 Thesis Overview ........................................................................................................... 1
1.2 The Work Practices Of Rural And Urban Practitioners-Generalist versus specialist functioning ................................................................................................................. 5
  1.2.1 Work practices-Differences in the client profiles of rural and urban practitioners ................................................................. 14
  1.2.2 Alcoholism in rural and urban populations ........................................... 14
  1.2.3 Depression and suicide in rural and urban populations .................. 16
  1.2.4 The health needs of the farming community .................................... 21
  1.2.5 The health and social-welfare needs of indigenous people in rural areas .............................................................................. 21
  1.2.6 The health and social-welfare needs of disabled people in rural areas ................................................................................... 25
  1.2.7 Summary of the health and social-welfare needs of rural populations ......................................................................................... 27

1.3 Relations With Community .......................................................................................... 28
  1.3.1 The dual relationships of rural psychologists with their clients .......... 30
  1.3.2 The traditionalism of rural populations ............................................. 31
  1.3.3 Natural helpers ...................................................................................... 35

1.4 Training - Scientist-practitioner model ...................................................................... 38
  1.4.1 Training-Course content and structure with a focus on rural practice ......................................................................................... 40

1.5 Demographic Background Of Rural And Urban Practitioners ................................ 44

1.6 Summary And Aims .................................................................................................... 45

METHOD

2.1 Subjects ....................................................................................................................... 49

2.2 Test Material ............................................................................................................... 50

2.3 Procedure .................................................................................................................... 53

RESULTS AND DISCUSSION .......................................................................................... 54

3.0 Preamble: Overview Of Data Analyses To Be Reported ....................................... 54

3.1 Comparison Of Rural And Urban Psychologists In Terms Of Demographic Variables ......................................................................................................................... 56

3.2 Comparison Of Rural And Urban Psychologists In Terms Of Their Formal Professional Qualifications, Professional Development Activities, And Their Evaluation Of The Adequacy Of Their Professional Training ............................................... 59
3.2.1 Comparison of rural and urban psychologists in terms of their formal qualifications and where these were obtained .................................. 60

3.2.2 Comparison of rural and urban psychologists in terms of ongoing professional development activities in psychology ......................... 62

3.2.3 Comparison of rural and urban psychologists in terms of their evaluations of the adequacy of their formal training in psychology.. 65

3.3 Comparison Of Rural And Urban Psychologists In Terms Of Their Work And The Clientele They Serve ......................................................... 67

3.3.1 Comparison of the work conditions and practices of rural and urban psychologists ........................................................................... 68

3.3.2 Comparison of clientele served by rural and urban psychologists.... 70

3.3.3 Summary.................................................................................................................. 73

3.4 Comparison Of Rural And Urban Psychologists In Terms Of Their Relations With Their communities .......................................................... 76

3.4.1 Comparison of rural and urban psychologists in terms of their relations with community members, prominent community members, and natural helpers ................................................. 76

3.4.2 Comparison of the ways in which rural and urban community members learn about mental health issues........................................... 77

3.4.3 Comparison of the opinions rural and urban psychologists have on training natural helpers to assist in the provision of psychological services ............................................. 79

3.4.4 Summary.................................................................................................................. 79

3.5 Conclusions And Implications Of Research Findings .............................. 81

References............................................................................................................................................. 85

Appendix 1........................................................................................................................................ 90

Appendix 2........................................................................................................................................ 91
Tables

Table 1. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit demographic information. .................................................. 57

Table 2. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items seeking information about where they and their spouses spent their childhood. .......................... 58

Table 3. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items seeking information about their formal professional qualifications and where these were obtained. ........................................................................................................... 60

Table 4. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about ongoing professional development. ............................................. 63

Table 5. Summary of responses (mean ratings on a five-point scale; standard deviations in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about evaluations of formal training in psychology. ........................................................................................................... 66

Table 6. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about work conditions. .................................................. 68

Table 7. Summary of responses (mean estimates of % time spent in each activity; standard deviations in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about work practices. 70

Table 8. Summary of responses (mean estimates of % of clients; standard deviations in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit demographic information about their clientele. .............. 71

Table 9. Summary of responses (mean estimates of % of work with clients; standard deviations in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about the problems presented to them by their clientele group. ........................................................................................................... 72

Table 10. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to obtain information on the ways in which rural and urban communities learn about psychological issues. ........................................................................................................... 78

Table 11. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit their opinions on training natural helpers. .................................................. 79
Abstract

To compare the work practices and training needs of rural and urban psychologists, 774 surveys were sent to psychologists throughout Australia. The psychologists were selected from the Australian Psychological Society (APS) Directory of Psychologists, 1992-1993. A total of 86 rural psychologists and 282 urban psychologists responded to the survey. The survey comprised of four sections with questions asking respondents their demographic and employment background, past and current training activities, work experience, and relations with community. Results showed that the decision to practice and remain in a rural area was influenced by psychologists’ childhood experience and professional training in a rural setting. A substantial proportion of rural psychologists (28%) had been working in rural practice for five years or less. These rural psychologists were identified as a group that had a demographic and training profile more similar to urban psychologists than their rural colleagues. The employment conditions and training background of rural and urban psychologists were similar, though rural psychologists were more likely to be working in private practice and have undertaken their studies in a rural setting. Rural and urban psychologists rated their undergraduate and postgraduate training in psychology as only somewhat adequate. Training in rural health and community issues received the lowest ratings from both groups of psychologists. The work practices of rural and urban psychologists were also similar. There were some differences in the demographic profile of the client groups seen by the two groups. Rural psychologists reported the type of relations with their communities that are conducive to rural practice. The main evidence of this was that rural psychologists were collaborating with the natural helpers of their communities, and expressed willingness to formally train natural helpers to assist in the provision of psychological services. There were several conclusions drawn from this study. The first conclusion was that rural psychologists with urban demographic and training backgrounds are a group that is likely to migrate from rural practice to urban practice. Secondly, training needs to be specialised for rural practice if there is to be an improvement in the number of psychologists practicing in rural settings. Thirdly, rural psychologists were conducting the type of relations with their communities that are important to the requirements of rural practice.
1.1 **THESIS OVERVIEW**

Australia is one of the most highly urbanised countries in the world, with only 15% of the population living in rural or remote areas (Skinner, 1997). Over half the people living in urban areas (63%) reside in the capital cities of the States and Territories, and the number of metropolitan regions (areas in proximity to capital cities) continues to grow, (519 in 1971 to 701 in 1991). Because of the population cluster in urban areas and the continuing urban sprawl, capital cities and surrounding metropolitan areas have always been the centres of government, administration, finance, transport, and communications. Services that provide a lifeline to the health and welfare needs of a community are also concentrated in urban areas. Rural areas have few if any health and social-welfare services that enhance the health and wellbeing of a community. As most of these services are concentrated in urban areas, they are more likely to be relevant to urban populations than rural populations. Researchers have found that rural and urban populations have unique health and welfare needs and require models of services tailored to these needs (Anderson, Bhatia, & Cunningham, 1996; Dunn, 1996; Harrison, 1996; Jorm, Rosenman, & Jacob, 1993; Manning & Cheers, 1995; McLeod, 1993; Picket & Frederico, 1992; Yellowlees, 1992). Examples of the diverse health and welfare needs of rural and urban populations are the differences in the economic, demographic, and sociocultural profile of Aborigines in rural Australia in comparison to the remainder of the rural population and the urban population. Economic, demographic, and sociocultural factors affect the health and social-welfare issues of a population. As a result, health and social-welfare services to Aborigines in rural Australia need to be more relevant to the specific problems of Aborigines rather than the Australian population overall. The health and welfare issues relevant to the indigenous population of Australia will be discussed in more detail in a later section of this thesis.

In addition to different health and welfare needs, rural populations have a greater demand for health and social-welfare services than urban populations. For example, in 1993 the Federal Commissioner for Human Rights, Brian Burdekin, reported that the rural recession had increased the level of stress and mental health problems in the rural population. He described a paradox within which the need for mental health services in Australia was greatest in rural areas, but their availability in these areas
was the lowest in the country. Since Burdekin's report there have been initiatives to improve the level and relevance of health services to rural populations (see the National Rural Health Strategy Update Report, 1996) but the main emphasis of these initiatives has been on physical health rather than mental health and related services.

The mental health needs of rural populations cross all ages, but a critical example of the urgency required in addressing the inadequate level of mental health services in rural areas is the male youth suicide rate. The male youth suicide rate in Australia is 50% higher in rural areas than it is in urban areas (Morrell, Taylor, Slaytor, & Ford, 1999). Between 1990 and 1992 the difference in the rate of suicide between male youths in remote rural and capital cities was 25 cases per 100,000 population in comparison to 50 cases per 100,000 population. Evidence that rural youth have inadequate access to mental health services has been found by Praeger and Liebenberg (1994), who made a comparison of the access rural and urban adolescents have to health care services and information. Praeger and Liebenberg surveyed 8% of all Western Australian adolescents in government schools from grades 8 through 12. The adolescents were required to indicate how regularly they used certain sources of health assistance and information (i.e., parents, peers), and whether these sources were easily attainable. The outcomes of the survey revealed that students from urban regions of Western Australia were significantly more likely to report they could acquire information on drug use, feelings of hopelessness, anxiety and nervousness in social situations, and proper nutrition than students from rural regions.

The maldistribution of health and social-welfare services across rural and urban areas is a problem common to most urbanised countries in the world. Similarly to studies conducted in Australia, research worldwide has provided evidence that rural populations have health and welfare needs that are failing to be met by accessible and appropriate services (Anderson et al., 1996; Harrison, 1996; Harvey & Hodgson, 1995; Jorm et al., 1993; Manning & Cheers, 1995; McLeod, 1993; Pucket & Frederico, 1992; Yellowlees, 1992). In Australia, the majority of this research has come from the medical and allied health professions, and social and welfare work (Andrews, 1990; Craig & Nichols, 1993; Davies, 1991; Harris, Sutherland, Cutter, & Ballangarry 1987; Jorm et al., 1993; Pucket & Frederico, 1992; Watts, 1993; Wise et
al., 1994; Yellowlees, 1992). In comparison to the literature on rural practice for health and social-welfare professionals, little documentation exists on the work practices of psychologists in rural Australia. One aim of the research reported in this thesis is to redress this imbalance. Increasing the research on the work practices of rural psychologists could lend further insight into the mental health needs of rural populations. In addition, differences that may be found in the work practices of rural and urban psychologists would have implications for current psychology training models in higher education institutions.

Most theoretical and practical training courses for health and social-welfare work have been developed in and for the urban environment (Berry & Davis, 1978; Carr, 1987; Craig & Nichols, 1993; Harvey, Linn, & Saville, 1980; Hays, 1991; Herring, 1992; Keller, Murray, Hargrove, & Dengerink, 1983; Kenkel, 1986; Liaw, 1992; Rolfe, Pearson, O’Connel, & Dickinson, 1995; Watts, 1993; Wise et al., 1994; Zejda, McDuffie, & Dosman, 1993). Considering the differences in the work practices of rural and urban practitioners, many researchers have questioned the relevance of these training courses to the health and welfare needs of rural populations (Berry & Davis, 1978; Carr, 1987; Craig & Nichols, 1993; Kenardy & Griffiths, 1996; Kenkel, 1986; Liaw, 1992; Rolfe et al., 1995). Graduates who embark on a career in a rural region could find that they have to practice skills and techniques that have been underdeveloped or ignored during training. For example, many rural general practitioners (GPs)\(^1\) carry out some forms of surgery that is usually the domain of specialist practitioners in urban areas. The techniques of this surgery are briefly covered in GP training because they pertain to a specialist practice. The inadequacy of training for rural practice has also been found to inhibit many practitioners to work in rural settings (Carr, 1987; Craig & Nichols, 1993; Harvey et al., 1980; Hays, 1991; Liaw, 1992; Watts, 1993; Rolfe et al., 1995; Rosenthal et al., 1992; Russel, Clark, & Barney, 1996; Sears, Evan, & Perry, 1998; Wise et al., 1994). In the case of GPs much of the resistance to practicing in rural areas lies within the lack of training for specialist procedures regularly demanded of rural GPs because of the demands of their practice (Wise et al., 1994).

\(^1\) "GPs" (General Practitioners) represents medical practitioners working in general medical practice.
In summary, rural communities are disadvantaged on many levels in their access to health and social-welfare services in comparison to urban populations. Firstly, health and social-welfare services are under represented in rural communities even in proportion to the sizes of their populations. In fact, the demand for health and social-welfare services is even greater in rural communities than it is in urban communities. Secondly, the models of current health and social-welfare services are not as relevant to rural populations as they are to urban populations. As outlined above, rural and urban populations have diverse health and social-welfare requirements that need to be attended to by appropriate and relevant services. Thirdly, the main concentration of health and social-welfare services in urban areas means that current training models for practitioners are based on urban community issues and problems. Moreover, the inadequate training in rural health and social-welfare issues creates stagnation in the flow of urban-trained practitioners to rural practice. Finally, the work practices and training needs of rural and urban psychologists in Australia is under-researched, and any argument to modify current practices and training methods should be based on more evidence. In response to this lack of research, the current study aims to explore the differences in the work practices and training needs of rural and urban psychologists in Australia. The differences in work practices will be measured by comparing and contrasting the work activities of rural and urban psychologists, and the demographic and psychological profile of their clients. The training needs of rural psychologists will be measured through their level of satisfaction with previous and ongoing training, and their perception of how relevant training has been to their experiences as rural practitioners.

A review of the research on the differences in the work practices of rural and urban practitioners follows in Sections 1.2-1.2.7. Research on the implications of community relations for the work practices of rural and urban practitioners will be discussed in Sections 1.3-1.3.3. A review the literature on the adequacy of current models of training for rural health and social-welfare practice will be provided in Sections 1.4-1.4.1. The influence of the demographic background of rural and urban practitioners on their decision to work in a rural or urban setting and their competency as professionals in those settings will be discussed in Section 1.5. Finally, a summary of the main points from the review on previous research and the aims of the current study will be provided in Section 1.6.
1.2 THE WORK PRACTICES OF RURAL AND URBAN PRACTITIONERS-
Generalist versus specialist functioning

The current section provides a review of the literature defining the differences between rural and urban psychologists, medical practitioners, psychiatrists, and social-welfare professionals in Australia, North America, and Europe. Most studies described in the literature show that the main difference between rural and urban practitioners is their ability to practice as specialists (Cheers, 1992; Hoe, 1982; Hood, Malcolmson, Young, & Abbey, 1993; Jerrel & Herring, 1983; Miller & Zuckerman, 1991; Pulakos & Dengerink, 1983). Psychologists in urban settings can specialise in their practice so they only offer counselling in a specific area such as couple and family therapy, and clients with problems falling outside the area of specialisation can be referred on to other psychologists and mental health services. The ready availability of other services also means that urban psychologists can choose to exclusively practice the core task of counselling and therapy, and need have no involvement in other activities such as public education programs. In contrast, psychologists in rural settings have to be generalists as there are few if any services or other practitioners to which clients can be referred. Psychologists in rural settings need to be flexible enough in their counselling methods to address the mental health needs of the wide range (in terms of presenting problems) of clients seeking their assistance. Rural psychologists are also often required to expand their role beyond the core task of counselling and conduct community work that enhances the familiarity of the public with mental health issues. The greater involvement with the community also means that rural psychologists frequently work with other professionals and organisations such as the Police to facilitate interactions between these professionals and mentally ill individuals.

In a study comparing the work activities of rural and urban psychologists in Washington, Pulakos and Dengerink (1983) found that rural psychologists spread their time among more activities than their urban colleagues. The data on the activities of 15 rural and 15 urban mental health centres were collected from a

---

2 The term 'generalist' in this section refers to a model of practice that includes multiple roles and tasks that are not traditionally carried out within the profession (e.g., the specialist surgical procedures performed by rural GPs). Specialist, on the other hand, refers to the type of practice that focuses on a particular area such as endocrinology with little crossover into other areas of professional practice.
management information system that held monthly reports of the activities of each centre. The data from all mental health centres in rural and urban areas were collated to produce overall results for rural and urban psychologists. The results showed that 48% of rural psychologists spent 90% of their time in two activities, and 67% of urban psychologists spent 67% of their time in one activity. In addition, a substantially higher percentage of rural psychologists compared to urban psychologists (24% and 7% respectively) reported spending more than 10% of their time in the two activities.

The generalist role of rural psychologists includes community work that educates the public in mental health issues, and clarifies the role of psychologists in the support and treatment of individuals with mental illness. Bergland (1988) proposed that staff and administrators of rural community mental health centres become active participants in the community they serve by developing strategies that reduce the stigma of mental illness, while attracting community members to mental health programs and services. He cited an example of a community mental health centre in Wyoming that offered services in financial management, legal issues, and educational information, as well as running the normal operations of a mental health centre. In this way the primary aim of the centre (to offer mental health services) was represented to the community as a secondary focus of the centre, and as a result drew potential clients who realised they needed the services of a professional mental health worker, but were initially hesitant and concerned about their image in the community.

Researchers have observed that psychologists who practice in rural areas and conduct a generalist model of practice, are also implementing principles of community and primary prevention mental health care (Bergstrom, Hill, & Miller, 1984; Hargrove, 1991; Kahn, McWilliams, Balch, Chang, & Ireland, 1976; Keller, 1982; Keller et al., 1983; Macleod, Masilela, & Malomane, 1998; Murray, 1984; O’Brien, 1998; Spoth, Goldberg, & Redmond, 1999). For the past two decades, advocates of community and preventive health care have argued that these models of practice are ideal ways of addressing the health needs of socio-economically disadvantaged and isolated communities. The initial enthusiasm for what was referred to as a new health care movement in the 1970s and early 1980s waned however, because of evidence that
health practitioners were adamantly maintaining client-oriented intervention models of practice. The generalist model of practice undertaken by rural psychologists encompasses professional contact and involvement with the community that leads to the communication of strategies to prevent mental illness in the community, as well as intervention in client-focused therapy. Practicing community and preventive techniques of health care in rural areas could possibly reduce the high rate of mental illness in the population, because the public are more aware of the causes and symptoms of mental illness, and mental health care initiatives are more integrated with the community (Bergland, 1988; Heyman, 1986; Humes-Noyes, 1980; Kenkel, 1986). The size and social structure of most rural communities also create an ideal environment for the practice of community and preventive models of health care. Kenkel suggested that the smaller population size of rural communities makes it easier for the population to see the overall effects and advantages of community and preventive mental health care initiatives. Rural populations would also be more eager to embrace preventive models of practice as they could reduce the necessity for people to seek treatment in a community that has negative views about mental illness.

McLeod (1993), who was a practicing nurse in East Arnhemland, Northern Territory, described the advantages of practicing community and preventive mental health care for the Aboriginal population of the region. In the past when Aboriginal patients were transferred to a Darwin psychiatric unit, their mental health problems were often exacerbated by the social isolation they felt when they were far from their relatives, friends, and their country. The social withdrawal and confusion patients exhibited as a result of the foreign environment were often misinterpreted as symptoms of psychiatric disorders and led to a misdiagnosis. Treating patients in their country was an advantage to the patient who had the support of their friends and relatives, and to the health care provider who could access the support networks in the community. Networks that were valuable to the treatment of patients were the patients' immediate and extended family, community groups, and health teams made up of Aboriginal health workers. McLeod also described preventive techniques of mental health care that were delivered in the area to reduce the occurrence of mental problems and illness in the population. Mental health care workers provided education in stress management and domestic violence, conducted growth and
development projects with school children, and ran women's resource health and mental health centres.

As already mentioned, medical practitioners in rural areas are also more likely to follow a generalist model of practice than their urban colleagues. To cover for the lack of other medical professionals in the area, rural GPs often practice techniques and skills that are exercised by specialist trained doctors. The practice of specialist skills by rural GPs has been a controversial issue in the medical profession. Rural GPs often cross the boundaries of what are considered appropriate practices for GPs when they carry out specialist procedures (Mohammed & Susman, 1992; Watts, 1993; Woollard & Hays, 1993). The rules restricting GPs from practicing specialist procedures however are questionable for rural GPs. Many writers have argued that rural GPs do not have the choice to avoid specialist procedures because of the lack of specialists in rural areas (Craig & Nichols, 1993; Craig, Nichols, & Price, 1993; Davies, 1991; Mohammed & Susman, 1992; Watts, 1993; Wise et al., 1994; Woollard & Hays, 1993).

The legal ramifications of a GP practicing skills and techniques beyond formal qualifications have to be reconsidered for rural GPs who do not have the professional support networks of their urban colleagues. Studies have shown that rural GPs conduct specialist procedures so regularly that they consider them to be normal components of general practice. Mohammed and Susman surveyed GPs in rural and urban Nebraska to ascertain whether there was a difference in the procedures they considered to be core duties of general practice. The results showed that rural GPs were more likely to perceive intrauterine device insertion, endometrial biopsy, and cervical biopsy procedures to be common procedures of general practice. Mohammed and Susman concluded that rural GPs had integrated these procedures into their practice because of the lack of specialists and health services to which patients could be referred. Rural GPs in Australia have also indicated they frequently perform specialist procedures (Craig & Nichols, 1993; Craig et al., 1993; Davies, 1991; Watts, 1993; Wise et al., 1994).

Wise et al. compared the characteristics of rural and urban general practice in Queensland. Rural doctors were significantly more likely to practice varied clinical
and specialist skills, and practiced them more frequently than their urban colleagues (at least monthly or occasionally). Watts (1993) described the most common specialist skills to be practiced by rural GPs in Australia as obstetrics, obstetric analgesia, and anaesthesia. Davies also found that rural GPs in Australia were more likely to practice specialist skills related to emergency surgery than their urban colleagues.

Interestingly, most rural GPs consider performing specialist procedures to be one of the most satisfying aspects of their work (Hays, 1991; Kamien & Buttfield, 1990; Mira, Cooper, & Mandaag, 1995; Sims, 1992; Watts, 1993). The main advantage that emerges from broadening a general practice to include specialist techniques is the opportunity to oversee a patient from their diagnoses to treatment to post-treatment care; a process that allows continuity of care (Watts, 1993). Conversely, most urban GPs report that the most undesirable feature of practicing in rural areas is the prospect of performing specialist procedures. Studies have shown that the fear of practicing specialist skills is a stronger influence on the decision of GPs not to practice in a rural area, than any social or physical characteristics of rural areas (Craig & Nichols, 1993; Liaw, 1992; Watts, 1993). Rural GPs on the other hand, report the isolation of rural practice, heavy workload, and difficulty in finding locum tenets to be the most negative features of rural practice (Dua, 1998; Kamien & Buttfield, 1990).

