

Rural and remote psychological service delivery:
Perceptions of rural psychologists, general practitioners,
and community members

Carly Rose Sutherland
School of Psychology
The University of Adelaide

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Abstract

This thesis explores psychological service delivery from the perspectives of three key stakeholders: fly-in, fly-out (FIFO) and drive-in, drive-out (DIDO) rural and remote psychologists; rural and remote General Practitioners (GPs); and rural and urban community members. The thesis builds on previous research with resident rural psychologists in exploring what is required of rural psychologists and psychological services in the context of unique challenges, including a lack of access to psychologists, ethical challenges, and poorer health and mental health outcomes for rural communities.

This thesis is comprised of three studies. Study 1 is a qualitative exploration of the experiences of FIFO/DIDO rural and remote psychologists. Study 2 is a qualitative exploration of the experiences of rural and remote GPs. These studies employed purposive sampling and a semi-structured interview format, and were subject to thematic analysis. Study 3 is a quantitative survey comparing rural and urban community members' understandings and perceptions of psychologists and psychology services.

The findings are presented in the form of four papers. FIFO/DIDO psychologists, as described in Paper 1, face similar challenges to resident rural psychologists, but also face additional unique personal and professional challenges due to working away from home, including caring for dependents, managing fatigue, greater intensity of work, and logistical challenges. While FIFO/DIDO work arrangements are contentious, there may be personal and professional advantages for psychologists, including financial and time compensation, greater support and fewer ethical dilemmas compared to resident rural psychologists. Support required to provided FIFO/DIDO services may include an appropriate induction into the community, the availability of local support, and appropriate compensation for lifestyle impacts.

GPs were the focus of Papers 2 and 3. Participants highlighted how rural psychologists may be a source of support for rural GPs and vice versa. While rural GPs tend to hold positive views about psychologists, they report challenges in communicating with psychologists, and gaps in their knowledge of psychologists' training and expertise. Given the knowledge gaps identified, Paper 3 is written for a GP professional audience and outlines '6 top tips' about working with psychologists.

Paper 4 reports on the results of Study 3, the quantitative survey. Rural participants were significantly less likely than urban participants to have seen a psychologist, more likely to perceive seeing a psychologist as helpful, more likely to endorse travel as a barrier to seeing a psychologist, scored significantly lower on a multiple-choice test of knowledge about psychologists, and were less aware of Medicare rebates for psychological services, highlighting a gap between rural and urban Australians regarding knowledge and understanding of psychologists.

This thesis demonstrates a need for greater awareness and initiatives to improve understanding of psychologists amongst rural GPs and rural communities, and highlights opportunities of alternative service delivery models (such as FIFO/DIDO) in addressing recruitment and retention problems in the rural psychology workforce. The findings of this thesis have implications in terms of models of rural psychological service delivery, professional development and education for rural psychologists and GPs, mental health and Medicare policy in rural areas, recruitment and retention, and primary care psychology.

Statement of originality of the work

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

In addition, I certify that no part of this work will, in the future, be used in a submission for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

I give consent to this copy of my thesis when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968. The author acknowledges that copyright of published works contained within this thesis resides with the copyright holder(s) of those works. I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library catalogue and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

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Date

List of publications arising from this thesis

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Sutherland C.R., Chur-Hansen, A., & Winefield, H. (2014, July). *Knowledge, Skills and Attitudes (KSAs) of rural and remote fly-in, fly-out (FIFO) and drive-in, drive-out (DIDO) psychologists*. Presentation at the International Congress of Applied Psychology, Paris, France.

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List of poster presentations based on this thesis

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Chapter 1 – Introduction

1.1 Thesis overview

This thesis focuses on rural psychological service delivery from the perspectives of psychologists, general practitioners, and community members. The thesis builds on research completed for the author's Honours thesis