Further evidence that rural GPs have more diversified work practices than urban GPs is their involvement with after-hours patient care. Traditionally, providing after-hours care was a core duty of most GPs. In most urban areas today, after-hours care and emergencies are mainly attended to by 24-hour medical services. In contrast, rural GPs are still taking charge of most of the after-hours and emergency needs of their patients. Mira et al. (1995) conducted a survey to investigate the level of Australian rural and urban GPs participation in after-hours patient care; 95% of the rural GPs provided after-hours care, and frequently did so in collaboration with other practices. However, 50% of the urban GPs provided after-hours care, and none collaborated with other practices to provide the service. Mira et al. attributed the lack of collaborative efforts by urban GPs to their greater competitiveness. Urban GPs who offer after-hours services have more administrative and professional support,
and can afford time to provide the after-hours care without collaborating with other practitioners or services. In comparison, rural GPs rarely have the time or resources to solely provide after-hours care to all their patients. There are so few medical services in rural areas that rural GPs need to collaborate with as many professionals and agencies possible to provide the optimal level of overall care. Rural GPs were also more satisfied with their after-hours arrangements than urban GPs. Participating in after-hours care gave rural GPs the opportunity to oversee their patients' continual care. Urban GPs who provided after-hours care also seemed to find the continuity of the patient-GP relationship agreeable, as they expressed the same level of satisfaction with their after-hours arrangements as rural GPs.

The need for rural GPs to expand their skills to after-hours and emergency services has also been reported in studies comparing rural and urban medical practitioners in the USA. Bross, Wiyyul, and Rushing (1991) studied the records of patients randomly selected from 17 rural hospital emergency departments (EDs) in Mississippi, and compared them to the records of urban patients. The patient profiles of rural and urban EDs showed no significant difference. However, rural GPs were found to be more involved with the services of the EDs in their region, often conducting procedures that would be undertaken by other medical workers in urban hospitals. Most of the EDs in rural areas were staffed by on-call doctors from the community, rather than in-house doctors employed by the hospital. In addition, rural GPs used the small EDs for outpatient surgery and other procedures, providing more comprehensive services for their patients than the services offered by most of their urban colleagues. The rural EDs also received patients who would be directly sent to a major hospital if in an urban area. On average, a major rural hospital was located 52 miles away from the ED, and it was the duty of the GP to stabilise the patients who had to be transferred. Bross et al. (1991) pointed to the inconstancy of GP training with the emergency medical procedures conducted by rural GPs. Rural GPs require more generalist training to prepare them for diverse procedures such as the stabilisation of seriously-ill patients. In urban areas critically-ill patients would be sent directly to a major hospital, and GPs in these areas would rarely be involved with the procedures of stabilisation and emergency surgery.
The requirement for rural psychologists and GPs to expand their work practices to make up for the lack of other health professionals and resources also applies to rural psychiatrists. There are very few psychiatrists in rural Australia (Andrews, 1990; Jorm et al., 1993; Yellowlees, 1992) with the ratio of psychiatrists to population falling well below that recommended by the Royal Australian and New Zealand College of Psychiatrists (one psychiatrist per 7,500 to 10,000 population). In 1990, Melbourne, Sydney, and Adelaide had a higher ratio of psychiatrists than 1 per 10,000 population, while rural areas had significantly lower ratios (Andrews, 1990). In the Far West Region of New South Wales for instance, there were approximately 1.1 full-time psychiatrists for a population of 33,398 (Yellowlees, 1992). Yellowlees described at length his experience as a psychiatrist in a rural community health centre. The community health centre was made up of a team of psychiatric nurses, psychologists, clerical assistant, and residential care assistants who offered 24-hour services. Clients with mild to severe psychiatric problems were referred to the centre as there were no exclusion criteria in the referral process. Clients included children, elderly people, forensic patients, and many patients with alcohol dependence. In the referral process and placement of patients in the base hospital, there was frequent collaboration between team members and the Police and GPs. The team also ran a group home set up as a rehabilitation house for ex-patients of psychiatric wards. The activities of the centre resembled the generalist model of practice conducted by rural psychologists and GPs. The centre accepted all referrals as there were few other resources for GPs and agencies such as the Police to refer patients on. There was also collaboration between other agencies and the centre to refer and place patients for therapy. The rehabilitation house was a way of maintaining continuity of care with patients, while expanding the scope of the centre to include community work. Community work also involved preventive mental health programs that educated the public in mental health issues. The community health centre team members worked with school counsellors to develop and run education sessions in the classroom on preventive mental health care. Finally, even non-medical team members administered medication, albeit with the supervision of a psychiatrist. The supervision often took place over the phone, since in many instances the team member had to travel great distances with the Royal Flying Doctor Service to consult the patient.
The administering of drugs by "unqualified" practitioners in rural settings emphasises the generalist nature of rural practice, and raises the question of whether rural psychologists should also be allowed prescription privileges. Deleon, Fox, and Graham (1991) have argued that the mental health needs of rural populations, and the scarcity of medical and non-medical health professionals to meet them, are sufficient justification to allow psychologists prescription privileges. In 1991 optometrists had prescription privileges in 24 states of the USA, and the majority of these states were rural. Brentar and McNamara (1991) stated less optimism about the possibility of such an expansion in the traditional core tasks of psychologists. They argued that although the number of psychologists in rural America was low, GPs who were more abundant in these areas often took on the role of the mental health practitioner. It is also unlikely that GPs and psychologists would collaborate in the prescription of drugs, as most of the resistance to allowing psychologists prescription privileges comes from medically-trained health professionals. Rural psychologists also have the disadvantage of being perceived unfavourably by rural community members. Evidence has shown that even if a psychologist is available, rural people are more likely to seek consultation and treatment for a mental health problem from their family doctor (Brentar & McNamara, 1991). Familiarity with the family doctor and the threat of being seen by community members when visiting a psychologist are the main reasons rural people prefer mental health care from GPs. Even so, Brentar and McNamara questioned the appropriateness of rural doctors administering psychotropic drugs, and suggested that the practice was not a viable solution to the lack of mental health services in rural areas. They argued that in comparison to psychologists, GPs might not be as knowledgeable in the theories and practice of psychopharmacology. Without psychiatrists, the next most appropriate professionals to administer psychotropic drugs would be other mental health professionals.

Similarly to health professionals, social and welfare workers in rural areas carry out a more generalist practice than their urban colleagues. Pucket and Frederico (1992) replicated a North American study to test whether there were differences in the work practices of Australian rural and urban welfare workers. A significantly higher percentage of rural welfare workers reported they worked with committees or community groups to create resources to meet the welfare needs of the community. In contrast, urban welfare workers worked in a clinical practice with individuals.
families, or small groups to produce specific changes in the behaviour of their clients. Rural welfare workers also more commonly participated in the collection and analysis of data to assist in the development of action plans. They were also more likely to manage a welfare program, service a unit or welfare organisation, and work with large groups, organisations, and communities to teach skills in solving welfare-related problems. Overall, rural welfare workers participated in more activities than their urban colleagues. They performed as generalists by more frequently branching out into non-counselling activities such as research, and contributing their knowledge and skills in a community and preventive style of practice. Because of the lack of other welfare workers and resources, rural welfare workers more regularly collaborated with other professionals and community members to increase the availability of their services in the community. Skills in preventing and solving social and welfare problems were taught in schools and to community members to enhance the level of wellbeing in the community.

In summary, there are differences between rural and urban practitioners that apply to most health and social-welfare professions. For example, conducting a generalist practice is appropriate for any health or social-welfare professional in a rural community where there are inadequate resources to refer clients on, and initiatives to prevent illness and social-welfare problems are preferred to intervention methods of treatment and assistance. It was briefly discussed above that rural GPs require training in specialist procedures to prepare them for their multi dimensional roles in rural areas. The same applies to other rural health practitioners and social-welfare workers who would benefit from training in a more generalist form of practice than what is usually carried out in urban centres.

So far specialist versus generalist work practices has been identified as the major difference between rural and urban practitioners. Work practices can also be influenced by the characteristics of rural and urban populations. As foreshadowed in the thesis overview, rural and urban populations have health and welfare needs that are unique to their environment and culture. A review of the literature that identifies the differences between rural and urban populations and the impact these differences have on the work activities of rural and urban practitioners follows.
1.2.1 Work practices-Differences in the client profiles of rural and urban practitioners

The economic, demographic, and socio-cultural profile of a community are linked to the health and wellbeing of its population (Brown & Prudo, 1981; Casey & Tyrer, 1990; Clarke & Jensen, 1998; Crandell & Dohrenwend, 1967; Cunningham, Sibthorpe, & Anderson, 1997; Dudley, Kelk, Florio, Water, Howard, & Taylor, 1998; Griffiths, 1996; Hargrove & Breazale, 1993; Human & Wasem, 1991; Kenkel, 1986; Liaw, 1992; Mazer, 1982; McLennan & Madden, 1997; Mueller, 1981; Norris, 1993; Silburn et al., 1996; Swan & Raphael, 1995; Yellowlees, 1992; Yellowlees & Kaushik, 1992). Poverty, sub-standard housing, and high unemployment, for example, can be a catalyst to the development of mental illness in people who are predisposed to a disorder, or worsen the condition in individuals already afflicted. Rural areas in Australia as well as overseas, are generally worse off in economic and socio-cultural conditions that secure the high standard of living and positive health status of a population (Australian Bureau of Statistics\(^3\), 1997). The greater number of health and social-welfare problems of rural populations in comparison to urban populations have implications for the work practices of rural and urban practitioners. Generalist work practices achieve the goal of increasing the level of services to rural populations. Moreover, generalist work practices are more flexible in meeting the needs of culturally diverse populations. A large part of the discussion below identifies the health and social-welfare needs of Aborigines in rural areas and how models of services to address these needs should be relevant to Aboriginal traditions and culture. The community and preventive work that are components of generalist work practices would also require rural practitioners who work with Aborigines to collaborate with prominent Aboriginal members and groups. Illustrations of this process are provided in Section 1.2.5.

1.2.2 Alcoholism in rural and urban populations

There is evidence that rural and urban populations exhibit different rates of mental illness in Australia. Yellowlees (1992) compared the diagnostic profile of psychiatric patients in Broken Hill with the profile of psychiatric patients Australia wide. Yellowlees derived the Broken Hill patient profile from his case notes on all 707

\(^3\) Australian Bureau of Statistics will be abbreviated to ABS from this point onwards.
patients examined in the region from 1986 to 1990. The urban psychiatric patient profile was created from two similar studies conducted nationwide. Alcohol abuse was four times more common in Broken Hill than in the whole of Australia, and most of the sufferers in both groups were males. Yellowlees suggested the percentage of his patients with alcohol problems was even higher, as many of his male patients had psychoses that could have been triggered by alcohol abuse. Alcohol abuse was the most common and severe problem in the rural patient population, with the effects of the disorder going beyond the individual sufferer. Yellowlees linked the frequent alcohol abuse by males in Broken Hill to the violent episodes and sexual abuse experienced by many of the females and children in his patient population (Yellowlees & Kaushik, 1994). A chronic level of alcohol abuse has also been reported for other rural areas in Australia. Harris et al. (1987) reported a high proportion of patients with alcohol related disorders in Western Australian rural hospitals. Results from their survey of rural hospital patients showed that 10% of the respondents had an alcohol-related disorder. Only 0.2% of the patients surveyed claimed to be non-drinkers—well below the percentage of people claiming to be non-drinkers nationwide.

The consistently higher rate of alcoholism in rural populations is partly perpetuated by the difficulties in treating alcoholics in underserviced areas. Treatment of alcoholic patients needs to continue after they are released from hospital because of the high probability of the illness recurring (Fortney, Booth, Blow, & Bunn, 1995; Wise et al., 1994). Fortney et al. investigated the effect of travel distance on recovering alcoholics’ usage of aftercare facilities and programs. Travel distance was likely to be greater in rural areas where services were fewer and at a greater distance than were accessible to urban people. The outpatient records (up to 30 days after completion of treatment) of 4,621 male veterans who had completed inpatient alcohol treatment were analysed. Results showed that distance from aftercare facilities and attendance to these facilities were negatively correlated. Elderly patients showed the most decline in aftercare attendance as distance to facilities increased. Rural elderly patients showed the least attendance at aftercare treatment facilities regardless of distance. The treatment of alcoholics is another example of how generalist and community health and social-welfare work would better serve rural populations. Alcoholics in rural areas lack the support services to assist them
with the long-term abatement of alcohol abuse, and so need the continual care of the health and social-welfare professionals in the community.

As outlined above, low standards of living, high unemployment, and severe health problems are just a few symptoms of an economically disadvantaged community that can cause or exacerbate mental health disorders such as depression and alcohol abuse. Bergstrom (1982) reported that the rate of mental health disorders in rural America was accelerating because an increasing number of rural people were living in poverty. At the time of his report, rural areas had 38% of people who lived in poverty, 67% of substandard housing, and 50% higher unemployment than urban areas. The higher level of mental illness was manifested by a greater rate of alcohol abuse in the overall population, and depression in rural adolescents that was twice as high as the rate of depression in urban adolescents. Human and Wasem (1991) linked the higher rate of mental illness in rural America to the demographic and socioeconomic breakdown of the people living there. In comparison to urban populations, rural populations were disproportionately represented by people who were at a high risk of developing a mental illness such as the poor, elderly, and chronically ill. Rural areas had almost one third of the country’s poor people, approximately 29% of the elderly, and a higher proportion of people aged 65 years and over.

1.2.3 Depression and suicide in rural and urban populations

It seems that the higher rate of alcoholism in rural areas is predominantly a male problem, with little difference in the rate of alcohol abuse in females in rural and urban settings. However, in a review of the literature comparing rates of psychiatric disorders in rural and urban areas, Mueller (1981) reported depression to be more common in females from urban areas than in females from rural areas. It is important to note that the evidence for a difference in the rate of depression between rural and urban populations is not as well defined as the evidence that shows alcoholism to be more prevalent among males in rural areas than males in urban areas. One of the studies reported below (Brown & Prudo, 1981), contradicts the assumption that depression is more common among females in urban areas than females in rural areas. The reason for reporting this study is for the finding that reveals the causes of
depression in females from rural and urban areas. For instance, most of the literature is in consensus that females in rural areas who adhere to a traditional lifestyle (following the work and social customs of the community) are less likely to suffer depression than females in urban areas who are less likely to be traditional (Blazer et al., 1985; Brown & Prudo, 1981; Mueller, 1981; Silburn et al., 1996).

Mueller (1981) suggested that the higher rate of depression in females from urban areas was related to the lack of social support in urban areas for females who work at home. Urban people who work away from home can develop friendships through work-related social functions. But those who work at home have less opportunity to form close ties with people, even though they may live in proximity to their homes. This creates a condition of isolation. Even working females who change jobs frequently or work part-time or casually to take care of their children are provided with less opportunity to become familiar with, or socially close to, people in their work environment. A house-worker from a rural area who spends most of her time at home and is experiencing a mental health problem can obtain support from people she sees regularly in the community. The small size of rural communities promotes greater familiarity among people, and means that house-workers have greater social support than their urban peers. There is a more pronounced sense of community among rural people of the same town, and individuals who are capable of offering psychological support (professional or non-professional) are more accessible. In a report on family and community health in Western Australia, Silburn et al. (1996) commented on the social and community networks available in rural areas that can alleviate the impact of a family’s experience with illness. They found that families living in rural areas were more likely to provide support to their neighbours, and show a greater willingness to share tasks such as child minding, and to offer financial assistance. Females in urban areas who spend most of their time at home to raise children are likely to be disconnected from social networks that are largely created from work and work-related activities.

The link between social isolation and depression in urban populations has been found in other studies. Blazer et al. (1985) conducted a study to test the differences in the rates of psychiatric disorders in rural and urban populations. The researchers interviewed 3000 people in North America asking them about life events and psychiatric symptoms that had occurred over the six months before the interview.
The study revealed that depressive episodes were three times more likely to appear in the urban population than the rural population. The urban population had expressed greater dissatisfaction with their social relationships, which Blazer et al. suggested was the main cause of the their more frequent depressive episodes.

Socioeconomic status and traditionalism of lifestyle have also been found to influence the occurrence of depression in rural and urban females (Blazer et al., 1985; Brown & Prudo, 1981; Mueller, 1981; Silburn et al., 1996). Brown and Prudo interviewed females in the Outer Hebrides asking them whether they had experienced psychiatric symptomatology over the previous 12 months. The results were compared with a similar study conducted on females in Camberwell, South London. Depression was the most frequently reported disorder for the rural and urban group of females, and there was no significant difference in the rate of depression between the two groups. There was however a difference in the factors that influenced the occurrence of depression within each group. In the urban group of females, depression was linked to low socioeconomic status (22% of working class females and 7% of middle class females). Socioeconomic status did not influence the likelihood with which rural females experienced depression (10% of working class females and 14% of middle class females) but integration with traditional lifestyle did. The more traditional the female’s style of life (level of participation in the most common and traditional form of occupation on the island; small-scale farming or crofts), the less likely they had suffered depression during the previous year. Females who were involved with crofting full-time had a 4% depression rate; females involved part time had a 6% rate; females involved with subsidiary crofting had a 14% rate; females living in private households but detached from crofts had a 10% rate; and females living in council houses had a 24% rate.

Traditional activities such as participating in crofting and attending church, are also social activities that create regular contact with family and friends. The females who were involved in the most traditional occupation in Brown and Prudo’s (1981) study maintained a link with the community by following the most accepted and valued lifestyle on the island. Another traditional and social activity linked to depression in the Outer Hebrides females was church attendance. Regular churchgoing females only had a 6% depression rate, whereas non-churchgoing females had a 20% rate.
Among non-churchgoers there was a progressive increase in the prevalence of depression as the traditionalism of lifestyle of crofting decreased. Non-church attendance with less than full or part time participation in crofting created the greatest social isolation that could have been experienced by females in the Outer Hebrides. Similarly to urban house-workers who are disconnected from social activities and support that comes from participating in paid employment, the rural females in Brown and Prudo’s study who deviated from the most traditional activities of crofting and church attendance, were less accessible to the social and support networks engendered by these activities. In their study comparing rates of psychiatric disorders between rural and urban populations, Blazer et al. (1985) also attributed the more frequent churchgoing activities of rural people to their lower chance of experiencing depressive episodes.

The findings discussed above seem to contradict the finding described in Section 1.1 that the male youth suicide rate is 50% higher in rural areas than it is in urban areas. If depression is less prevalent in rural populations than urban populations, it would seem likely that the rate of suicide would also be lower in rural populations than urban populations. However, factors such as traditionalism of lifestyle that have been attributed to the lower rate of depression in adults from rural communities in comparison to adults in urban communities, has been found to have an inverse effect for some members of rural communities (Morrell et al., 1999). Morrell et al. described the findings from previous literature that the rate of suicide in rural and urban populations only differs significantly for males. Females in rural areas were no more likely to commit suicide than females in urban areas. Morrell et al. found that the difference in the suicide rate between adult males living in rural and urban areas only occurred with adult migrant males. The community environment in rural areas that create a supportive network for males and females living in these areas can be exclusive of people not considered members of the community. Adult migrant males who live in rural areas are likely to be excluded from the cohesive network of community members as they would be considered outsiders; particularly those migrants from a non-English speaking background. Morrell et al. explained the lower rate of suicide among migrant females living in rural areas in comparison to migrant males living in rural areas to the greater number of life choices available to migrant females overall. Migrant females in rural areas can find solace and support in raising
a family if employment is not an option for them. Many migrant males living in rural areas have most likely left their country of origin for better living conditions in Australia, but are then faced with the prospect of long-term unemployment. The lack of opportunity to thrive in work in combination with the exclusion from community life creates the type of isolation that can cause depression and suicide. It could be argued that male youth living in rural areas are also excluded from the community support networks that help females and older males in rural areas overcome depression and difficult periods of unemployment. Male youth living in rural areas have less employment opportunities than the employment opportunities that were available to their fathers and other adult males when they were youths. The opportunity therefore to create the social networks through work and involvement with the community are reduced for male rural youth today in comparison to the opportunities for previous generations of male rural youth. In addition, the difference in culture between rural and urban youth has widened as technology and employment patterns have increased and changed considerably more in urban areas than they have in rural areas. For instance, youth in rural areas do not have the access to computers that urban youth have, and working life on a farm may seem dull in comparison to the type of jobs available in larger metropolitan areas. As a result, what is perceived as a fulfilling lifestyle for a youth in today's western world is significantly less accessible to youths in rural areas than it is to youths in urban areas. As discussed above, females living in rural areas can still feel adequate in pursuing family life. As rural populations are more traditional than urban populations, female youth in rural areas can fulfill part of their traditional role by pursuing family life. Male youth in rural areas on the other hand, have difficulty in fulfilling the most basic aspect of their traditional role, which is to be working males who will eventually marry and support a family.

The diversity in the types of illness predominant in rural and urban populations emphasises the need for health and social-welfare professionals to have knowledge and skills relevant to their communities. Alcoholism is such a common problem in rural populations that rural practitioners should receive extensive training in the effects of alcoholism on the individual sufferer, the family, and the community. Alcoholism is also a problem in urban populations, but the condition is less
prevalent, and in urban areas there are specialist services that oversee the treatment and post-treatment care of alcoholics and their families.

1.2.4 The health needs of the farming community

Other health problems that occur more frequently in rural populations are linked to the farming and agricultural industry. Farmers are a group in the rural community that has different rates and intensity of some health problems when compared to non-farming rural and urban people. Zejda et al. (1993) suggested that rural doctors in Canada need intense training on the diseases that were likely to be contracted by farmers. They also advocated community and preventive work for rural doctors that would entail educating the farming community on diseases and accidents that are common to farmers and their families. Farmers are at higher risk of illness and injury because of their exposure to pesticides and toxic chemicals, and their work with dangerous machinery. Zejda et al. listed the most serious health problems of farmers to be respiratory diseases, cancer, neurologic problems, skin diseases, hearing loss, injuries and traumatic deaths, and stress.

1.2.5 The health and social-welfare needs of indigenous people in rural areas

Another group of people who mainly live in rural areas and are worse off in most health and social-welfare conditions than their rural and urban counterparts are indigenous people. Indigenous people such as Australian Aborigines and Native American Indians can be as different from the overall rural population as they can be from urban populations. Moreover, indigenous people in rural areas are often socio-economically and culturally different to indigenous people in urban areas (Anderson et al., 1996; Harrison, 1996; Herring, 1992). Rural areas of Australia have approximately 70% of the nation's Aboriginal and Torres Strait Islander population. Indigenous Australians have a poorer health status than all Australians combined (Anderson, Kuldeep, & Cunningham, 1994; Cunningham et al., 1997; Harrison, 1996; McLennan & Madden, 1997; Swan & Raphael, 1995). Cunningham et al. reported the results of the National Aboriginal and Torres Strait Islander Survey (NATSIS) highlighting the effects of economic, demographic, and socio-cultural factors on the health status of indigenous people. Comparisons of the NATSIS results were made with the National Health Survey (NHS) results. NATSIS was conducted
in 1994 by the ABS and included 15,700 Indigenous Australians from all States and Territories. The NHS was conducted by the Australian Institute of Health and Welfare from 1995 to 1996. Overall, 17% of the respondents aged 15 years and over in both the NATSIS and NHS reported fair or poor health. The main difference found between the two survey populations was in the 35 to 65 year age group. Indigenous people in this age group were twice as likely to report fair or poor health as the same age group from the NHS. Socio-economic factors that made a significant difference on NATSIS respondents’ reporting poor or fair health were employment and household incomes per year. Twenty-nine per cent of NATSIS respondents who were unemployed reported fair or poor health in comparison to 21.3% of NATSIS respondents who were employed. Fair or poor health was also reported by 52% of NATSIS respondents who had a household income of $20,000 or less in comparison to 26.4% of NATSIS respondents who had a household income of $40,000 or more. Unemployment and low income are also factors that can increase stress and related health problems for the non-indigenous population, but indigenous people experience lower standards of living than Australian people overall. McLennan and Madden reported that between the years 1992 and 1994, indigenous people were twice as likely to require housing assistance as non-indigenous people, and almost four in ten indigenous households lacked the income to provide adequate housing and meet other basic needs. The socio-cultural event to have most influence on the reported health status of indigenous Australians was removal from natural parents as children. Fifty-nine per cent of indigenous Australians who had been removed from their natural parents as children reported fair or poor health. Fair or poor health was reported by 32.3% of indigenous Australians who had not experienced the same dislocation.

McLennan and Madden (1997) reported the differences in the rates of physical and mental illness between the Australian indigenous and non-indigenous population over the years 1992 to 1994. The life expectancy of indigenous Australians was 15 to 20 years lower than for non-indigenous Australians. Indigenous females gave birth at a younger age, and their babies were two to three times more likely to be low birth weight, and two to four times more likely to die at birth. Indigenous infant mortality rate has been linked to geographic location (Skinner, 1997). In rural areas of the Northern Territory in 1986, there were 31 indigenous infant deaths per 1000 infants
ever born, compared to 22 deaths per 1000 infants born in urban areas. Skinner related the higher rate of indigenous infant deaths in rural areas to the unavailability of health services. NATSIS revealed that indigenous people in rural areas were less likely to have permanent access to health services within 25 kilometres of their residential area than indigenous people in urban areas. In McLennan and Madden's study, indigenous Australians also had a higher rate of obesity and poorer overall nutrition than all Australians. In addition, indigenous Australians were four to five times more likely to be hospitalised for an infectious disease such as tuberculosis and sexually transmitted diseases. Deaths from infectious diseases were also 15 to 18 times higher in the indigenous population than for the non-indigenous population.

About the mental health of indigenous and non-indigenous Australians, McLennan and Madden (1997) concluded that indigenous people were more frequently diagnosed with indicators of mental illness such as self-harm, suicidal behaviour, and substance abuse. Although indigenous people were more inclined to abstain from drinking alcohol than non-indigenous people (33% and 45% respectively), those that did drink were more likely to do so at a dangerous level (79% and 12% respectively). Anderson et al. (1994) analysed the mortality of indigenous people from South Australia, Western Australia, and the Northern Territory over two years, and estimated that the rate of deaths that could be attributed to a mental disorder such as alcoholism was six times higher than for non-indigenous people. Anderson et al also found that indigenous children were exposed to a greater amount of violence in the household. Yellowlees (1992) had linked the sexual abuse and violent episodes experienced by the females and children in his patient population to male alcohol abuse in the family. McLennan and Madden also reported that State and Territory social and welfare authorities verified more notifications of child abuse and neglect for indigenous children. The rate of physical, emotional, and sexual abuse was two to three times higher for indigenous children than for non-indigenous children, and the rate of neglect six times higher.

As discussed in the beginning of this section, generalist health and social-welfare practice can improve the level of services to indigenous people. There are however "cultural gaps" between indigenous people and non-indigenous practitioners that can prevent the best quality of care. "Cultural gaps" could include differences in non-
verbal communication, religious beliefs, and approaches to health and mental health care. Herring (1992) suggested that the two main reasons Native Americans accessed psychological services less than any other American group was their residency in rural areas and the "cultural gap" between Native Americans and non-Native practitioners. Herring highlighted the failure of cross-cultural psychology to adapt counselling methods to the Native American culture and tradition. In the past the main focus of cross-cultural psychology had been on the largest ethnic groups of the nation such as Italians.

To test the cultural relevance of counselling services to Native Americans, Herring (1992) examined the counselling attendance patterns of Native American mental health patients. He found that 50% of Native Americans who entered counselling ended the process after the first session. In comparison, 30% of Anglo-American patients withdrew from counselling after the first session. Herring conjectured that Native Americans were more likely to withdraw from counselling because of the differences between the communication styles and values of Native Americans and non-Native American counsellors. Counsellors of Anglo-American background had difficulty interpreting and using the non-verbal communication styles of Native Americans. The content and process of counselling methods were also loaded with Anglo-American values and beliefs that were in conflict with the lifestyles of Native Americans.

Herring (1992) proposed that counsellors involved with Native Americans undertake training to learn the communication styles of Native Americans. He argued that approaching the mental health care of the Native population with the same principles and training that are used with other Americans is being blind to their unique economic and socio-cultural characteristics. McLennan and Madden (1997) made the same arguments for Australia's indigenous population. They also gave two reasons health and social-welfare services were failing to meet the needs of the Australian indigenous population. The first reason was the inadequate amount of health and social-welfare services in rural areas where most indigenous people live. The second reason was the failure of modern health and social-welfare services to be relevant to the economic and socio-cultural characteristics of indigenous people. Supporting McLennan and Madden's argument, Swan and Raphael (1995) described Australian
indigenous people's perception that mainstream health services were irrelevant to their holistic approach to health care, and their spiritual and cultural beliefs. McLennan and Madden maintained that indigenous Australians would be better served if more indigenous people were involved with the delivery of health and social-welfare services. Introducing more Australian indigenous people into the delivery of health and social-welfare services would go a long way to closing the gap between the methods and value systems of current services to the culture of indigenous people. In 1991 only 0.8% of the indigenous population were employed in health related occupations, in comparison to 2.1% of the non-indigenous population (McLennan & Madden, 1997).

1.2.6 The health and social-welfare needs of disabled people in rural areas

So far, farmers and indigenous people have been identified as specific groups in rural areas that have health and mental health needs that are diverse and more severe than the rest of the rural population. Indigenous people have the added disadvantage of dealing with health services that are inconsistent with their cultural views on health and mental health care. Physically and intellectually disabled people in rural areas also experience a lack of health and social-welfare services that are relevant to their specific health and welfare needs. Moreover, the shortage of health services in rural areas is often the cause of physical or intellectual disability that occurs during pregnancy and birth. Rural females overall receive poor antenatal and perinatal care during pregnancy (Ashman, Hulme, & Sutte, 1990; Wellesley, Hockey, & Stanley, 1991). Wellesley et al. compared the level and aetiology of intellectual disability in all 1602 6-16 year old intellectually disabled children in rural and urban Western Australia. The occurrence of intellectual disability per 1000 births was 9.9 in rural areas and 6.5 in urban areas. Wellesley et al. categorised the main causes of intellectual disability in rural children as postnatal cerebral infection, culturally familial, and unknown. They ascribed the greater prevalence of intellectual disability in rural children to the distance of major hospitals from most rural areas, poor antenatal care, inadequate perinatal services, and delayed prenatal, perinatal and postnatal treatment of infections. Wellesley et al. also suggested that socioeconomic status had little influence on the occurrence of intellectual disability in rural children. At the time of their study, the major occupations of rural people in Western Australia
were in the middle income range farming or fishing in the South; pearlting, fishing, or mining in the North; and mining in the East.

Social and welfare services are just as important to disabled persons as are medical facilities. In rural areas social-welfare services are less adequate for disabled people than they are for rural people overall (Gething, 1997). In a time when the care of intellectually disabled children and adults involves deinstitutionalisation, it is important to have accessible support services that assist the process of integration with mainstream community. Disabled people in rural areas have fewer opportunities to live independent lives and enjoy relationships with their peers because of the insufficient level of community homes and care in rural areas. Ashman et al. (1990) interviewed 196 mild-to-moderately intellectually disabled people aged 50 years and over in rural and urban Queensland to assess their life circumstances and usage of facilities and services. Interviewees from rural areas were more likely to be living at the family home or in their own homes than urban interviewees. Rural interviewees were unable to leave home because of the lack of alternative accommodation in their area. Parents of disabled interviewees in rural areas were also more likely to keep their adult child at home from fear of losing them to larger metropolitan areas. One of the negative effects of living at home was that rural interviewees enjoyed less contact with their peers than urban interviewees. In addition, the greater the distance of the rural area from a larger metropolitan and urban area, the less likely the interviewee had relationships with other disabled people. Rural interviewees did however have more contact with their family and relations than their urban counterparts.

Improved medical care and community support for intellectually disabled people means they have a longer life expectancy and can rear children of their own. Six of the urban interviewees had children whereas none of the rural interviewees had any. Overall, insufficient health and community resources were responsible for the more restricted lives led by the rural interviewees. Carers of the urban interviewees reported that the availability of health and community services was adequate in their areas, even for the severely disabled adults. In contrast, carers for the rural interviewees expressed concern about the lack of specialist services and community support and facilities for their wards. Rural carers reported nursing, audiology,
physiotherapy, occupational therapy, speech therapy, psychology, and nutrition to be the least available services in their areas.

1.2.7 Summary of the health and social-welfare needs of rural populations

In this section it was discussed how the economic and socio-cultural disadvantages of rural people make them more vulnerable to health and social-welfare problems. Their problems are further prolonged and intensified by their inability to access adequate and relevant services. Health and social-welfare professionals in rural areas have fewer resources to work with, and are usually isolated from other professionals in their field. Their work is often impeded by an inability to access the personnel and facilities required to conduct a comprehensive practice that is effective and far-reaching enough to alleviate the health and social-welfare problems of the population. Male adults and youth, farmers, and Aborigines were identified as groups in rural areas that are most likely to suffer from health and social-welfare problems. For males in rural areas it was mainly economic and socio-cultural circumstances that led to alcoholism in adult males and suicide in male youth. Aborigines in rural areas had all the economic and socio-cultural disadvantages of the overall rural population but at a more severe level. The difference in the rate of depression between rural and urban populations was also offered as further evidence of how the two populations differ in their health and welfare needs. In this case it was females in urban areas who were more likely to suffer from depression than females in rural areas. It was also discussed how disabled people living in rural areas suffer inadequate level of services for their specific needs and as a result experience lower quality of life than the remainder of the rural population and the urban population.

The evidence summarised above supports the point made at the beginning of this thesis that rural populations have a greater need for health and social-welfare services than urban populations. The current lack of these services in rural areas is addressed to some extent by generalist work practices. Rural medical practitioners, for example, would deal with patients who have health problems that arise from alcoholism, depression (for male youth), and farmers whose health is affected by their work environment. It was also discussed at the beginning of this section that rural practitioners could expand their practice by making their models of services relevant to rural populations through community and preventive work. To implement
successful community and preventive care work programs rural practitioners would have to collaborate with members and community groups in their area. To collaborate with these community members and groups, rural practitioners need to be integrated with their communities on a social and professional level. In other words, rural practitioners need to have good relations with their communities. The type of relations rural and urban practitioners have with their communities and how those relations affect work practices are further discussed in the next section.

1.3 **RELATIONS WITH COMMUNITY**

The relations rural practitioners have with their communities are influenced by the economic, demographic, and socio-cultural profile of the community. For instance, rural populations have different views of what are appropriate health and social-welfare services to urban populations. Their perceptions of non-medically trained mental health professionals and social-welfare professionals are likely to be negative, with reservations as to the ability of these professionals to improve the quality of their lives (Dunn, 1986). Brentar and McNamara (1991) suggested that most rural people would consider the GP the primary medical and mental health care provider. Rural people would prefer the services of a GP for a mental health problem than any other practitioner. Doctors are recognised as the main providers of health care in most Western societies, and the practice of psychologists treating individuals with a mental health problem is relatively new (particularly in Australia). This is more so in rural communities, where there are few psychologists and the opportunities for rural people to experience their effectiveness as mental health carers have been far less than for urban people. Psychologists in rural areas would need to gain the faith of people who are unaccustomed to non-medically trained mental health practitioners. Rural people also hold more negative views about mental illness, and are less likely to acknowledge mental illness in themselves and to seek treatment. Rural social-welfare workers can also face animosity in a community where families perceive their interventions as intrusive and a threat to family privacy. Even for issues such as child abuse, rural people would prefer the assistance of other community members.

---

4 There are non-medically trained para-professionals called natural helpers in rural areas who are sought out for assistance on health and social-welfare issues by rural people. A more comprehensive definition of natural helpers and how they affect the relationship between rural practitioners and their clients is provided in Section 1.3.1.
than the interventions of professionals who are unknown to them or the community (Manning & Cheers, 1995).
1.3.1 The dual relationships of rural psychologists with their clients

An important and critical aspect of the relationship between practitioners and their clients is the maintenance of privacy and anonymity. A clause in the Australian Psychological Society (APS) Code of Professional Conduct for Australian psychologists specifies that psychologists should not conduct relationships with clients other than the one that is inherent in the consultation procedure: "Psychologist must avoid dual relationships that could impair their professional judgement or increase the risk of exploitation. Examples of such dual relationships include, but are not limited to, treatment of employees, students, supervisors, close friends or relatives." (p. 5). Maintaining privacy and anonymity is more difficult to achieve in rural settings than in urban settings. In a rural area a person's visit to a psychologist could become common knowledge in a small community that has negative views of mental illness. There is also the problem of a psychologist's familiarity with community members who could become clients. Most psychologists would prefer to keep their professional and personal lives separate, with any extra-work contact with clients kept to a minimum. As well as the desire to maintain distinct professional and personal lives, there are ethical reasons for separating the two. The integration of rural psychologists with their communities on a professional and personal level means they cannot always pursue a separate social life in the way urban psychologists can. Without other practitioners in the area, rural psychologists often face the difficulty of conducting a client-practitioner relationship with people well known to them. In contrast, psychologists in urban areas can avoid taking on friends and acquaintances as clients because of the ready availability of other practitioners.

Horst (1989) argued that dual relationships are almost impossible for rural psychologists to avoid, but might not be detrimental to the client-practitioner interaction. Horst surveyed psychologists in rural and urban areas of Minnesota to test whether rural psychologists experienced more dual relationships than their urban colleagues. Results showed that a significantly larger number of rural psychologists experienced out-of-session contact with clients. The majority of these relationships were casual in nature however, and did not appear to be a threat to the professional relationship. Nonetheless, frequently interacting with clients outside practice, even casually, can be a new and stressful experience for a psychologist. During practical training in an urban setting, psychology students are unlikely to come across the
constraints rural settings can place on a practitioner’s efforts to maintain client confidentiality and strict professional relations. Students are also taught ethical responsibilities that emphasise the professional role of the therapist towards the patient. Even counselling techniques encompass a form of communication that is somewhat more restrained than the verbal and physical communication between friends and relatives. Psychologists may be sensitised to avoid developing personal relationships with clients, but there is little preparation for dealing with friends or acquaintances who of necessity become clients. As much as rural psychologists would prefer to avoid client-practitioner relationships with friends and acquaintances, many would be too isolated from other psychologists or services to seek the professional backup and support to do so. Rural practitioners therefore would require training in the different relations they could expect to have with their communities in comparison to the community relations of urban psychologists. Practicums could involve counselling sessions with fellow students who are either friends or acquaintances. In addition, the strict guidelines against counselling friends or acquaintances by formal organisations such as the APS may need to be adjusted for rural psychologists who have problems abiding by the guideline.

1.3.2 The traditionalism of rural populations

The traditionalism of rural people also has an impact on their relations with mental health and social-welfare professionals (Berry & Davis, 1978; Hedlund & Berkowitz, 1979; Jorm et al., 1993; Levant, Majors, & Kelley, 1998; Nurmi, Poole, & Kalakoski, 1994; Osher et al., 1994; Pucket & Frederico, 1992; Sladen & Mozdzierz, 1989; Yellowlees, 1992). The age and social demographics of most rural populations could explain the greater traditionalism in rural communities. Rural communities are often depleted of the post-school leavers and upwardly mobile members of the community who migrate to urban centres for more diverse lifestyles and better education and employment opportunities (Hargrove & Breazeale, 1993; Human & Wasem, 1991; Mazer, 1982). The young people that remain are less inclined to pursue higher education, but more willing to follow the life and work patterns of their parents. Traditional lifestyles in the rural community are reinforced when the majority of the population is either elderly, or individuals with a greater tolerance for conventional lifestyles.
To compare the traditionalism of rural and urban adolescents, Nurmi et al. (1994) investigated the future oriented goals and concerns of 13 to 14 year old, and 16 to 17 year old Australian and Finnish adolescents. The adolescents were administered the 'Hopes and Fears' questionnaire that contained open-ended questions on future hopes and fears. The adolescents were additionally asked the age at which they believed their hopes and fears would materialise, to investigate differences in the temporal extensions of their goals. Rural adolescents from both the Australian and Finnish groups were more likely to have traditional gender-typed future-oriented goals and concerns. In addition, as the age of the rural adolescents increased, the interest in a future occupation decreased. In contrast, urban adolescents expressed continuing interest in a future occupation as age increased. The greatest differences found were between the Australian rural adolescents and all other groups. Australian rural adolescents were least interested in future education, but most interested in, and concerned about, topics related to family. Moreover, Australian rural adolescent females were the only group to become less interested in education as age increased. Nurmi et al. concluded that the diversity in responses between Australian rural adolescents and the other groups were due to the more conservative values and lifestyles of Australian rural populations. Such lifestyles included the pursuit of family life at an early age in preference to educational advancement.

The traditionalism of rural people can also affect their attitudes towards people with mental illness and mental health practitioners. Jorm et al. (1993) made a comparison of the regularity with which rural and urban populations and people from high and low socioeconomic status use public psychiatric services in Australia. They conducted an analysis of the number of psychiatric services and persons becoming patients per 100,000 population over a one-year period, using the 1990 National Health Survey carried out by the ABS. The results revealed that urban populations and people from high socioeconomic status were more likely to utilise public psychiatric services than people from rural populations and low socioeconomic status. Jorm et al. explained these differences in terms of the stigma that rural populations and people from low socioeconomic background attach to mental illness, and the act of undertaking psychiatric treatment.
Further evidence that rural people are more traditional in their attitudes about issues of health is their reactions to people with AIDS (Carwein, 1990; Levine & Joyce, 1985; Preston, Koch, & Young, 1991). AIDS patients who return to their rural home after living in an urban area find a more conservative community with negative views of homosexuals and people with AIDS (Preston et al., 1991). Rural AIDS patients are also often rejected by family members who view homosexuals negatively. Rural nurses who care for AIDS patients have reported that a large proportion of their work involves overcoming the prejudices of rural populations towards their patients (Dillman & Hobbs, 1982). Similarly to mental health patients in rural areas, rural AIDS patients have problems keeping their illness and treatment private.

Families that are traditional in their interactions with one another are likely to have a male leader who is authoritarian in his roles as husband and father. In his report on the demographic and diagnostic profile of rural psychiatric patients in Broken Hill, Yellowlees (1992) made the observation that males considered heavy drinking and treating females as possessions acceptable and the norm. With these attitudes, rural males may see a family member's interaction with a psychologist as a threat to their position of influence and leadership in the family. Seeking consultation from a mental health practitioner shows that a person external to the family is needed to solve family problems, and could be considered a slight on the male's ability to provide for and protect his family.

Welfare workers in rural communities have identified the traditional values of rural populations as obstacles to early intervention in cases of child abuse. Manning and Cheers (1995) studied the effect of traditional values on rural people's perceptions of child abuse, and their willingness to report incidences. Semi-structured interviews were conducted in a small remote town in western Queensland with people aged 18 and over from 60 non-Aboriginal groups. Groups were defined to be two or more people who normally shared a household, financial arrangements, and strong emotional relationships. Overall, the interviewees stated a strongly negative view of child abuse, and a high level of concern for the welfare of the community and the children who lived in it. They also expressed a lack of confidence in the relevant statutory authorities in the notification procedure of child abuse, reflecting what
Manning and Cheers believed to be inexperience with these authorities, and a lack of knowledge of their procedures. A large proportion of the interviewees (in particular the longer-term residents of the country town) stated they would prefer to notify a local professional member of the community about child abuse, rather than a professional external to the community. Traditional beliefs about the family and its right to privacy were apparent through the interviewees’ negative view of welfare intervention, and the determination to uphold the independence and privacy of adult family members. The majority of the interviewees revealed they would be most hesitant to notify a case of child abuse when they had previous knowledge of the family in question, or knew one or more of its members. Manning and Cheers described this last deterrent to be the greatest impediment to identifying cases of child abuse, as most people in a small rural community know each other either casually or by friendship or relation.

Overall, efforts to increase the level and relevance of rural health and social-welfare services are futile if rural practitioners cannot pursue positive relations with their communities. Rural practitioners who have had previous experience in a rural area through demographic ties (i.e., rural practitioner or his or her spouse may have spent their childhood years in a rural area), or previous training in a rural setting, have the advantage of some knowledge of the dynamics of rural community life. For rural practitioners who have had no previous experience with a rural setting, the issue once again becomes a matter of training in the type of relations rural practitioners could expect to have with their communities. As discussed at the end of Section 1.2.1, the community and preventive type of work that is required for a generalist practice requires rural practitioners to have favourable relations with community members and groups. The community members that rural practitioners would need to make alliances with to increase the scope of their services are mainly influential and prominent figures in the community. The next section provides a discussion on the advantages of collaborating with community members and groups for the delivery of health and social-welfare services in rural areas.
1.3.3 Natural helpers

The influential figures with whom rural practitioners would need to collaborate are people in the community who have a reputation as helpers in health care and welfare related issues. Non-professional helpers are mainly referred to as natural helpers in the literature and their roles as healers and advisers have been recognised by rural practitioners for their importance to the health and wellbeing of most rural communities. Formal training of natural helpers to assist in the delivery of health and social-welfare services has also been suggested as a means of reducing the inadequate level of these service to rural populations (Giffiths, 1996; Heyman, 1986; Heyman & Vandenbos, 1989; Keller & Prutsman, 1982; Kelley, Kelley, Gauron, & Rawlings, 1977; Kenkel, 1986; Libertoff, 1980; McLennan & Madden, 1997; Pucket & Frederico, 1992). Natural helpers would also have credibility as teachers of preventive health care because of their established reputation in the community (Libertoff, 1980). There are however two sides to the influence natural helpers can have on the relationship between rural practitioners and their communities. Natural helpers could be supportive of rural practitioners and offer them assistance such as referring community members to their services. On the other hand, natural helpers could resist the intrusion of formally trained practitioners on their own efforts to act as helpers and advisers, and fail to endorse the services of practitioners to other community members. Literature providing cases of the positive and negative influences of natural helpers for the relationship between rural practitioners and their communities is discussed below.

Pucket and Frederico (1992) highlighted the advantages of Australian rural welfare workers collaborating with natural helpers. Similarly to indigenous people who require health and social-welfare practitioners who have an understanding of their culture and beliefs, rural people prefer the services of professional or non-professional practitioners who understand and respect the social and economic structure of their communities. McLennan and Madden (1997) suggested indigenous Australians become more involved with the provision of health services to improve the effectiveness of health care to indigenous people. There are also the indigenous and non-indigenous natural helpers who provide health and social-welfare services to their communities without professional qualifications. Helpline and Crisisline are examples of services that could be run by natural helpers. Past efforts to involve
natural helpers in such services have been mostly successful, and the practice has been valuable to natural helpers who gain training in psychological issues, and positive for people more inclined to discuss their psychological difficulties with persons known to them, rather than with less familiar professionals (Berry & Davis, 1978; Keller et al., 1983; Kenkel, 1986).

An example of how natural helpers could be included in the provision of health services was provided by Berner (1992). Nurse practitioners in Alaska have trained the natural helpers of the rural communities of Alaska to offer emergency and preventive health care services to the indigenous population. The natural helpers selected for training were always residents of the community they served, usually indigenous people, and were chosen by community members to be the primary health care providers. Once trained as para-professionals, natural helpers were referred to as Community Health Aids (CHAs) and conducted their services with the assistance of a referral physician who was often as far as 2000 kilometres away. CHAs were trained in the procedures of patient history recording, physical assessment, and diagnosis, which provided them with enough skills to exercise acute care, dispense medication, and offer dental care such as placing temporary fillings. CHAs maintained daily contact with their supervisors over the phone, and usually took care of most medical situations in the community. During training CHAs were encouraged to practice preventive measures of health care such as routine prenatal services, health surveillance, and preventive dental care including fluoride treatments. CHAs also offered mental health care services, and acted as referral agents for medical and psychiatric conditions.

McLeod (1993) also described the advantages of integrating the informal services of natural helpers into the East Arnhemland community Mental Health Centre. By collaborating with community groups and Aboriginal leaders, the Centre increased its profile in the community and gained the acceptance of residents who were apprehensive of the Centre's relevance to Aboriginal people. The natural helpers of the community were often the first contact for people seeking psychological counselling. After links between natural helpers and the Mental Health Centre were made, natural helpers often referred these people to the Centre. As a result, attendance to the centre increased markedly and people came from isolated areas
who had no previous knowledge of the centre, but had heard of its existence and services from their initial consultation with a natural helper.

As discussed above there can be disadvantages to the existence and influence of natural helpers in the community to the work of rural practitioners. The availability of natural helpers could be another reason rural people are less likely to seek the assistance of professionals for psychological and social-welfare problems. Greater social networks and community support in rural areas explained the lower prevalence of depression in females living in rural communities in comparison to females living in urban communities. Natural helpers would be part of the social network, and their prominence and long-term residence in the community often make them the first contact for people in need of health or social-welfare care. The natural helpers in the case study offered by McLeod (1993) were willing to refer community members to the Mental Health Centre. A lack of relations with natural helpers could mean a health or welfare service that fails to reach the more isolated members of a rural community.

In summary, rural health and social-welfare professionals need to collaborate with natural helpers to increase the number of people delivering their services, and gain the trust and confidence of people who are used to relying on non-professional networks such as natural helpers. Rural people would be less likely to perceive the work of psychologists and social-welfare workers as intrusive if their services were integrated with community support networks. In some communities, natural helpers have been offering what the community perceives as psychological and social-welfare counselling long before psychologists and social-welfare workers appeared in the community to offer their professional services. Working against established support networks such as natural helpers would most likely exacerbate the prejudices of rural people towards mental health and social-welfare professionals, and stifle the progress made by rural practitioners who have had some success in alleviating the health and social-welfare problems of their communities.
1.4 TRAINING-Scientist-practitioner model

The previous discussion has emphasised the differences in the work practices, community and client profile, and community relations of rural and urban health and social-welfare professionals. The literature often points to these differences as justifications for reassessing current models of training to more appropriately represent the health and social-welfare issues of rural populations. The case is often argued that if in-depth and comprehensive training was offered for rural practice, more practitioners would be interested in transferring their knowledge and skills to rural communities (Carr, 1987; Craig & Nichols, 1993; Harvey et al., 1980; Hays, 1991; Liaw, 1992; Rolfe et al., 1995; Rosenthal et al., 1992; Russell et al., 1996; Sears et al., 1998; Watts, 1993; Wise et al., 1994). A discussion on the adequacy of current training models for psychological practice in rural areas needs to include a description of the scientist-practitioner model. Most psychology courses in Australian universities are based on this model. The inadequacy of current training for rural practice therefore may be attributed to flaws in the scientist-practitioner model in addition to a lack of focus on rural health and community issues.

The structure of the training undertaken by professional psychologists in Australia had to have at least two levels for membership of the APS and registration as a psychologist at the time of the survey. The APS accredits university courses at each level with guidelines that ensure courses are structured and organised in ways that maintain consistency across universities and are appropriate for psychological practice. The State and Territory Registration Boards register psychologists based on their completion of courses that have been accredited by the APS. Psychologists need to be registered to acquire a license to practice. To fulfil the requirements for a Bachelor degree (the first level of study) students need to complete a three-year sequence of study in psychology. To register as psychologists the respondents in the current study would have had to complete at least at an Honours or Fourth-year graduate diploma (the second level of study) after their sequence of study for a
Bachelor degree. The courses that fulfill the requirements of psychology training have as their underlying structure the scientist-practitioner model.

The scientist-practitioner model (Boulder Model) was introduced in 1949 and has relevance as a framework for training undergraduate and postgraduate psychology students interested in pursuing a career in professional psychology. According to the model, practitioners should keep abreast of research findings on assessment and treatment, evaluate their own work as psychologists by using empirical methods, and conduct research with a view to producing publishable data (Haring & Vacc, 1988; Stricker & Trierweiler, 1995). Knowledge of the theoretical basis of the discipline and current research issues is also integral to the scientist component. Practical clinical skills are the province of the practitioner component of the model and these include interactions with clients. In Australia and the USA, training in clinical psychology aims to prepare psychologists for the dual role of scientist and practitioner. The principles taught in the scientist-practitioner model, however, do not necessarily translate to the intricacies of clinical practice (Belar & Perry, 1992; Cotton, 1998; Hoshmand & Polkinghorne, 1992; John, 1998; Masters, 1984). The debate about the relevancy of psychological training for rural clinical practice can therefore be seen as part of a wider debate about the relevancy of current psychological training.

Since implementing the scientist-practitioner model into clinical psychology programs, research has consistently found that clinical psychologists regard the model positively, but fail to use its principles during client-practitioner interactions (Belar & Perry, 1992). According to many clinical psychologists and critics of the scientist-practitioner model, there is a need to redesign the model to meet the demands of practitioners who cannot realistically be scientists as well as practitioners. In the USA, new models of training have been proposed that place less emphasis on the principles of research and more emphasis on activities that fulfill the practitioner role (Hoshmand & Polkinghorne, 1992; Masters, 1984). Professional psychologists would also argue that there are time constraints on conducting both

5 In recent years the training requirements for psychology graduates to become registered psychologists has changed. Psychology graduates in addition to the first two levels of qualifications described above, need to have a minimum of a two-year postgraduate qualification (coursework Masters), or two years supervised experience to become registered as psychologists.
scientific studies and a practice, and their interest in pursuing a career in clinical psychology was for the client-practitioner relationship rather than research.

The criticisms of the scientist-practitioner model above apply to rural and urban practice. Hoe (1982) however argued that the scientist-practitioner model of training is necessary for rural psychologists. Rural psychologists could use their research training to undertake studies that expand the knowledge base of work practices in rural settings. As mentioned in the overview of this thesis, identification of work practices that are unique to rural psychologists can lend insight into the mental health needs of rural populations, and the appropriate methods of addressing these needs. In contrast to Hoe, Carr (1987) argued against the scientist-practitioner model of training for rural psychologists. Carr suggested that the emphasis on research in the scientist-practitioner model is particularly inappropriate for rural psychologists who are too underresourced to conduct the work activities that are relevant to the practitioner component of the model and research simultaneously. Training rural psychologists would be more effective if less emphasis was placed on research activities and more on the work practices that are relevant to rural areas.

The following section provides a discussion on the advantages of training rural practitioners with a focus on rural health and community issues. In Australia there are few training courses that are designed for psychological practice in rural communities. Most Australian universities are also situated in the capital cities of States and Territories and surrounding metropolitan areas.

1.4.1 Training: Course content and structure with a focus on rural practice

In the description of the differences between rural and urban GPs, it was mentioned that GPs avoided practice in rural areas because of the likely necessity to practice specialist skills in rural practice. On completion of training, many GPs perceive themselves as inadequately prepared for such procedures. Even rural GPs are wary of their inadequate training in specialist skills, which can affect their capacity to conduct the generalist practice required of rural doctors. Wise et al. found that although most rural GPs in Queensland practiced specialist skills, there was a relation between frequency of conducting specialist skills, and perceived adequacy of
training in each skill. Knowledge of specialist skills is less important for urban GPs who can refer patients to specialists for procedures such as minor surgery. Rural GPs however, are likely to practice specialist procedures with few other alternatives for their patients.

Rural psychologists and social-welfare workers also experience the same incongruence between their training and the skills they need to work as rural practitioners. The lack of specialists in rural areas applies to most health areas, and social-welfare professionals also have a dearth of colleagues with whom they can work. Rural health and social-welfare professionals require specific training to be adept at practicing most procedures of their profession, and conducting the community work undertaken by many rural practitioners. Conducting community work involves aligning with community networks that can assist in the delivery of services, and undertaking initiatives that promote preventive health care and the prevention of social-welfare problems. Aligning with community networks also involves maintaining positive relations with the community. Rural practitioners also require training in the type of relations they are likely to have with their communities. The research described below provides illustrations of the type of training that would be appropriate for rural practitioners.

Hoe (1982) proposed that rural psychologists require training that prepares them for the multiple skills that are needed for the generalist role, which includes clinical practice and community work. He described a university course that would be appropriate for the training of rural psychologists. The major components of the course involved training in multiple consultative approaches for clinical practice, and community work and liaisons. The training for rural clinical practice involved students practicing diverse therapeutic techniques with clients from varied age groups and backgrounds (e.g., preschoolers, elderly, and prisoners). One of the two placements that students were required to undertake took place in a rural setting that was distant from the university. The remoteness of this rural placement prepared students for the isolation and lack of collegial support that is common to rural practice. Community work that involved collaboration with community groups and conducting preventive mental health care programs was taught to students by placing them in rural churches and schools. Working in churches and schools also gave
students the opportunity to gain insight into rural life from the perspective of influential community institutions. Concerning theoretical training, Hoe cited physiological psychology and criminal psychology as examples of two units that are particularly important for rural psychology students. Physiological psychology is important to rural psychologists as they are likely to deal with farmers who are suffering the effects of insecticides and herbicides. Criminal psychology is important because rural psychologists are often called upon by the Police to make psychological assessments of law-breaking citizens.

The literature describing the best methods of training students for rural practice frequently refers to the importance of the training taking place in rural settings (Bergstrom et al., 1984; Carr, 1987; Carter, 1987; Culhane, Kamien, & Ward, 1993; Hays, 1991; Higgins, 1982; Hoe, 1982; Kahn et al., 1976; Keller, 1982; Keller et al., 1983; Magnus & Tolland, 1993; Murray, 1984; Rolfe et al., 1995; Wise et al. 1994). Training, or at least conducting practicums in rural settings, gives students the ability to experience the generalist nature of rural practice, and the lifestyles and traditions of rural people. Practice in rural community work is also made possible when students are placed in rural settings that require collaboration with community groups, and the development and implementation of preventive care strategies. Culhane et al. surveyed final year medical students who had undertaken practicums in rural settings to test whether these students had increased their knowledge and skills in specialist and emergency services. Overall, 80% of the medical students reported greater competency in specialist skills after the rural placement in comparison to their competency in the specialist skills before the placement. Culhane et al. suggested that supervisors in rural hospitals were willing to allow their students direct practice of specialist skills, rather than pure observation. Rural supervisors had themselves worked as generalists in rural practice, and considered it important to transfer specialist skills to their students.

Another major advantage of training students in rural settings is the possibility that the direct experience with rural settings will influence the students' decision to practice permanently in a rural area. Magnus and Tolland (1993) surveyed graduates of a medical school in northern Norway that had been established with the purpose of increasing the amount of GPs in rural Norway. All medical graduates over 11 years
were asked (i) whether they lived or intended to live in northern Norway, (ii) the type of work they were conducting at the time of the survey, and (iii) where they spent the majority of their childhood and adolescent years. The last survey question was to test whether residency in northern Norway as a child and adolescent had an influence on the medical graduates’ decision to practice in the area. The medical school was also required to fill 50% of its quota with northern-Norwegian students, with the expectation that many of these students would remain in their hometown after graduation. The results showed that medical training in a rural setting influenced the decision of graduates to practice in that same rural setting. Moreover, the training experience in rural settings seemed to offset the high turnaround of rural medical practitioners who often leave rural practice for an urban practice. Overall, 56% of the graduates were working in northern Norway at the time of the survey. A large proportion (43%) had spent the majority of their childhood and adolescent years in northern Norway, and of these, 80% had remained in the area to practice as GPs. As mentioned above, training medical students in rural Norway was also influential on the retention of GPs in the area. Of the graduates who were raised in northern Norway, 83% were working in the area 6 to 10 years after completing their internship. However, only 34% of graduates who had been raised in southern Norway, were working in northern Norway 6 to 10 years after completing their internship.

In summary, the training needs of rural practitioners are related to the generalist work practices that are necessary to meet the high demand for services when few resources are available, and the preferences of rural populations for practitioners that are integrated with community groups and institutions. Moreover, rural and urban populations differ in health and social-welfare issues that require the interventions and services of practitioners. Training curricula and location need to be relevant to the service models that best suit the rural environment, and the health and social-welfare issues pertinent to rural populations. Magnus and Tollan (1993) also made reference to the influence of previous childhood experience in a rural setting to the decision of practitioners to work and remain there. The following section describes research that supports Magnus and Tollan’s premise that the recruitment and retention of rural practitioners could be improved if training applicants were chosen on the basis of their rural background.
1.5 DEMOGRAPHIC BACKGROUND OF RURAL AND URBAN PRACTITIONERS

In Magnus and Tollen's (1993) study, the university's requirement to fill 50% of their student quota with northern Norwegians was recognition that previous experience with living in a rural area was an influential factor in the decision of graduates to practice in rural areas. Other researchers have also suggested that the recruitment and retention of rural practitioners begin in the selection process of undergraduate and postgraduate students (Davies, 1994; Kassebaum & Szenas, 1993; Keller, 1982; Riley, Myers, & Scneweiss, 1991; Rolfe et al., 1995; Wise et al., 1994).

Once in university, rural background students intending to practice in a rural area also choose different levels and specialties of qualifications in comparison to urban background students from the same disciplines. In medical school, the different qualification and specialty selections of rural background students have been found to be correspondent with the generalist nature of rural practice (Kassebaum & Szenas, 1993; Rolfe et al., 1995). Kassebaum and Szenas found, for example, that the majority of rural background students and students intending to practice in rural areas were working towards certification in a generalist specialty. The most popular generalist specialty selected by these students was family practice (66%).

In a study comparing the work practices and demographic profile of rural and urban doctors, Miller and Zuckerman (1991) also found that a significantly higher percentage of urban doctors (70%) had higher level qualifications in comparison to rural doctors (60%). Pucket and Frederico (1992) found significant differences in the training profile of rural and urban Australian welfare workers. The researchers found that rural workers were less formally qualified than urban welfare workers; 24% of the rural respondents held formal social work qualifications compared to 84% of urban welfare workers.

Davies (1991) compared the practice location choice of rural and urban Royal Australian College of General Practitioners (RACGP) trainees in Australia. Of the trainees who had spent the majority of their childhood and adolescent years in a rural area, 32.6% stated they were intending to practice in a rural area. Six of the 14 rural background trainees who indicated a preference for rural practice came from towns
with a population of less than 5000, suggesting that the more rural the background of the trainee the more likely they were planning on living and practicing in a rural area. Kassebaum and Szenas (1993) found that medical school graduates with a rural background were more likely to choose rural practice in the USA. The data on rural and urban background students over 10 years were analysed for student practice plans at the beginning of the course, and four years later at graduation. Rural background students were four times more likely than urban background students to plan a rural practice at the beginning of the course (16.2% and 4.1% respectively) and at the end of the course (13.2% and 3.2% respectively).

1.6 SUMMARY AND AIMS

The literature reviewed in the previous sections shows evidence that rural health and social-welfare practitioners perform different work practices. Firstly, the main difference between rural and urban practitioners is that rural practitioners are more likely to be working as generalists than urban practitioners. As described throughout the current Chapter, a generalist model of practice covers a more diverse range of activities (such as psychological counselling in varied psychological areas), and involves community and preventive style of health care and social-welfare work. A comprehensive example of a generalist practice was offered by Yellowlees (1992) and described in Section 1.2 of this Chapter. Secondly, the work practices of rural and urban practitioners differ because of the diverse economic, demographic, and socio-cultural characteristics of rural and urban populations. As discussed in Sections 1.3-1.3.3, these characteristics are related to the health and mental health of people in a community. Health and social-welfare problems are also more severe in a population that experiences adverse conditions such as economic downturns. Rural populations in Australia and other parts of the world are more likely to experience difficult conditions such as poverty and low employment than urban populations. Finally, the work practices of rural practitioners are also dependent on the relations they have with their communities. Rural practitioners need to collaborate with influential community members and groups to be effective as professionals. By aligning with individuals and groups that also offer health and social-welfare assistance, rural practitioners can increase the scope of their practice and gain the confidence of the population. Natural helpers were offered as an example of how influential members of a community can bridge the physical and cultural gap
between a health or social-welfare professional and the more isolated members of a community (see Section 1.3.3).

Most of the evidence described above comes from research in the areas of medical and allied health and social-welfare practice. These areas of practice included general medical, psychiatric, nursing, psychological, and social-welfare. Most of the studies were carried out in North America and Europe, and this was particularly the case for research in psychological practice. The main aim of the current study is to confirm the general findings of differences in rural and urban practices by investigating psychologists working in rural and urban areas of Australia.

The investigation will be undertaken in the form of a comprehensive questionnaire designed to obtain information on the work practices and training needs of rural and urban psychologists. The areas of interest have been identified in the questionnaire as, (i) background and demographic details, (ii) training experience, (iii) work experience, and (iv) relations with community. It is expected that the patterns of differences in the work practices of rural and urban psychologists will be similar to those discussed in the current Chapter. The literature reviewed in Section 1.5 showed evidence that rural background medical students were more likely to choose to enter rural practice after graduation than urban background students. It is expected that rural psychologists in the current study will show stronger demographic ties to rural areas than urban psychologists. In other words, rural psychologists will have had more childhood and adolescent experience in a rural setting, and have spouses with similar rural experience than urban psychologists and their spouses. Training experience in a rural setting was also delineated as an influential factor in the decision of graduates to enter rural practice. In the current study therefore it is predicted that a higher proportion of rural psychologists will have undertaken their studies in a rural or non-metropolitan setting than urban psychologists. Training experience also includes professional development activities such as workshops and current enrolment in a university course. There may be a trend for rural psychologists in the current study to be less involved in current and ongoing training activities because of their distance from urban settings where most of these activities take place.
The literature reviewed in Section 1.4 – 1.4.1 provided evidence that current models of training health and social-welfare professionals are more relevant to urban practice than rural practice. Training experience in relation to undergraduate and postgraduate curricula and preparation in the scientist-practitioner model of practice will be evaluated by rural and urban psychologists in the current study. It is predicted that rural psychologists will express less satisfaction with their training experience for work in providing psychological services than urban psychologists.

The main difference expected to be found for work experience is that rural psychologists will be performing more generalist work practices than urban psychologists. Generalist work practices were described at length in Section 1.2. In the current study one of the ways generalist work practices are examined is by investigating the scope of clients seen by rural and urban psychologists. That is, the more diverse the clientele group (in terms of demographic background and problems presented to the psychologist) seen by psychologists in each setting, the more generalist the work practices. Generalist work practices also involve community and preventive work. Rural and urban psychologists will be compared on their involvement in this type of work by asking them to indicate if they are a source of information on mental health issues in their communities. It is expected that a larger proportion of rural psychologists will report that they are one of the main sources of information in their communities than urban psychologists. Another way of investigating generalist work practices is comparing approaches used by rural and urban psychologists in their counselling work with clients. It was discussed in Section 1.2 that psychologists in rural settings need to be flexible enough in their counselling methods to address the mental health needs of the wide range (in terms of presenting problems) of clients seeking their assistance. It is therefore predicted that rural psychologists will use a more eclectic approach in their therapy work with clients than urban psychologists. Another component of generalist work practice is the continual care with clients described in Section 1.2. The lack of emergency and specialist services in rural areas means that similarly to rural GPs, rural psychologists would need to attend to more emergency calls than urban psychologists. Psychologists in the current study will most likely show more involvement with after-hours care than urban psychologists. In regards to relations with community, the main expectations are that rural psychologists will report more frequent
interaction as professionals with natural helpers, and experience dual relationships with more of their clients than urban psychologists.

The implications of these results for the training of psychologists will be explored. In particular it will be argued that specialist training in what might be called "rural psychology practice" should be developed. Features of such a specialist course will be discussed based on the needs identified in the responses to the questionnaire. A more detailed description of questionnaire items and the rationales for including them in the survey are provided in the next Chapter.
METHOD

2.1 SUBJECTS

A sample of 774 Australian psychologists was surveyed for this research. The psychologists were selected from those listed as members of the APS Boards of either Clinical or Counselling psychology in the APS Directory of Psychologists 1992-1993. For each psychologist the Directory provided full name, work or residential address, and age. For the purposes of this research the directory was made accessible by computer database from the APS.

It should be noted that psychologists had to have at least a fourth year qualification to be registered as psychologists and listed in the APS database at the time of the survey (see Section 1.4). There may be psychologists practicing in rural or urban settings with only three-year level degrees. However, as the current study focuses on training issues for rural and urban psychologists, it was considered necessary to survey those psychologists who had received similar training. In addition, the results would be more generalisable to psychologists who have graduated in the past few years, as one of the criteria for registration as a psychologist has increased from four to six years of formal training.

To provide an initial classification of rural and urban psychologists from the APS Directory, information about population density of the postcodes related to each of the psychologist’s address was used. This information was obtained from the 1986 Australian census data provided by the Australian Bureau of Statistics (ABS). Postcodes were segregated into rural and urban postcodes by using the ABS criteria for rural and urban population density: Any postcode with less than 8.7 persons per hectare was defined as rural; any postcode with a population density of 8.7 persons per hectare and above was defined as urban. On the basis of this definition the total number of rural and urban Counselling and Clinical psychologists listed in the APS Directory at the time of the survey was 224 and 1212 respectively. All 224 rural psychologists and 500 of the 1212 urban psychologists were surveyed.

This initial identification of rural and urban psychologists based on the population density of their postcodes was undertaken for the purpose of ensuring that the mailout of the survey reached as many rural psychologists as possible. However, the postcode-population-density criterion for the rural-urban classification was not used to classify the respondents who completed the survey. Given that the survey was completed anonymously, such classification was not possible. Instead respondents
were asked as part of the survey to indicate whether their current work setting was rural, rural/remote, or urban. In addition, it was of interest to investigate if the self-stated rural or urban status of respondents was similar to the most accepted definition of rural and urban in the literature; 50,000 or below (Bosak and Perlman, 1982). Psychologists were therefore asked to indicate if their work setting had a population of (i) less than 100, (ii) 100-900, (iii) 1,000-49,999, or (iv) 50,000 or above.

In the current study 64% of psychologists who stated they were from a rural area were in a community of a population of 50,000 or below. Of respondents who indicated they were working in an urban setting, 96% reported their communities had a population of over 50,000. The high proportion of psychologists in rural settings who indicated they were located in a community of more than 50,000 people (36%) could be a result of the physical dispersion of metropolitan and rural areas in Australia. For instance, Darwin has a population of just over 70,000 but due to its distance from other major urban centres, and the populations lesser access to the facilities and services available to urban populations, Darwin could be considered a rural area. There were only three psychologists who indicated they were from a rural-remote area and their responses were recoded to be analysed as rural psychologists.

Respondents were comprised of 86 rural psychologists and 282 urban psychologists. The split between rural and urban respondents based on respondents' report was similar to the split of rural and urban psychologists gained from linking the ABS data with the postcodes in the APS directory. Of all respondents, 23% identified themselves as rural and 77% as urban. The proportions of rural and urban psychologists in the linking of databases were 16% and 84% respectively.

2.2 TEST MATERIAL

The survey was developed specifically for the research reported in this thesis. An earlier version of the survey was piloted to two counselling psychologists within the Student Services Division of Deakin University. Adjustments were made according to comments on the structure and content of the survey for the final version. The final version of the survey consisted of 62 items of various types (yes/no; open-ended; Likert scale), designed to provide information in five areas of relevance to the research being investigated. A copy of the survey is provided in Appendix 1. Set out below is a summary of the survey consisting of the number of items in each of the
five sections of the survey together with an outline of the rationale underlying the inclusion of the items in each section.

Section One: Background/Demographic Information.

Section One consisted of 14 items designed to provide the following information:

- demographic (six items: age; sex; ethnic background; income; nature of community [rural/urban] that respondent and their spouse were raised in)
- work-related (six items: status [full-time/part-time]; duration of current employment; employer; work setting [rural/urban]; work setting [rural/urban] five years previously; extent of choice in selection of current work)
- importance of rural/urban setting in selection of work (two items: in relation to current work; in relation to future work)

Section Two: Training Experience.

Section Two consisted of 19 items designed to provide the following information:

- completed formal qualifications in psychology (four items: undergraduate/fourth year/postgraduate qualifications; institution; study load [full-time/part-time]; year of completion; placements)
- current formal study (two items: current enrolment in psychology/non-psychology course; institution; reasons for no enrolment)
- professional development in past 12 months (three items: workshop/conference attendance; accessing work-related literature; consultation with colleagues)
- evaluation of adequacy of formal training in psychology (10 items: undergraduate/fourth year/postgraduate training; training for rural and urban community issues; training in research; interviewing clients [test administration/interpretation]; most useful units for work)
Section Three: Work Experience.

Section Three consisted of 12 items designed to gain information on the following information.

- **work activities** (five items: percentage of time in practitioner activities over past two weeks; formal presentation or publication of research over past 12 months; proportion of clients referred to other professionals over past two weeks; proportion of emphasis on counselling approaches)

- **after-hours and emergency care** (two items: availability of 24 emergency services for clients; respondent availability for emergency services)

- **dual relationships** (one item: frequency of encountering clients outside of work)

- **client group profile** (four items: percentage of clients from different age groups, ethnic backgrounds, and educational backgrounds over past two weeks; percentage of work in different psychological problem/disorder areas)
Section four: Relation with Community.

Section Four consisted of 11 items designed to provide information the following information.

- relations with prominent community members (five items: support from prominent community members [e.g., clergy, natural helpers]; importance of this support to psychological work)

- relations with other community members (four items: acceptance by community members for the psychological work undertaken by respondent; extent of knowledge of mental health issues by community members; difficulty in maintaining client confidentiality)

- training of natural helpers (two items: whether natural helpers should be trained and by whom)

Section Five: APS Items-Rural and Remote Issues.

Section Five consisted of six items designed to provide the following information.

- training for rural psychologists (two items: opinion of what professional development activities should be provided; likelihood of enrolment in specialised postgraduate course)

- APS activities (four items: APS membership of respondent; distance in kilometres from closest APS regional unit; permission for results to be entered in database; ways APS could better serve rural psychologists)

2.3 PROCEDURE

Approval to carry out the survey was received from the Deakin University Ethics Committee and the APS. The survey was mailed with a letter (provided in Appendix 1) explaining the purposes of the research, the way in which the sample was selected, and the role of the APS in the development of the survey and providing the database of directory members. Participation in the survey was voluntary, and confidentiality of responses was guaranteed by requesting respondents to omit their names from the completed survey. Reply paid envelopes were provided with the survey to facilitate responses. A second survey with a reminder letter summarising the points of the first mailout letter was sent to all subjects four weeks after the first mailout.
RESULTS AND DISCUSSION

Chapter 3 consists of four combined results and discussion sub-sections corresponding to the first four components of the survey\(^6\). In each sub-section, relevant data are summarised and discussed. Chapter 3 concludes with a sub-section in which the main features of the overall results are summarised, conclusions that can be drawn from these results are presented, and implications of the results canvassed. This format of having combined results and discussion sections for the four sections of the survey was adopted to enable easier comprehension of the total set of responses.

3.0 PREAMBLE: OVERVIEW OF DATA ANALYSES TO BE REPORTED

As outlined in Chapter 2 (Section 2.1), surveys were posted to all psychologists in the APS Directory whose work address postcode indicated that they worked in a community with a population density of less than 8.7 persons per hectare. In addition, surveys were sent to 500 psychologists randomly selected from those that did not meet this criterion. All respondents were asked to identify whether they currently worked in a rural or urban setting, and whether they worked in a rural or urban setting five years previously. Of the 86 respondents who reported themselves as currently working in a rural setting, a large minority (24; 27.9\%) reported that they had worked in an urban setting five years previously. That is, almost 28\% of psychologists describing themselves as currently working as Rural psychologists had been working in a rural setting for five years or less. Interestingly, such evidence of changing work setting was not reflected in the responses of the 282 psychologists who reported themselves as working currently in an urban setting. Of these, only three (1.1\%)\(^7\) reported themselves as having worked in a rural setting five years previously. Almost all psychologists describing themselves as currently working as Urban psychologists had been working in an urban setting for more than five years.

---

\(^6\) As mentioned in Chapter 2, the APS developed Section 5 of this survey and any data analysis on the Section was undertaken by the APS. There will be no discussion of the results in the present thesis.

\(^7\) The reported percentages are for the samples of rural and urban respondents who responded to the question of whether their work was located in a rural or urban setting five years previously. One rural psychologist and 14 Urban psychologists did not respond to this question.
On the basis of this pattern of responses it was decided to treat the total sample of respondents as consisting of three sub-groups as follows:

Long-Term (L-T) Rural psychologists (i.e., those 61 respondents working in a rural setting for five years or more).

Short-Term (S-T) Rural psychologists (i.e., those 24 respondents working in a rural setting for less than five years).

Urban psychologists who were made up of all the respondents indicating that they were currently working in an urban setting.

In the analyses to be reported in the present Chapter, responses provided by these three sub-groups to the items making up the separate sections of the survey were compared to determine the nature and extent of rural-urban differences reflected in the data, and to determine whether any differences were influenced by the duration of experience working as a psychologist in a rural setting.

As discussed in Chapter 1, the retention of rural health and social-welfare workers in rural areas is just as an important an issue as the recruitment of practitioners to rural areas. L-T Rural psychologists were already showing at least some commitment to working in a rural setting from the duration of time they had already spent in a rural setting. It was expected therefore that L-T Rural psychologists would have more of a commitment to continuing their work in a rural setting than S-T Rural psychologists.

Commitment to a rural or urban work setting was investigated by asking psychologists if they had a choice in working in a rural or urban setting, whether that choice was made on the basis of the setting being rural or urban, and if they would prefer to work in a rural or urban setting in the next five years. Overall, a higher proportion of Rural psychologists reported that they had a choice in selecting their current work location than Urban psychologists (L-T Rural, 65.6% S-T Rural, 54.2%, and Urban, 27%). $\chi^2 (2, N = 366) = 36.6, p < .001$. Of those psychologists who stated they had a choice the majority reported that the rural or urban work setting was a major factor in making that choice, (L-T Rural, 74.3%, S-T Rural, 54.5%, and Urban, 65.3%). There was a significant difference in the proportions of L-T Rural and S-T Rural psychologists who reported a preference for the same type of work setting over the next five years, $\chi^2 (4, N = 359) = 186.9, p < .001$. Of the L-T Rural psychologists, 80% stated they would prefer to be working in a rural setting
in the next five years in comparison to 54.2% of the S-T Rural psychologists. The proportion of Urban psychologists reporting a preference for the same work setting was similar to L-T Rural psychologists (82.5%).

The finding that over half the Rural psychologists overall had a choice between a rural or urban work setting indicates that the decision to work in a rural setting was based on preference rather than necessity caused by conditions such as low employment opportunities in urban areas. In addition, the choice to work in a rural setting was made because of a preference for a rural setting. The results to the question on preference for work setting over the next five years was the most revealing of the desire of Rural psychologists to remain in rural practice. Just under half of the S-T Rural psychologists reported that they would prefer to work in an urban setting in the next five years.

The above results support the expectation that L-T Rural psychologists have more of a commitment to remaining in a rural setting than S-T Rural psychologists. In relation to the two sub-groups of rural respondents, these results will be taken into consideration with other findings that could further explain the difference in their level of commitment to rural practice.

3.1 COMPARISON OF RURAL AND URBAN PSYCHOLOGISTS IN TERMS OF DEMOGRAPHIC VARIABLES

Table 1 summarises the responses of the three sub-groups of respondents (L-T Rural, S-T Rural, Urban) in relation to the demographic variables of age, sex, and ethnic background.
Table 1. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit demographic information.

<table>
<thead>
<tr>
<th>Demographic variables</th>
<th>Respondents’ sub-group</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L-T Rural (N=61)</td>
<td>S-T Rural (N=24)</td>
<td>Urban (N=282)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>20-29 years</td>
<td>00</td>
<td>(00.0%)</td>
<td>00</td>
</tr>
<tr>
<td></td>
<td>30-39 years</td>
<td>09</td>
<td>(14.8%)</td>
<td>06</td>
</tr>
<tr>
<td></td>
<td>40-49 years</td>
<td>28</td>
<td>(45.9%)</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>50-50+ years</td>
<td>24</td>
<td>(39.3%)</td>
<td>07</td>
</tr>
<tr>
<td>Sex</td>
<td>Female</td>
<td>26</td>
<td>(44.8%)</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>32</td>
<td>(55.2%)</td>
<td>11</td>
</tr>
<tr>
<td>Ethnic background&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Australian</td>
<td>50</td>
<td>(82.0%)</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Anglo</td>
<td>04</td>
<td>(06.6%)</td>
<td>04</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>11</td>
<td>(11.5%)</td>
<td>07</td>
</tr>
</tbody>
</table>

Inspection of Table 1 shows that there were few large differences in the profile of responses provided by respondents in the three sub-groups to the items designed to obtain demographic information. In relation to the Age variable, almost half the respondents in each sub-group were in the 40-49-year-old category, with about an additional third in the 50-years-and-more category. The Sex variable revealed a small difference in the proportion of female and male psychologists in the three sub-groups. While there were more female (61.0%) than male (39.0%) Urban psychologists, there were fewer female (44.8%) than male (55.2%) L-T Rural psychologists. The female-male proportion of S-T Rural psychologists fell in between that for Urban and L-T Rural psychologists. This distribution of female-male psychologists across the three sub-groups suggests that male psychologists are more likely to remain working in a rural setting than female psychologists. Over half of the respondents in each sub-group were from an Australian ethnic background. There was only a small difference for respondents from an Anglo ethnic background, with around 10% more in the S-T Rural and Urban groups of psychologists in comparison to the L-T Rural group.

---

<sup>8</sup> The 'other' category in the ethnic background variable is a combination of the Asian, Chinese, Greek, Italian, Vietnamese, and 'other' categories in item 1.3.
Table 2 is a summary of the responses of the respondents in the three sub-groups to the items asking where the respondents and their spouses had spent their childhood years. The purpose of these items was to determine whether the experience of childhood in a rural environment (for respondents or spouses) was influential in current status as Rural or Urban psychologists.

Table 2. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items seeking information about where they and their spouses spent their childhood

<table>
<thead>
<tr>
<th>Childhood setting</th>
<th>Respondents' sub-group</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L-T Rural (N=61)</td>
<td>S-T Rural (N=24)</td>
<td>Urban (N=282)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respondent’s childhood</td>
<td>Spent in rural setting</td>
<td>19 (31.1%)</td>
<td>06 (25.0%)</td>
<td>044 (15.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spent in urban setting</td>
<td>34 (55.7%)</td>
<td>13 (54.2%)</td>
<td>220 (78.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spent in both equally</td>
<td>08 (13.1%)</td>
<td>05 (20.8%)</td>
<td>017 (06.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse’s childhood</td>
<td>Spent in rural setting</td>
<td>25 (41.0%)</td>
<td>05 (22.7%)</td>
<td>039 (14.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spent in urban setting</td>
<td>27 (44.3%)</td>
<td>12 (54.5%)</td>
<td>186 (66.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spent in both equally</td>
<td>05 (08.2%)</td>
<td>02 (09.1%)</td>
<td>017 (06.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not applicable</td>
<td>04 (06.6%)</td>
<td>03 (13.6%)</td>
<td>036 (12.9%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 shows that there are large differences in the rural or urban background of the sub-groups of respondents and their spouses. Based on previous evidence that rural background practitioners are more likely to enter rural practice than urban background practitioners (Davies, 1991; Davies, 1994; Kassebaum & Szenas, 1993; Keller, 1982; Magnus & Tolan, 1993; Riley et al., 1991; Rolfe et al., 1995; Wise et al., 1994) it was expected that larger proportions of L-T Rural and S-T Rural psychologists would report that they and their spouses had spent their childhood in rural settings in comparison to Urban psychologists and their spouses. In relation to L-T Rural and Urban psychologists, the results in Table 2 support the expectations. A higher proportion of L-T Rural psychologists reported that they came from a rural background than Urban psychologists, $\chi^2 (4, N = 366) = 19.7, p = .001$. The proportion of L-T Rural and S-T Rural psychologists who had an urban background was similar, but S-T Rural psychologists were just as likely to come from a rural and urban background equally as they were to come from a rural background only. In addition, a higher proportion of L-T Rural psychologists had spouses who had a
rural background than S-T Rural and Urban psychologists, $\chi^2 (6, N = 361) = 25.8$, $p < .001$.

Overall, the demographic details of L-T Rural, S-T Rural, and Urban psychologists in respect of age, sex, and ethnic background were similar. Differences were found for the rural background of respondents and their spouses. If the childhood setting of rural respondents and their spouses is a predictor of how long they are likely to remain in rural work settings, the results in Table 2 indicate a continuation in the paucity of psychologists in rural Australia. L-T Rural psychologists were the most likely to come from a rural background and have spouses who came from a rural background out of the three sub-groups of respondents. S-T Rural psychologists were more similar to Urban psychologists in their previous experience with a rural setting. In particular, the proportion of S-T Rural psychologists who had spouses with a rural background was substantially lower than for the group of L-T Rural respondents. The evidence suggests that S-T Rural psychologists are a group that is likely to leave rural practice for urban practice. This conclusion is further supported by the finding discussed previously (Section 3) that 45.8% of S-T Rural psychologists prefer to work in an urban setting over the next five years.

3.2 COMPARISON OF RURAL AND URBAN PSYCHOLOGISTS IN TERMS OF THEIR FORMAL PROFESSIONAL QUALIFICATIONS, PROFESSIONAL DEVELOPMENT ACTIVITIES, AND THEIR EVALUATION OF THE ADEQUACY OF THEIR PROFESSIONAL TRAINING

As described in Chapter 2 (see also the survey in Appendix 1), there were 19 items designed to obtain a range of specific information in relation to respondents' training in psychology, and their opinions about their training. The data will be presented and discussed in the following three sub-sections:

- **Information** about respondents' formal professional qualifications in psychology and where these qualifications have been obtained.
- **Information** about respondents' ongoing professional development activities in psychology.
- **Respondents' evaluations** of the adequacy of their formal training in psychology.
3.2.1 Comparison of rural and urban psychologists in terms of their formal qualifications and where these were obtained

The basic qualification for membership of the APS and for registration in the various Australian States and Territories at the time of the survey was (i) completion of a Bachelor degree part of which was a three-year sequence of study of psychology, and (ii) completion of a fourth year of study of psychology, both being accredited by the APS (see Section 1.4, Chapter 1). Table 3 sets out the frequencies (together with % of the sub-groups in parentheses) of respondents in each of the three sub-groups who reported having completed a three-year Bachelor degree, an Honours year in psychology or some other fourth-year of study, and a Master degree. The results are grouped by the location (rural/urban) of the university respondents had undertaken their course of study.

Table 3. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items seeking information about their formal professional qualifications and where these were obtained.

<table>
<thead>
<tr>
<th>Qualification</th>
<th>L-T Rural (N=61)</th>
<th>S-T Rural (N=24)</th>
<th>Urban (N=282)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>15</td>
<td>32</td>
<td>03</td>
</tr>
<tr>
<td>(31.9%)</td>
<td>(68.1%)</td>
<td>(17.6%)</td>
<td>(82.4%)</td>
</tr>
<tr>
<td>Honours degree</td>
<td>04</td>
<td>19</td>
<td>01</td>
</tr>
<tr>
<td>(17.4%)</td>
<td>(82.6%)</td>
<td>(90.9%)</td>
<td>(13.2%)</td>
</tr>
<tr>
<td>Other Fourth year</td>
<td>11</td>
<td>12</td>
<td>01</td>
</tr>
<tr>
<td>(47.8%)</td>
<td>(52.2%)</td>
<td>(12.5%)</td>
<td>(87.5%)</td>
</tr>
<tr>
<td>Masters degree</td>
<td>05</td>
<td>20</td>
<td>01</td>
</tr>
<tr>
<td>(20.0%)</td>
<td>(80.0%)</td>
<td>(10.0%)</td>
<td>(90.0%)</td>
</tr>
</tbody>
</table>

9 The results pertaining to location of university in Table 3 and in the discussion below are calculated from the respondents in each of the three sub-groups who had attended an Australian university. It was unknown whether the overseas universities specified by some respondents were rural or urban. For the complete data set see Appendix 2.
Inspection of Table 3 shows that the training qualifications of the three sub-groups of respondents were similar. The overall percentage of L-T Rural, S-T Rural, and Urban psychologists who had a fourth year qualification was also similar, although L-T Rural psychologists were less likely to have an honours qualification (L-T Rural, 37.7%, S-T Rural, 50%, and Urban, 51.4%). This could be a result of the age distribution of L-T Rural psychologist who were generally older than S-T Rural and Urban psychologists (Table 1). There has been an increase in Honours-degree places at universities over the past 10 years and respondents in the lower age-groups would have had more opportunity to complete the qualification. Those L-T Rural psychologists who did not possess an honours qualification had a Graduate Diploma in Counselling Psychology instead.

L-T Rural psychologists were more likely to have undertaken their undergraduate studies $\chi^2 (2, N = 360) = 5.9, p < .05$, and Masters qualification $\chi^2 (2, N = 213) = 12.6, p < .05$, on a part-time basis than S-T Rural psychologists and Urban psychologists. The difference for the Masters qualification was particularly notable with 71.4% of L-T Rural psychologists undertaking the qualification as part-time students in comparison to 41.7% of S-T Rural psychologists and 35.8% of Urban psychologists. On average, year of completion for each level of study was similar for the three sub-groups of respondents (undergraduate, 1976, fourth-year 1979, and Masters, 1983).

There were significant differences in the proportions of respondents from each of the three sub-groups who had attended a university in a rural or non-metropolitan setting for undergraduate and fourth-year qualifications. L-T Rural psychologists more commonly attended rural or non-metropolitan universities for their undergraduate $\chi^2 (2, N = 314) = 14.2, p = .001$, and fourth year studies $\chi^2 (2, N = 276) = 17.6, p < .001$, than S-T Rural and Urban psychologists.

The majority of Rural and Urban psychologists had completed a placement of more than 20 hours in an applied setting during their higher education training (L-T Rural, 71.7%, S-T Rural, 83.3%, and Urban, 77.5%). There was no significant difference in the average number of weeks spent in a placement among the three sub-groups with
a total group mean of 27.6 (SD = 51.7) weeks. There was a significant difference in
the rural or urban location of placements. Larger proportions of L-T Rural and S-T
Rural psychologists had undertaken their placements in a rural location in
comparison to Urban psychologists (L-T Rural, 28.6%, S-T Rural, 15%, and Urban,
4.3%), $\chi^2 (2, N = 272) = 26.7, p < .001$. In addition, 27.3% of L-T Rural
psychologists who had undertaken a second placement did so in a rural location in
comparison to 12.5% of S-T Rural psychologists, and 5.4% of Urban psychologists
who had also undertaken a second placement, $\chi^2 (2, N = 160) = 11.4, p < .01$.

In summary, previous studies have shown that rural health and welfare workers have
lower level qualifications than urban practitioners (Kassebaum & Szenas, 1993;
Miller & Zuckerman, 1991; Pucket & Frederico, 1992; Rolfe et al., 1995). In the
current study Rural psychologists were as highly qualified as their urban colleagues.
The main difference in training background was found was for the rural or urban
location of universities and placements. Overall, L-T Rural psychologists had the
most training experience in a rural setting either through the location of the
university they attended or the location of their placements.

S-T Rural psychologists had less demographic ties to rural areas than L-T Rural
psychologists, and when comparing the training backgrounds of the two sub-groups
they became even more differentiated. Except for location of first placement, S-T
Rural psychologists were more similar to Urban psychologists in their training
experience than they were to Rural psychologists.

3.2.2 *Comparison of rural and urban psychologists in terms of ongoing
professional development activities in psychology*

Continuing education and training is a valuable way of keeping abreast of methods
of treatment and ways of operating an effective practice for most health and mental
health professionals. There were five items designed to elicit information about
professional development activities undertaken by respondents to maintain their
expertise in professional practice. Such activities ranged from enrolment in courses
designed to provide further formal qualifications (e.g., enrolment in coursework
Masters courses), attendance at workshops/conferences, obtaining work-related
literature, and consulting with colleagues. Table 4 summarises the responses to four of these items under two areas, namely formal study and informal activities. The responses to the item asking respondents about their consultation with colleagues were provided on a Likert scale. The responses to this item are presented in the discussion below Table 4.

Table 4. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about ongoing professional development.

<table>
<thead>
<tr>
<th>Professional development activity</th>
<th>Respondents' sub-group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L-T Rural (N=61)</td>
</tr>
<tr>
<td>Formal study</td>
<td></td>
</tr>
<tr>
<td>Psychology courses</td>
<td>10 (16.4%)</td>
</tr>
<tr>
<td>other courses</td>
<td>02 (03.8%)</td>
</tr>
<tr>
<td>Informal activities</td>
<td></td>
</tr>
<tr>
<td>Attending workshops/conferences</td>
<td>55 (93.2%)</td>
</tr>
<tr>
<td>Obtaining work-related literature</td>
<td>35 (59.3%)</td>
</tr>
</tbody>
</table>

Inspection of Table 4 shows that the three sub-groups of respondents reported similar patterns of ongoing professional development activities, but with a few differences. Small proportions of Rural and Urban psychologists were enrolled in a psychology or non-psychology (e.g., Master of Business Administration, Diploma in Computing) university course at the time of the survey. Most psychologists enrolled in a course were undertaking their study in an on-campus mode. There was no significant difference in the reasons Rural and Urban psychologists were not undertaking further studies in a psychology course with most of them reporting there was no need. A large majority of Rural and Urban psychologists had attended a workshop or conference in the past 12 months relevant to their work as psychologists.

In addition to workshops and conferences, reading relevant literature is a way of updating and expanding knowledge and work related skills. A significantly lower proportion of S-T Rural psychologists had accessed a university to obtain information relevant to work over the past 12 months in comparison to L-T Rural
psychologists and Urban psychologists, $\chi^2 (2, N = 364) = 13.6$, $p = .001$. S-T Rural psychologists who accessed universities for literature did so less times than L-T Rural psychologists and Urban psychologists, (only 1-2 times in the past 12 months, L-T Rural, 21.2%, S-T Rural, 42.9%, and Urban, 13.3%). Most psychologists who had not accessed a university for literature had stated there was no need.

Consulting colleagues for advice and information on work-related issues could also be considered a form of upgrading knowledge and skills. Psychologists were asked how easy it was for them to consult colleagues on issues such as dealing with a client who had a psychological problem with which the psychologist was inexperienced in treating. Psychologists rated the ease of consulting colleagues on a scale of 1 to 5 with 1 representing "not at all easy" and 5 "very easy". L-T Rural and S-T Rural psychologists were significantly more likely to report difficulty in consulting colleagues than Urban psychologists (L-T Rural, $M = 3.2$, $SD = 1.3$, S-T Rural, $M = 3$, $SD = 1.4$, and Urban, $M = 4.2$, $SD = 1.1$), $F (2, 361) = 26.5$, $p < .001$.

L-T Rural psychologists were similar in their ongoing training activities to Urban psychologists. The only difference between the two groups was for consultation with colleagues for which Rural psychologists overall found it more difficult than Urban psychologists. S-T Rural psychologists were less likely to be continuing with their professional development through further academic training or reading work-related literature than L-T Rural and Urban psychologists. It is likely that S-T Rural psychologists were finding it more difficult to pursue these activities than the other two sub-groups of psychologists. For instance, almost half of the S-T Rural psychologists stated that their reason for not enrolling in a non-psychology course was that it was too hard to organise because of work commitments. In addition, the lower proportion of S-T Rural psychologists obtaining work-related literature cannot be attributed to a lack of interest in printed information. Psychologists were asked whether they accessed this information from a university. There are other means of accessing literature such as subscription to a journal or magazine. Moreover, S-T Rural psychologists showed a commitment to professional development by attending work-related workshops and conferences as frequently as the other two groups of psychologists.
3.2.3 Comparison of rural and urban psychologists in terms of their evaluations of the adequacy of their formal training in psychology

There were 10 items designed to elicit respondents' evaluations of their formal training in psychology. For each item, respondents were asked to rate their undergraduate and postgraduate training on a scale of 1 to 5 where 1 was "completely inadequate" or "not useful" and 5 was "completely adequate" or "very useful". Responses to questions that tapped into views on training in the scientist-practitioner model were combined to create separate scientist and practitioner training variables. Questions combined for the scientist variable were: usefulness for psychological work of undergraduate and postgraduate training in research report writing, statistical techniques, and research methodologies. Questions combined for the practitioner variable were: adequacy of undergraduate and postgraduate training for interviewing clients and obtaining their histories, psychometric testing, and interpreting test results.

Table 5 summarises the mean evaluations (together with standard deviations in parentheses) provided by respondents in each of the three sub-groups to items that are discussed below.
Table 5. Summary of responses (mean ratings on a five-point scale; standard deviations in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about evaluations of formal training in psychology.

<table>
<thead>
<tr>
<th>Evaluation items</th>
<th>Respondents’ sub-group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L-T Rural</td>
</tr>
<tr>
<td>Training in urban issues and problems</td>
<td>3.0 (1.0)</td>
</tr>
<tr>
<td>Training in rural issues and problems</td>
<td>2.0 (1.1)</td>
</tr>
<tr>
<td>Training in scientist role</td>
<td>3.5 (1.1)</td>
</tr>
<tr>
<td>Training in practitioner role</td>
<td>3.5 (1.4)</td>
</tr>
</tbody>
</table>

Inspection of Table 5 shows that overall, L-T Rural, S-T Rural, and Urban psychologists in the current study considered their overall formal training in psychology as only somewhat adequate for their work in providing psychological services. The lowest ratings were received for the adequacy of training for rural community issues and problems. Training in urban community issues received higher ratings, although the responses were still in the somewhat adequate range. Most respondents gave higher ratings to their research training than their training in practitioner activities such as psychometric testing. L-T Rural psychologists rated training in practitioner activities significantly lower than S-T Rural and Urban psychologists, F (2, 360) = 6.6, p < .01.

Psychologists were also asked to rate the usefulness to psychological work of some areas taught in most psychology courses. Overall, the highest ratings were received for cognitive psychology, (M = 3.7, SD = 1.1), developmental psychology, (M = 3.7, SD = 1.1), and personality, (M = 3.6, SD = 1.1). Perception received the lowest overall ratings (M = 2.7, SD = 1.1). In addition to rating areas of psychology training, psychologists were given the opportunity to list at least three of the most useful training units for their work in providing psychological services. The most identified units for all psychologists were counselling (34%), psychopathology (28%), and cognitive-behavioural psychology (21%). Training in research methodologies and statistics were also listed frequently by all psychologists (20%).

It was outlined above that respondents from the three sub-groups perceived their overall training in psychology as only somewhat adequate for their work in providing psychological services. Even in the psychologists’ listings of most useful areas of training, areas that are considered core to the client-practitioner relationship
(such as psychometric testing and interpretation) received the lowest ratings.
Contrary to Carr's (1987) argument that training Rural psychologists in the scientist-
practitioner model is counterproductive, Rural and Urban psychologists in the
current study rated training in research as more than useful. The positive views on
training in research were also likely to be related to research activities during
employment. Substantial proportions of L-T Rural, S-T Rural, and Urban
psychologists had presented at least one paper at a conference in the past 12 months,
(L-T Rural, 46.7%, S-T Rural, 54.2%, and Urban, 55.7%). In addition, more than
10% of psychologists from each group had also published at least one paper based
on experiences in practice over the past 12 months, (L-T Rural, 15%, S-T Rural,
25%, and Urban, 26.3%). Psychologists' greater satisfaction with their training in
research could also rise from their appreciation for training in critical thinking and
interpreting scientific literature. As discussed in section 3.2.2, most L-T Rural and
Urban psychologists were at least accessing universities for work-related books and
journals.

L-T Rural, S-T Rural, and Urban psychologists' similar levels of satisfaction with
previous training for current work do not necessarily translate to similar work
practices. Training could be falling short of more than adequately preparing
psychologists for work in any setting, as well as the possibility that there are core
work functions to rural and urban practice. The following section presents the
differences in the work practices of L-T Rural, S-T Rural, and Urban psychologists
in the current study.

3.3 **COMPARISON OF RURAL AND URBAN PSYCHOLOGISTS IN TERMS
OF THEIR WORK AND THE CLIENTELE THEY SERVE**

As described in Chapter 2 (see also the survey in Appendix 1), there were 18 items
designed to obtain a range of specific information in relation to respondents' work
conditions, work practices, and the clients they see in their practices. Preliminary
analysis of the data indicated that there was a degree of consistency in the responses
to some items, and that there were very few responses to other items. To make
presentation and interpretation of the data as clear as possible responses to some
items have been combined. In the analyses to be reported such data combination will
be indicated by footnote. The data will be presented and discussed in the following two sub-sections:

- Information about respondents’ work conditions and practices
- Demographic information about respondents’ clientele.

The items required responses in the form of estimations of percentage of time spent in various work activities over the past two weeks or more; 5-point Likert scales, and yes/no responses.

### 3.3.1 Comparison of the work conditions and practices of rural and urban psychologists

Table 6 is a summary of the responses to items designed to gain information on the work conditions of Rural and Urban psychologists. The items included full-time or part-time nature of employment, main employer, and annual salary.

Table 6. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about work conditions.

<table>
<thead>
<tr>
<th>Respondents’ sub-group</th>
<th>L-T Rural (N=61)</th>
<th>S-T Rural (N=24)</th>
<th>Urban (N=282)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nature of employment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>39 (65.0%)</td>
<td>17 (73.9%)</td>
<td>203 (73.8%)</td>
</tr>
<tr>
<td>Part-time</td>
<td>21 (35.0%)</td>
<td>06 (26.1%)</td>
<td>72 (26.2%)</td>
</tr>
<tr>
<td><strong>Type of employment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private practice</td>
<td>32 (52.5%)</td>
<td>08 (33.3%)</td>
<td>088 (31.2%)</td>
</tr>
<tr>
<td>Non-Government Organisation</td>
<td>01 (01.6%)</td>
<td>03 (12.5%)</td>
<td>032 (11.3%)</td>
</tr>
<tr>
<td>Government Organisation</td>
<td>20 (32.8%)</td>
<td>12 (50.0%)</td>
<td>123 (43.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>08 (13.1%)</td>
<td>01 (04.2%)</td>
<td>039 (13.8%)</td>
</tr>
<tr>
<td><strong>Annual salary for full-time work</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>under $40,000</td>
<td>04 (10.3%)</td>
<td>06 (35.3%)</td>
<td>032 (15.8%)</td>
</tr>
<tr>
<td>over $40,000</td>
<td>35 (89.7%)</td>
<td>11 (64.7%)</td>
<td>170 (84.2%)</td>
</tr>
</tbody>
</table>

Inspection of Table 6 shows that there were a few differences in the work conditions of respondents from the three sub-groups. Similar proportions of respondents from each sub-group were working full-time. L-T Rural psychologists were significantly more likely to be in private practice and less likely to be in a non-government

---

10 The variable 'Government organisation' is a combination of the State government and Local Government categories in item 1.7.
organisation than S-T Rural and Urban psychologists, $\chi^2 (6, N = 367) = 14.9$, $p < .05$. It was expected that Rural psychologists would be earning less than Urban psychologists, but in fact similar proportions of the two sub-groups were earning an annual salary of over $40,000. A substantially lower proportion of S-T Rural psychologists was earning over $40,000 per annum. The difference can mainly be attributed to the private practice employment sector for which S-T Rural psychologists were less likely to be earning over $40,000 per annum than L-T Rural and Urban psychologists in the same sector (L-T Rural, 81.8%, S-T Rural psychologists, 40%, and Urban psychologists, 83.1%). The lower salaries of S-T Rural psychologists in private practice can be attributed to the fact that on average S-T Rural psychologists had only been practicing in their present type of work for 5.9 (SD = 5.7) years. The average number of years in current employment for L-T Rural and Urban psychologists was 8 (SD = 5.3) and 8.5 (SD = 6.4) respectively.

Table 7 summarises the responses to items designed to gain information on the work practices of Rural and Urban psychologists. In relation to counselling, diagnosing, and administration, respondents estimated the proportion of time they had spent in each of the activities over the past two weeks. Administration was segregated into two components in case generalist work practices also involved non-client related administration. The second item summarised in Table 7 is the approach to therapy used by Rural and Urban psychologists in their counselling work with clients. Respondents were asked to estimate the proportion of emphasis they placed on the cognitive-behavioural, psychodynamic/psychoanalytic, humanistic-existential, and eclectic approaches of counselling.
Table 7. Summary of responses (mean estimates of % time spent in each activity: standard deviations in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about work practices.

<table>
<thead>
<tr>
<th>Activity undertaken</th>
<th>L-T Rural (N=61)</th>
<th>S-T Rural (N=24)</th>
<th>Urban (N=282)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>40.8% (21.1)</td>
<td>41.6% (23.5)</td>
<td>44.0% (27.5)</td>
</tr>
<tr>
<td>Diagnosing</td>
<td>23.5% (17.8)</td>
<td>12.6% (12.3)</td>
<td>19.0% (19.6)</td>
</tr>
<tr>
<td>Administration - clients</td>
<td>11.2% (08.0)</td>
<td>13.5% (09.5)</td>
<td>11.7% (09.8)</td>
</tr>
<tr>
<td>Administration - other</td>
<td>09.7% (12.8)</td>
<td>19.4% (24.1)</td>
<td>11.1% (14.7)</td>
</tr>
</tbody>
</table>

**Approach to therapy**

<table>
<thead>
<tr>
<th>Approach to therapy</th>
<th>L-T Rural (N=61)</th>
<th>S-T Rural (N=24)</th>
<th>Urban (N=282)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive-Behavioural</td>
<td>41.7% (32.8)</td>
<td>41.0% (34.2)</td>
<td>38.0% (35.0)</td>
</tr>
<tr>
<td>Psychodynamic/Psychoanalytic</td>
<td>05.7% (11.3)</td>
<td>04.0% (08.5)</td>
<td>17.2% (27.8)</td>
</tr>
<tr>
<td>Humanistic-Existential</td>
<td>10.0% (15.5)</td>
<td>09.0% (13.2)</td>
<td>09.8% (16.4)</td>
</tr>
<tr>
<td>Eclectic</td>
<td>38.0% (36.9)</td>
<td>25.8% (33.8)</td>
<td>20.6% (30.7)</td>
</tr>
</tbody>
</table>

The results in Table 7 show that there were differences in the profile of responses provided by respondents in the three sub-groups to the items designed to obtain information on work practices. S-T Rural psychologists had spent less time on diagnosing clients, $F(2, 364) = 3, p < .05$, and more time in non-client related administration, $F(2, 364) = 3.7, p < .05$, than L-T Rural and Urban psychologists.

The most commonly used counselling approach by all psychologists was cognitive-behavioural. L-T Rural psychologists were significantly more likely to be using an eclectic approach than Urban psychologists, $F(2, 364) = 7.3, p = .001$. Urban psychologists on the other hand were devoting more emphasis to the psychodynamic/psychoanalytical approach in their therapy work with clients than L-T Rural and S-T Rural psychologists, $F(2, 364) = 7.5, p = .001$.

### 3.3.2 Comparison of clientele served by rural and urban psychologists

Table 7 is a summary of the responses made by L-T Rural, S-T Rural, and Urban psychologists to items related to the demographic characteristics of the clientele they serve. Those items related to clients' age, ethnic background, and level of formal education. Respondents were required to estimate the proportion of their clients that belonged to the demographic groups summarised below.
Table 8. Summary of responses (mean estimates of % of clients; standard deviations in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit demographic information about their clientele.

<table>
<thead>
<tr>
<th>Demographic variables</th>
<th>Respondents’ sub-group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L-T Rural (N=61)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>00-19</td>
<td>22.0% (28.0)</td>
</tr>
<tr>
<td>20-39</td>
<td>36.5% (20.7)</td>
</tr>
<tr>
<td>40-64</td>
<td>19.2% (20.6)</td>
</tr>
<tr>
<td>65-85+</td>
<td>01.2% (03.3)</td>
</tr>
<tr>
<td>Ethnic background11</td>
<td></td>
</tr>
<tr>
<td>Indigenous Australian</td>
<td>03.4% (06.7)</td>
</tr>
<tr>
<td>Australian</td>
<td>85.3% (25.6)</td>
</tr>
<tr>
<td>Anglo</td>
<td>00.0% (00.0)</td>
</tr>
<tr>
<td>Other</td>
<td>03.0% (05.6)</td>
</tr>
<tr>
<td>Level of formal education</td>
<td></td>
</tr>
<tr>
<td>Primary (year 1 to 6)</td>
<td>12.4% (20.7)</td>
</tr>
<tr>
<td>Secondary (year 7 to 12)</td>
<td>43.9% (30.9)</td>
</tr>
<tr>
<td>Post-secondary trade</td>
<td>14.9% (17.4)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>14.5% (21.8)</td>
</tr>
</tbody>
</table>

Inspection of Table 8 shows that there were a few differences in the demographic characteristics of the clientele served by respondents in the three sub-groups. Respondents in each sub-group were interacting with clients of similar ages. Most clients fell within a 20 to 50 year age range for all groups. There was somewhat more diversity in the ethnic backgrounds of the clients seen by the three sub-groups of respondents. L-T Rural and S-T Rural psychologists were significantly more likely to be seeing clients with an Australian ethnic background, and less likely to be seeing clients from a non-Australian or non-Anglo ethnic background, F (2, 364) = 15.9, p < .001. The clients with a non-Australian or non-Anglo background seen by Urban psychologists were mainly Asian, (M = 5.2, SD = 9.1), Italian, (M = 3.4, SD = 6.3), and Greek (M = 2.7, SD = 5.1). It was expected that Rural psychologists overall would be interacting with a greater number of indigenous Australians as clients than Urban psychologists. The proportion of clients made up of indigenous Australians was in fact similar for L-T Rural, S-T Rural, and Urban psychologists. Overall, L-T Rural psychologists were seeing clients with lower educational

11 The ‘other’ category in the ethnic background variable is a combination of the Asian, Chinese, Greek, Italian, Vietnamese, and ‘other’ categories in item 3.12.
qualifications than Urban psychologists. The greatest difference was for clients with a university education, $F(2, 364) = 3.6, p < .05$.

Table 9 is a summary of the responses made by L-T Rural, S-T Rural, and Urban psychologists to items related to psychological problems presented by their clientele. These items were anxiety-related, depression, alcoholism, self-esteem issues, sexual abuse, post-trauma stress, marital relationships, learning/education, stress management, and rehabilitation. Respondents were required to estimate the proportion of their work with clients that was allocated to the problems listed in Table 9.

Table 9. Summary of responses (mean estimates of % of work with clients; standard deviations in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit information about the problems presented to them by their clientele group.

<table>
<thead>
<tr>
<th>Problem presented $^{12}$</th>
<th>Respondents' sub-group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L-T Rural (N=61)</td>
</tr>
<tr>
<td>Anxiety-related</td>
<td>13.2% (16.9)</td>
</tr>
<tr>
<td>Depression</td>
<td>11.5% (12.2)</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>02.4% (09.3)</td>
</tr>
<tr>
<td>Self-esteem issues</td>
<td>04.9% (06.3)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>04.9% (08.2)</td>
</tr>
<tr>
<td>Post-trauma stress</td>
<td>08.7% (10.0)</td>
</tr>
<tr>
<td>Marital relationship</td>
<td>07.2% (08.9)</td>
</tr>
<tr>
<td>Learning/educational</td>
<td>08.1% (17.4)</td>
</tr>
<tr>
<td>Stress management</td>
<td>05.6% (08.1)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>04.5% (14.8)</td>
</tr>
</tbody>
</table>

The results in Table 9 show that L-T Rural, S-T Rural, and Urban psychologists were counselling clients with similar problems. In Chapter 1 it was discussed that alcoholism is more prevalent in rural populations and depression in urban populations (see Sections 1.22-1.23). A difference in the rate of these problems in the client-group of Rural and Urban psychologists in the current study was not

$^{12}$Except for alcoholism, only the items that received a mean proportion of 5 or above from either of the sub-groups of respondents are included in Table 9. For items not included in the Table see Appendix I.
evident. The most common problems or disorders experienced by clients of the three sub-groups of respondents were anxiety, depression, self-esteem, and marital.

3.3.3 Summary

The main differences in the work practices of Rural and Urban psychologists overall was their use of counselling approaches and the demographic profiles of their client groups. In addition, the work practices of L-T Rural and S-T Rural psychologists were either similar or did not differ significantly on most variables. The most significant finding for the ethnic profiles of the L-T Rural and S-T Rural client groups was the small proportion of clients who were indigenous Australians. It was already discussed in Chapter 1 that approximately 70% of indigenous Australians live in rural areas and their need for mental health services is greater than the remainder of the rural and urban population (Anderson et al., 1994; Cunningham et al., 1997; Harrison, 1996; McLennan & Madden, 1997; Swan & Raphael, 1995). The finding that Rural psychologists in the current study were no more likely to be seeing indigenous Australians as clients than Urban psychologists, adds credence to the observations of McLennan and Madden (1997) that rural mental health services in Australia may be failing the population’s indigenous people. Moreover, only 1 out of the 367 psychologists in the current study was indigenous Australian. McLennan and Madden (1997) and Swan and Raphael (1995) argued that one of the first steps to improving health and mental health services to indigenous Australians was to increase the number of indigenous Australian practitioners.

The ethnic profile of Urban psychologists in the current study (Table 1) was congruent with the ethnic profile of the urban client group. Urban psychologists were seeing more non-Australian and non-Anglo background clients than Rural psychologists overall. This finding was expected as the large majority of non-Australian and non-Anglo background migrants in Australia live in urban areas. The percentage of overseas born Australians who come from a non-English speaking country is 14% (ABS, 1997). The proportion of Urban psychologists in the current study from a non-Australian or non-Anglo ethnic background was 12%. 
L-T Rural psychologists were less likely to be seeing clients who had completed a university education than S-T Rural and Urban psychologists. Hargrove and Breazeale (1993), Human and Wasem (1991), Mazer (1982), and Nurmi et al. (1994) had linked the more traditional and conservative values of rural populations to their lower overall level of education than urban populations. The main implication of working as a psychologist in a population with traditional and conservative values is the effects on the client-practitioner relationship and the psychologist's relations with the community. An example was offered by Manning and Cheers (1995) who attributed the traditional and conservative values of rural people to their lack of incentive to report incidences of child abuse. Rural people were resistant to reporting cases of child abuse to professionals such as social workers, and were concerned about upholding the privacy of the family in question.

There was some evidence Rural psychologists were performing generalist work activities, however similar evidence was found for Urban psychologists. There were a few differences in the demographic characteristics of the clients seen by Rural and Urban psychologists, but the mean proportion of time spent with clients who fell within different backgrounds was similar for the three groups of psychologists. In addition, Urban psychologist did not show they were specialising in particular areas of psychological problems as they were spending 5% or more of their time with clients in six different problems areas. Urban psychologists were also referring less of their clients to other professionals and agencies than Rural psychologists (proportion of clients referred in the past two weeks-none, L-T Rural, 34.5%, S-T Rural, 60.9%, and Urban, 54.4%). It is interesting to note however that Rural psychologists were more likely to be placing an emphasis on an eclectic approach to therapy than Urban psychologists. Though Urban psychologists were also seeing a diverse range of clients, these psychologists were more likely to be using one of the most specialised styles of counselling approaches, the psychoanalytic/psychodynamic approach.

Involvement with after-hours care was described as a component of generalist work practices in Chapter 1. Rural psychologists in the present study were showing more involvement with after-hours care than Urban psychologists. The majority of psychologists in each sub-group reported that when unavailable there were
emergency and other services they could refer their clients to. L-T Rural and S-T Rural psychologists however were significantly less likely to state that they were never available for after-hours emergency services and care than Urban psychologists. (L-T Rural, 29.5%, S-T Rural, 41.7%, and Urban, 67.7%), $\chi^2 (6, N = 364) = 48.1, p < .001$.

The evidence that Urban psychologists were also performing generalist work practices (treating a diverse range of problems presented to them by clients and referring low proportions of clients to other practitioners) is in conflict with the findings of other researchers (Cheers, 1992; Hood et al., 1993; Hoe, 1982; Jerrel & Herring, 1983; Miller & Zuckerman, 1991; Pulakos & Dengerink, 1983). Most studies comparing the work practices of rural and urban health and mental health practitioners, come from the USA (Bergstrom et al., 1984; Hargrove, 1991; Kahn et al., 1976; Keller, 1982; Keller et al., 1983; Macleod et al., 1998; Murray, 1984; Pulakos & Dengerink, 1983; Spoth et al., 1999). Urban psychologists in Australia have a much smaller population to extract clients from than their colleagues in the USA. An implication of a smaller population is the reduced opportunity for specialisation in a practice. Moreover, Americans are known as a people that seek psychological counselling more readily and frequently than any other people in the world.

Specialist work practices are also less defined for psychologists in Australia than they are in the USA. For example, clinical psychologists in the USA are required to have a PhD qualification to practice specialist functions such as therapy with suicidal patients. The three groups of psychologists in the current study had similar levels of qualifications, and it would be difficult to define areas of practice that are specialist. In the medical profession the boundaries of generalist versus specialist work practices are clearly defined, and it is more comprehensible to investigate whether rural GPs are crossing these boundaries to cover for a lack of specialists in the area.
3.4 **COMPARISON OF RURAL AND URBAN PSYCHOLOGISTS IN TERMS OF THEIR RELATIONS WITH THEIR COMMUNITIES**

As described in Chapter 2 (see also the survey in Appendix 1), there were 11 items designed to obtain a range of specific information in regards to respondents' relations with community members, prominent community members, and natural helpers. Preliminary analysis of the data indicated that there was a degree of consistency in the responses to some items, and that there were very few responses to other items. To make presentation and interpretation of the data as clear as possible responses to some items have been combined. In the analyses to be reported such data combination will be indicated by footnote. The data will be presented and discussed in the following three sub-sections:

- Respondents' evaluations of their relations with community members, prominent community members, and natural helpers.
- Information on how community members learn about mental health issues.
- Respondents' opinions of training natural helpers to assist with psychological services.

Respondents were asked to indicate their responses to the items on community relations in the forms of a 5-point Likert scale and yes/no, agree/disagree responses.

3.4.1 **Comparison of rural and urban psychologists in terms of their relations with community members, prominent community members, and natural helpers**

Rural and Urban psychologists were asked about the attitudes of community members towards the respondent as a professional and the services he or she provides. L-T Rural, S-T Rural, and Urban psychologists perceived members of their communities to be neutral about the act of seeking professional help from a psychologist. That is, community members had neither a positive or negative view about the psychologist’s role in providing psychological services.

Other studies have shown that Rural psychologists have difficulty keeping their interactions with clients inside the bounds of practice, and maintaining client confidentiality, because of the small size of most rural communities (Horst, 1989; Manning & Cheers, 1995). Discussed in Chapter 1 were studies that have found these difficulties affect the relations between Rural psychologists and their
communities (see Section 1.3; Brentar & McNamara, 1991; Horst, 1989; Manning & Cheers, 1995). In the current study, L-T Rural and S-T Rural psychologists were significantly more likely to report that they often encountered their clients outside of practice than Urban psychologists, (L-T Rural, 44.3%, S-T Rural, 33.3%, and Urban, 5.4%), \( \chi^2 (4, N = 364) = 92.6, p < .001 \). L-T. Psychologists rated the difficulty in maintaining client confidentiality on a 5-point scale where 1 represented "not at all difficult" and 5 represented "very difficult". L-T Rural and S-T Rural psychologists reported that maintaining client confidentiality was more difficult than what Urban psychologists reported, (L-T Rural, \( M = 2.1, SD = 1.0 \), S-T Rural, \( M = 2.0, SD = 1.0 \), and Urban, \( M = 1.4, SD = 1.0 \)), \( F (2, 359) = 28.2, p < .001 \).

Psychologists from the three sub-groups also reported that the support of prominent community members such as local politicians and clergy was only somewhat important. When asked whether these prominent community members offered support or opposition to the psychologist, psychologists from the three sub-groups indicated they received a lot support.

As discussed in Chapter 1, Rural psychologists can more easily achieve positive community relations if they have the acceptance of natural helpers. L-T Rural, S-T Rural, and Urban psychologists in the present study reported that the natural helpers of their communities provided them with positive support. Natural helpers from rural and urban areas showed collaboration by advising community members to seek assistance from the respondent at least occasionally. L-T Rural, S-T Rural, and Urban psychologists also stated that they at least occasionally sought advice from natural helpers concerning clients.

3.4.2 Comparison of the ways in which rural and urban community members learn about mental health issues

Relations with a community would be made easier for psychologists who are working in a community that has some understanding of psychology as a profession, and the issues psychologists deal with. Rural and Urban psychologists were asked the level of knowledge of community members about psychological problems/disorders, and the sources of this knowledge. L-T Rural, S-T Rural, and Urban psychologists perceived members of their communities to have some
knowledge about psychological problems and disorders. Table 10 summarises the responses of the three sub-groups of psychologists in relation to the item listing sources of knowledge from which the community could learn; i.e., psychologist (respondent), GP, other community members, public education programs, school and university, and the mass media.

Table 10. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to obtain information on the ways in which rural and urban communities learn about psychological issues.

<table>
<thead>
<tr>
<th>Sources of knowledge</th>
<th>L-T Rural (N=61)</th>
<th>S-T Rural (N=24)</th>
<th>Urban (N=282)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist (respondent)</td>
<td>44 (72.1%)</td>
<td>17 (70.8%)</td>
<td>160 (56.7%)</td>
</tr>
<tr>
<td>GP</td>
<td>47 (77.0%)</td>
<td>18 (75.0%)</td>
<td>189 (67.0%)</td>
</tr>
<tr>
<td>other Community members</td>
<td>29 (47.5%)</td>
<td>10 (41.7%)</td>
<td>114 (40.4%)</td>
</tr>
<tr>
<td>Public education programs</td>
<td>26 (42.6%)</td>
<td>13 (54.2%)</td>
<td>127 (45.0%)</td>
</tr>
<tr>
<td>School and university</td>
<td>21 (34.4%)</td>
<td>09 (37.5%)</td>
<td>114 (40.4%)</td>
</tr>
<tr>
<td>Mass media(^{13})</td>
<td>41 (67.2%)</td>
<td>11 (45.8%)</td>
<td>210 (74.5%)</td>
</tr>
</tbody>
</table>

Inspection of Table 10 shows that there were differences in the ways in which rural and urban community members learned about psychological disorders/problems. L-T Rural and S-T Rural psychologists were more likely to report that they themselves were sources of information on psychological problems/disorders in their communities than Urban psychologists. S-T Rural psychologists were less likely to affirm the mass media as sources of knowledge than L-T Rural and Urban psychologists. The results in Table 10 also reveal that the dissemination of information of psychological problems/disorder was more dispersed among the sources presented in the Table for Urban psychologists. The responses of L-T Rural psychologists in particular showed that GPs and the psychologist responding to the survey disseminated the bulk of information on psychological problems/disorders.

\(^{13}\) The 'mass media' variable is a combination of the 'television', 'radio', and 'newspapers' categories in item 4.6.
3.4.3 Comparison of the opinions rural and urban psychologists have on training natural helpers to assist in the provision of psychological services

Table 11 summarises the responses to items designed to elicit the opinions of L-T Rural, S-T Rural, and Urban psychologists’ on the question of whether natural helpers should be trained to assist psychologists with work activities (i.e., counselling and emergency services), and what agencies or professionals should train natural helpers to provide this assistance.

Table 11. Summary of responses (frequencies; % of each sub-group in parentheses) of L-T Rural, S-T Rural, and Urban psychologists to items designed to elicit their opinions on training natural helpers.

<table>
<thead>
<tr>
<th>Training variables</th>
<th>Respondents’ sub-group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L-T Rural (N=61)</td>
</tr>
<tr>
<td>Train natural helpers</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>36 (60.0%)</td>
</tr>
<tr>
<td>No</td>
<td>09 (15.0%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>15 (25.0%)</td>
</tr>
<tr>
<td>Ways of training natural helpers</td>
<td></td>
</tr>
<tr>
<td>Psychologists in community</td>
<td>39 (63.9%)</td>
</tr>
<tr>
<td>Formal training (e.g., university)</td>
<td>28 (45.9%)</td>
</tr>
<tr>
<td>other</td>
<td>10 (16.4%)</td>
</tr>
</tbody>
</table>

The results in Table 11 show that overall, Rural psychologists were more receptive to the idea of training natural helpers to assist psychologists with work activities such as counselling and emergency services than were Urban psychologists, $\chi^2 (4, N = 351) = 12.7, p < .05$. Most L-T Rural, S-T Rural, and Urban psychologists stated that psychologists in the community should train natural helpers rather than professional trainers such as university lecturers.

3.4.4 Summary

The main picture that emerges from the findings above is that Rural psychologists overall have the kind of relations with their communities that have been identified in the literature as the most conducive to rural practice (Heyman, 1986; Heyman & VandenBos, 1989; Horst, 1989; Keller & Prutsman, 1982; Kelley et al., 1977; Kenkel, 1986; McLennan & Madden, 1997; Pucket and Frederico, 1992). L-T Rural and S-T Rural psychologists were one of the most common sources of information
on psychological problems/disorders in their communities. Urban psychologists were more likely to indicate that they were the third most common source of information after the mass media and GPs. Rural psychologists' greater involvement with disseminating information on mental health issues support the argument that rural practitioners are more likely to perform preventive and community work than Urban psychologists (Bergstrom et al., 1984; Hargrove, 1991; Kahn et al., 1976; Keller, 1982; Keller et al., 1983; Macleod et al., 1998; Murray, 1984; O'Brien, 1998; Spath et al., 1999).

Respondents in all three sub-groups reported that they did not perceive any opposition from prominent community members to their work as psychologists. L-T Rural psychologists in particular reported positive relations with the prominent members of their communities such as local politicians and clergy. Manning and Cheers (1995) described the importance of these relations for social workers in the prevention of child abuse. These researchers observed that rural people were more likely to seek help from prominent community members on issues such as child abuse than seek the help of social workers. Hoe (1982) also argued that placements during training for psychological practice in rural settings should take place within organisations such as the church and schools. The students on placement in these settings would likely interact with influential members of the community such as priests and school principals who could offer insight into the health and community issues relevant to rural people.

Previous literature has described the resistance of some rural people to seeking professional help for a mental health problem, because of their fear of being seen by other community members (Berry & Davis, 1978; Griffiths, 1996; Horst, 1989; Levant et al., 1998; Osher et al., 1994). Rural psychologists in the current study reported difficulty in maintaining client confidentiality within their communities. L-T Rural and S-T Rural psychologists however were no more likely to perceive that members of their communities rate the act of seeking professional help from a psychologist as negative than Urban psychologists.

As mentioned in the beginning of this section, Rural psychologists in the current study had the kind of relations with their communities that is conducive to rural
practice. Rural psychologists were acting as conduits of information on mental health issues, and they were experiencing positive relations with other community members such as prominent figures and natural helpers. The high proportion of Rural psychologists who stated that natural helpers should be trained by psychologists to offer psychological services also shows a willingness to align with informal helping networks for the needs of the population. Considering the lack of psychologists in rural areas of Australia, training natural helpers in addition to creating more rural based training curricular for professionals, would be a large step towards improving mental health services to our rural populations.

3.5 CONCLUSIONS AND IMPLICATIONS OF RESEARCH FINDINGS

Overall, several conclusions can be drawn from this study on the work practices and training needs of Rural and Urban psychologists. The first is that a group of Rural psychologists (S-T Rural psychologists) have a demographic and training profile that is more similar to Urban psychologists than other Rural psychologists (L-T Rural psychologists). As discussed in Chapters 1 and 3, the two most effective ways of recruiting rural practitioners and assuring their retention is to choose training applicants with rural backgrounds and train those applicants with a curricular focused on rural health and community issues. The results that S-T Rural psychologists were less likely to come from a rural background or train in a rural setting than L-T Rural psychologists differentiated them as a group that is likely to migrate from rural practice to urban practice. The assumption that S-T Rural psychologists have characteristics that may steer them away from rural practice was supported from the evidence that S-T Rural psychologists were significantly more likely to prefer to practice in an urban setting in the next five years in comparison to L-T Rural psychologists. It was discussed in Section 3 that similarly to L-T Rural psychologists, S-T Rural psychologists were likely to have chosen rural practice because of previous experience with a rural community through childhood experience, or spouse’s childhood experience. The five years that S-T Rural psychologists had spent in their current work setting however were not enough to maintain the desire to work in rural practice. It could be argued that L-T Rural psychologists had entered rural practice better prepared than S-T Rural psychologists. L-T Rural psychologist had stronger demographic ties to a rural
community and they were more likely to have undertaken their training in a rural or non-metropolitan area.

Given the lack of emphasis on the community and mental health issues of rural populations in Australian psychology courses, it was expected that Rural psychologists overall would express greater dissatisfaction with their previous training than Urban psychologists. In fact, all psychologists reported that training overall was only somewhat adequate for their work in providing psychological services. This point leads into the second conclusion of the current study, that current models of psychology training could be more adequate for the provision of psychological services in any setting, particularly in practitioner skills. In Chapter 1, the lack of rural content in training curricular was highlighted as the primary reason for the inadequacy of training for rural practice. Rural and Urban psychologists in the current study perceived their training in rural communities and issues as the least adequate aspect of their overall training. The lack of training in rural practice could be addressed by introducing a course component in undergraduate and postgraduate level training that focuses on the features of rural practice. In addition, these courses should be introduced in rural and urban higher education institutions. Rural background students who have migrated to urban areas for better education opportunities may be enticed back to rural settings after graduation if their training has been relevant to rural practice. There should also be more clinical placements in rural settings regardless of the location of the university. Offering comprehensive training in rural practice to students in rural universities may not be sufficient to alleviate the dearth of psychologists in rural settings. Rural and Urban psychologists did express more than adequate satisfaction with their training in research-related skills but gave average ratings to their training in some aspects of the practitioner role in clinical practice such as psychometric testing and counselling.

It was important then to link the common perceptions of training for psychological work among the three sub-groups of psychologists to their work practices. The ratings showing that training was perceived as only somewhat adequate for preparation in providing psychological services could have applied to generic work practices or work practices unique to rural or urban settings. The third conclusion of the current study is that Rural and Urban psychologists showed similar work
practices, with little evidence that Rural psychologists were more likely to be performing as generalists than Urban psychologists. The generalist model of practice was consistently referred to as a rural trait of practice in Chapter 1 (Bergland, 1988; Cheers, 1992; Hood et al., 1993; Hoe, 1982; Jerrel & Herring, 1983; Miller & Zuckerman, 1991; Pulakos & Dengerink, 1983), but Urban psychologists also showed evidence of generalist work practices in the type of clients they served and their allocation of time to various work activities. There was evidence that Rural psychologists were involved in more community and preventive work activities than Urban psychologists from the patterns of responses to questions on relations and interactions with community members and natural helpers. Further research is required to investigate if Rural psychologists in Australia are conducting the type of community and preventive mental health care activities described by Yellowlees (1992) for psychiatrists in rural Australia (see Chapter 1).

The current study also showed that Rural psychologists were pursuing the type of community relations that are advantageous to rural practice. The inclination of Rural psychologists to offer greater support to their communities by collaborating with natural helpers was also apparent in the current study. Considering the large proportion of Rural psychologists who were identified as respondents likely to leave rural practice in the next five years, the training of natural helpers to assist with the delivery of psychological services remains an important issue.

The willingness of Rural psychologists to collaborate with natural helpers and assist with their training is a point that brings the thesis to its final conclusion. Rural psychologists in the current study were showing work practices and community relations that were similar to the models of rural practice endorsed by most of the literature (Cheers, 1992; Heyman & VandenBos, 1989; Hood et al., 1993; Hoe, 1982; Jerrel & Herring, 1983; Keller & Prutsman, 1982; Kelley, Kelley, Gamon, & Rawlings, 1977; Kenkel, 1986; McLennan & Madden, 1997; McLcod, 1993; Miller & Zuckerman, 1991; Pucket & Frederico, 1992; Pulakos & Dengerink, 1983; Silburn et al., 1996; Swan & Raphael, 1995). The main issue therefore remains with the recruitment and training of psychology students for rural practice. 'Specialised' training in rural practice becomes even more important when considering the large proportion of Rural psychologists who had an urban background and spouse with an
urban background (25%). In other words, urban background psychologists are choosing to enter rural practice, and relying solely on the practice of recruiting training applicants with a rural background may not be sufficient to improve mental health services to rural areas for the long-term. Finally, the results that Rural psychologists were collaborating with natural helpers and agreed with the prospect of training them was evidence of an effort to improve their services to rural populations. It remains with the policy makers and governments to support these efforts by implementing the types of training initiatives that will lead to a more equitable distribution of mental health services across rural and urban Australia.
References


Dunn, (1996). Leaving much to the imagination: rural and remote psychology services. In R. Griffiths, P. Dunn, & S. Ramanathan (Eds.), Psychology services in rural and remote Australia (pp. 5-7). Australian Rural Health Institute.


Gething, L. (1997). Sources of double disadvantage for people with disabilities living in remote and rural areas of New South Wales, Australia. Disability and Society, 12, 513-531.


Norris, G. (1993). Where we've been, where we are now, and where we are going. *Mental Health in Australia, 5*, 82-87.


Sims, T. (1992). Rural physicians have chance to make a difference. *Indiana Medicine, 288-291.*


Appendix 1

Opening letter and questionnaire
Dear Colleague,

I am a postgraduate psychology student at Deakin University doing my Masters (by research) degree under the supervision of Professor Boris Crassini. My research is based on a survey of those involved in the provision of psychological services working in urban and rural communities. I want to determine the kind of "psychological work" that typifies their professional practice in urban and rural communities and the general conditions under which this work is carried out. In addition I am interested in the views of urban and rural psychological workers on both their work and their undergraduate and postgraduate training in psychology. I am particularly interested in views about the relevance and usefulness of their training in psychology to psychological work.

This research project has been considered by the Australian Psychological Society (APS) Limited and is taking place under APS auspices. The information derived from the survey will not only form the basis of my thesis, but also will be of use to the APS as it reviews the support and resources it provides for its members both urban and rural. In addition, the APS has contributed the last section of this questionnaire exploring its own role in providing services for psychologists in rural settings.

I am sure you appreciate that the more questionnaires that are completed and returned the more confidently I will be able to interpret the data I collect. I would be grateful for your assistance in my Masters research project by taking a few minutes to complete the attached questionnaire and returning it no later than the 19th April 1995. If for some reason you are unable to complete the entire questionnaire it would be of some help to me if you could at least complete Section One and return the questionnaire in the envelope provided.

I want to stress that responses are anonymous and are unable to be identified. Two samples of participants (one "urban", the other "rural") were chosen at random from the APS Directory of Members on the basis of post codes drawn from addresses given in the Directory. There is nothing on the questionnaire that will enable identification of any respondent. When the survey is completed I will prepare a summary for the APS to distribute to all participants.

My supervisors (Professor Boris Crassini, Mr John Hinchy) and I would be most happy to answer any questions you might have concerning this research project. You can contact us at the phone numbers and addresses set out below.

Ms. Thalia Dimogiannis
Ph: (052) 272926

Professor Boris Crassini
Ph: (052) 271410

Mr. John Hinchy
Ph: (052) 272976

School of Psychology
Deakin University
GEELONG, Victoria. 3217.

Thank you in advance for your highly valued assistance.

Yours sincerely,

Thalia Dimogiannis
Most of the items are of the tick-the-box type and are indicated by a □ symbol.

Where other responses are sought you will find instructions highlighted by being italicised.

Thank you for taking time to complete this questionnaire
SECTION ONE: BACKGROUND/DEMOGRAPHIC INFORMATION

This section of the questionnaire is designed to obtain information about your demographic background.

1.1 Age  □ 20-29 years  □ 30-39 years  □ 40-49 years  □ 50 years and over

1.2 Sex  □ Female  □ Male

1.3 Ethnic background

□ Indigenous Australian  □ Greek
□ Australian  □ Italian
□ Anglo-Saxon  □ Vietnamese
□ Asian (other than Vietnamese)  □ Other (please specify) __________________________
□ Chinese

1.4 Were the majority of your childhood and adolescent years spent in a rural community or an urban community?

□ In a rural community
□ In an urban community
□ Both equally

1.5 Were the majority of your spouse’s/defacto’s childhood and adolescent years spent in a rural community or an urban community?

□ In a rural community
□ In an urban community
□ Both equally
□ Not applicable

1.6 What is your current employment status in providing psychological services? (Please answer both parts)

(a) (tick one)  (b) (tick one)
□ Full time  □ Casual
□ Part time  □ Permanent

1.7 Who is your main employer(s)? (tick boxes as appropriate)

□ Federal Government
□ State Government
□ Local Government
□ Organisation/firm in the private sector (excluding private practice)
□ Private practice
□ Other (please specify) __________________________

1.8 Please indicate your current, approximate gross annual income.

□ $9,999 and below  □ $50,000 to $59,999
□ $10,000 to $19,999  □ $60,000 to $69,999
□ $20,000 to $29,999  □ $70,000 to $79,999
□ $30,000 to $39,999  □ $80,000 and over
□ $40,000 to $49,999
1.9 **Currently** is your main place of work in providing psychological services situated in a rural, rural/remote or urban community?

- Rural
- Rural/remote
- Urban

What is the population of this community?

- Less than 100
- 100 - 999
- 1,000 - 49,999
- 50,000 or above

1.10 **Five years ago** was your main place of work in providing psychological services situated in a rural, rural/remote or urban community?

- Rural
- Rural/remote
- Urban

1.11 Referring to your main source of employment how many years have you spent in your present place of work? ________________ years

1.12 In selecting your present place of work, did you have a choice between a rural and an urban community?

- Yes
- No → go to 1.14

1.13 Was the rural, rural/remote or urban setting of your current workplace a major factor in taking up your current position?

- Yes
- No

1.14 Overall, in what kind of community would you prefer to work, over the next five years?

- Rural
- Rural/remote
- Urban
- No preference

**SECTION TWO: TRAINING EXPERIENCE**

This section of the questionnaire is designed to obtain your views about your psychological training. Part 1 attempts to map out your training history, any training that you are currently undertaking, and any other use that you might have made of universities. Part 2 asks about your perceptions of the adequacy of various components of your psychological training in preparing you for professional practice.

**PART 1: TRAINING HISTORY AND CURRENT STUDY**

2.1 Please provide a summary of your undergraduate qualifications (years 1-3) and training using the headings set out below.

<table>
<thead>
<tr>
<th>Degree/Diploma</th>
<th>Institution (please specify campus)</th>
<th>Study load (tick one)</th>
<th>Year completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Full time</td>
<td>Part time</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.2 Please indicate any Honours/Fourth year qualifications you have gained using the headings set out below.

<table>
<thead>
<tr>
<th>Degree/Diploma</th>
<th>Institution (please specify campus)</th>
<th>Study load (tick one)</th>
<th>Year completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Full time</td>
<td>Part time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

2.3 Please indicate any Postgraduate qualifications you have gained using the headings set out below.

<table>
<thead>
<tr>
<th>Degree/Diploma</th>
<th>Institution (please specify campus)</th>
<th>Study load (tick one)</th>
<th>Year completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Full time</td>
<td>Part time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

2.4(a) Are you currently enrolled in any University course relevant to psychology (e.g., coursework masters etc.)?

- □ No (please indicate reason(s) then go to 2.5)
- □ No need
- □ Too hard to organise with work commitments
- □ Other (specify)

2.4(b) What is your "mode" of study?

- □ Off-campus (your work is delivered to you via the post or e-mail and your attendance at the University is minimal if required at all)
- □ On-campus (conventional mode of study involving attendance at lectures and/or tutorials)

2.5(a) Are you currently enrolled in a University in an area other than psychology (e.g. Diploma in Computing, Masters in Business Administration)?

- □ No (please indicate reason(s) then go to 2.6)
- □ No need
- □ Areas of interest not offered
- □ Too hard to organise with work commitments
- □ Other (specify)

- □ Yes (specify course/institution including campus)

Do not put your name on this questionnaire
2.6 During the past 12 months have you completed any workshops or attended any conferences/seminars that you consider relevant to your work in the provision of psychological services?

- No (please indicate reasons then go to 2.7)
  - No need
  - Areas of interest not offered
  - Too hard to organise with work commitments
  - Other (specify)

- Yes (please specify the names of the workshops/conferences/seminars and whether they took place in a rural or urban community)

<table>
<thead>
<tr>
<th>Workshops/conferences/seminars</th>
<th>Location (tick one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
</tr>
</tbody>
</table>

2.7 Over the last year have you used a University to obtain information relevant to your work in providing psychological services (e.g. books on psychological disorders, journal articles)?

- No (please indicate reason(s) then go to 2.8)
  - No need
  - Areas of interest not offered
  - Too hard to organise with work commitments
  - Other (specify)

- Yes (please specify how many times)
  - 1-2 times
  - 3-6 times
  - 7-11 times
  - 12 or more times

**PART II: VIEWS ON THE ADEQUACY OF TRAINING**

2.8 Overall, how adequate was your undergraduate training in psychology in preparing you for your work in providing psychological services?

<table>
<thead>
<tr>
<th>not at all adequate</th>
<th>somewhat adequate</th>
<th>completely adequate</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
SECTION TWO: TRAINING EXPERIENCE

(Complete item 2.9 only if you are working in an urban community)

2.9 Overall, how adequate was your training in covering urban community issues and problems as they relate to your work in providing psychological services?

<table>
<thead>
<tr>
<th>not at all</th>
<th>somewhat</th>
<th>completely</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Complete item 2.10 only if you are working in a rural or a rural/remote community)

2.10 Overall, how adequate was your training in covering rural community issues and problems as they relate to your work in providing psychological services?

<table>
<thead>
<tr>
<th>not at all</th>
<th>somewhat</th>
<th>completely</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.11 Many undergraduate psychology courses include training in research report writing (APA format). If you received training in research report writing, how useful has it been to your work in the provision of psychological services?

<table>
<thead>
<tr>
<th>not useful</th>
<th>somewhat useful</th>
<th>very useful</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.12 At any stage during your training in psychology did you complete any "placements" of more than 20 hours duration in an applied setting?

☐ No  (go to 2.13)

☐ Yes  (Please outline the location(s) of the placement(s) (i.e., "In the personnel section of an organization"), the nature of the work you carried out, its duration, and whether the placement(s) occurred in a rural or urban community.)

<table>
<thead>
<tr>
<th>Location of the placement</th>
<th>Nature of the work carried out</th>
<th>Duration (weeks)</th>
<th>Location (tick one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.13 If you received undergraduate training in statistical techniques, how useful has it been to your work in the provision of psychological services?

<table>
<thead>
<tr>
<th>not useful</th>
<th>somewhat useful</th>
<th>very useful</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.14 Many undergraduate psychology courses include training in a range of research methodologies (e.g., experimental and survey methodologies, etc.). If you received undergraduate training in research methodologies, how useful has it been to your work in providing psychological services?

<table>
<thead>
<tr>
<th>not useful</th>
<th>somewhat useful</th>
<th>very useful</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do not put your name on this questionnaire
2.15 Reflecting on the undergraduate three year and fourth year sequence of study of psychology that you received, how adequate was your preparation for:

(a) interviewing clients and obtaining their histories.

<table>
<thead>
<tr>
<th>not at all adequate</th>
<th>somewhat adequate</th>
<th>completely adequate</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

(b) testing clients using standardised tests of intelligence, personality, etc.

<table>
<thead>
<tr>
<th>not at all adequate</th>
<th>somewhat adequate</th>
<th>completely adequate</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

(c) interpreting test results.

<table>
<thead>
<tr>
<th>not at all adequate</th>
<th>somewhat adequate</th>
<th>completely adequate</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

2.16 Please indicate how useful your overall (undergraduate, fourth year and post-graduate) training in the following areas of psychology has been to your work in providing psychological services?

<table>
<thead>
<tr>
<th>Area</th>
<th>not useful</th>
<th>somewhat useful</th>
<th>very useful</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social psychology</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Personality</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cognitive psychology</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Physiological psychology</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Developmental psychology</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Perception</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Statistical techniques</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Research methodology</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

2.17 Reflecting on all of your psychological training, which three or four of your units/courses have been most useful to your work in the provision of psychological services?

<table>
<thead>
<tr>
<th>Unit/course</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

2.18 Thinking about all the ways in which you have learnt psychological skills, either formally or informally, please describe the two or three ways that have been most useful to your work in providing psychological services?

<table>
<thead>
<tr>
<th>Experiences</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
SECTION THREE: WORK EXPERIENCE

This section of the questionnaire is designed to obtain information about the nature of the psychological work that you perform and a broad profile of the clients with whom you work.

3.1 Reflecting on the past fortnight of your work in providing psychological services, what percentage of time did you spend in the following activities: (percentages should sum to 100%)

<table>
<thead>
<tr>
<th>%</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interviewing, assessment/diagnosis testing of clients</td>
</tr>
<tr>
<td></td>
<td>Counselling, psychotherapy with clients</td>
</tr>
<tr>
<td></td>
<td>Administration related to clients (e.g., updating clients’ files)</td>
</tr>
<tr>
<td></td>
<td>Administration not related to clients</td>
</tr>
<tr>
<td></td>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>

3.2 Over the past 12 months have you presented any case studies or made presentations at conferences based on your experiences in practice?

☐ No
☐ Yes → How many case studies/presentations? _________________________

3.3 Over the past 12 months have you published any case studies or the results of any other work in a professional, refereed journal based on your experiences in practice?

☐ No
☐ Yes → How many publications? __________________________
3.4 Reflecting on the past fortnight of your work that involved working with clients, what percentage of this work can be allocated to each of the particular areas listed below?

Percentages should sum to 100%. The list of areas is not meant to be exhaustive, and you may add relevant areas that have been omitted.

<table>
<thead>
<tr>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorders</td>
<td>Post trauma stress</td>
<td>Intellectual disability</td>
</tr>
<tr>
<td>Depression</td>
<td>Marital relationships</td>
<td>Physical disabilities</td>
</tr>
<tr>
<td>Self-esteem/identity</td>
<td>Sexual problems</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Homosexuality issues</td>
<td>Pain management</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Vocational</td>
<td>Weight control</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Unemployment</td>
<td>Community</td>
</tr>
<tr>
<td>Gambling</td>
<td>Educational/Learning</td>
<td>Sport</td>
</tr>
<tr>
<td>Eating disorders.</td>
<td>Loss/Bereavement</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Stress management</td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify)

3.5 During the past fortnight what proportion of your clients have you referred to other professionals/agencies?

- none
- half
- all or nearly all
- not applicable

3.6 Reflecting on your work involving therapy with clients, please indicate the degree of emphasis you place on the following approaches or orientations with percentage representing relative emphasis.

Percentages should sum to 100%. The list of approaches/orientations is not meant to be exhaustive, and you may add relevant approaches/orientations that have been omitted.

<table>
<thead>
<tr>
<th>%</th>
<th>Approaches/orientations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Behavioural/Cognitive Behavioural</td>
</tr>
<tr>
<td></td>
<td>Humanistic/Existential</td>
</tr>
<tr>
<td></td>
<td>Psychodynamic/Psychoanalytic</td>
</tr>
<tr>
<td></td>
<td>Eclectic</td>
</tr>
<tr>
<td></td>
<td>Other (please specify below)</td>
</tr>
</tbody>
</table>

3.7 How often do you encounter your clients in settings away from your place of work (e.g., at the supermarket; at the squash/tennis courts, etc.)?

- never
- occasionally
- very often

3.8 Are there emergency or other services to whom you can refer your clients when you are unavailable (e.g., evenings, weekends)?

- Yes
- No
3.9 Are you available 24 hours a day to other service providers (e.g., police, emergencies services) for the provision of psychological services?

☐ Never
☐ Occasionally
☐ Frequently
☐ All the time

3.10 How easy is it for you to consult colleagues for advice about your work in providing psychological services (e.g., seeking advice about dealing with a psychological problem with which you are unfamiliar)?

<table>
<thead>
<tr>
<th>not at all easy</th>
<th>somewhat easy</th>
<th>very easy</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If you answered 'Not at all easy' please indicate any reasons for your response.

__________________________________________________________________

3.11 Reflecting on the past fortnight of your work as a psychologist, what percentage of your clients fell within the age ranges set out below? (Your responses should sum to 100%)?

<table>
<thead>
<tr>
<th>%</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 9 years</td>
</tr>
<tr>
<td></td>
<td>10-19 years</td>
</tr>
<tr>
<td></td>
<td>20-29 years</td>
</tr>
<tr>
<td></td>
<td>30-39 years</td>
</tr>
<tr>
<td></td>
<td>40-49 years</td>
</tr>
<tr>
<td></td>
<td>50-64 years</td>
</tr>
<tr>
<td></td>
<td>65 years and over</td>
</tr>
<tr>
<td></td>
<td>Not sure of age</td>
</tr>
</tbody>
</table>

3.12 Reflecting on the past fortnight of your work in the provision of psychological services, what percentage of your clients fell within the following ethnic groups? (Your responses should sum to 100%)

<table>
<thead>
<tr>
<th>%</th>
<th>Ethnic group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indigenous Australian</td>
</tr>
<tr>
<td></td>
<td>Australian</td>
</tr>
<tr>
<td></td>
<td>Anglo-Saxon</td>
</tr>
<tr>
<td></td>
<td>Asian (other than Vietnamese)</td>
</tr>
<tr>
<td></td>
<td>Chinese</td>
</tr>
<tr>
<td></td>
<td>Greek</td>
</tr>
<tr>
<td></td>
<td>Vietnamese</td>
</tr>
<tr>
<td></td>
<td>Italian</td>
</tr>
<tr>
<td></td>
<td>Not sure</td>
</tr>
<tr>
<td></td>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>
3.13 Reflecting on the past fortnight of your work as a psychologist, what percentage of your clients fell within the educational-background groups set out below? (Your responses should sum to 100%)

<table>
<thead>
<tr>
<th>%</th>
<th>Educational background</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary education (year 1 to year 6)</td>
</tr>
<tr>
<td></td>
<td>Secondary (year 7 to year 12)</td>
</tr>
<tr>
<td></td>
<td>Post-secondary trade education</td>
</tr>
<tr>
<td></td>
<td>Tertiary education</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
</tbody>
</table>

SECTION FOUR: RELATIONS WITH COMMUNITY

This section of the questionnaire is designed to obtain information on characteristics of the community in which you are currently working as well as your professional relationship with that community.

The last five items of this section ask about natural helpers in your community. Natural helpers are members of a community who are recognised and sought out by other members of the community for help on personal or psychological matters (e.g., advice on marital problems). They may play a large role in the relationship between the local psychologist and the community. Natural helpers may have gained their reputation within the community as ideal persons to turn to in time of need because of their profession (e.g., local priest), or by personal traits such as helpfulness or altruism. Natural helpers need not exist in all communities, however they are usually more common in small communities.

4.1 How positively or negatively do you think your community rates the act of seeking professional help from a psychologist?

<table>
<thead>
<tr>
<th>very negatively</th>
<th>neutral</th>
<th>very positively</th>
<th>unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td>☒</td>
<td>☐</td>
</tr>
</tbody>
</table>

4.2 How important is the support of prominent community members (e.g., local politicians, clergy) to the acceptance of your work providing psychological services by the community?

<table>
<thead>
<tr>
<th>not at all</th>
<th>somewhat</th>
<th>very important</th>
<th>important</th>
<th>unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

4.3 Overall would you say prominent community members provide you with support or opposition in respect of your work providing psychological services?

<table>
<thead>
<tr>
<th>lots of opposition</th>
<th>neutral</th>
<th>lots of support</th>
<th>unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
</tr>
</tbody>
</table>

4.4 How difficult is it for you to maintain client confidentiality given the size of your community?

<table>
<thead>
<tr>
<th>not at all difficult</th>
<th>somewhat difficult</th>
<th>very difficult</th>
<th>unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
</tr>
</tbody>
</table>

4.5 How much knowledge do members of your local community have about psychological problems/disorders?

<table>
<thead>
<tr>
<th>no knowledge</th>
<th>some knowledge</th>
<th>lots of knowledge</th>
<th>unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
</tr>
</tbody>
</table>
4.6 In which of the following ways does your local community learn about psychological problems/disorders?

- Television
- Radio
- Newspapers
- Books
- School
- University/Colleges
- Cinema
- Public education programs
- Other community members
- General Practitioner
- Yourself
- Don’t know
- Other (please specify) __________________________

4.7 Overall would you say the natural helpers of your community provide support or opposition in respect of your work providing psychological services?

<table>
<thead>
<tr>
<th>lots of opposition</th>
<th>neither</th>
<th>lots of support</th>
<th>not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>□..................□</td>
<td>□..................□</td>
<td>□..................□</td>
<td></td>
</tr>
</tbody>
</table>

4.8 Do the natural helpers of your community refer individuals to you for counselling?

- never
- occasionally
- all the time
- not applicable

4.9 Do you seek advice concerning clients from the natural helpers of your community?

- never
- occasionally
- all the time
- not applicable

4.10 Should natural helpers be trained to assist psychologists with work functions such as counselling and emergency services?

- Yes
- No
- Unsure

4.11 Who should train natural helpers to assist psychologists with work functions? (tick boxes as appropriate)

- Psychologists in the community
- Professional trainers (e.g. universities)
- Other (please specify) __________________________

Do not put your name on this questionnaire.
SECTION 5: A.P.S. ITEMS: RURAL AND REMOTE ISSUES

The APS is very keen to improve its services to psychologists living and working in rural and remote areas. The following items have been included by the APS to assist the Society in this endeavour.

5.1 What specific professional development activities would you like to see provided for psychologists working in rural and remote communities

5.2 If 5th and 6th year distance education courses were mounted for psychologists working in rural and remote communities, how likely is it that you would enrol in such a course?

very likely not very likely not applicable
☐ .......................... ☐ .......................... ☐ .......................... ☐

5.3 Are there any other ways in which APS could better serve the needs of psychologists working in rural and remote communities?

5.4 Are you a member of an APS regional unit?

☐ Yes (please specify) ____________________________
☐ No

5.5 How many kilometres is your place of employment from the closest APS regional unit? ____________________________ km

5.6 Would you be willing to have the information from items 5.1 through 5.5 entered into a confidential rural and remote psychologists data base for use by the A.P.S.?

☐ Yes
☐ No
☐ Undecided
Thank you for taking time to answer this questionnaire. To help us ensure that we have addressed all the relevant issues we would appreciate any comments about urban/rural issues relating to training or practice. We would also appreciate any comments about the questionnaire.

Thank you again for your time in completing this questionnaire.

Do not put your name on this questionnaire.
Appendix 2

Raw data

(available on request)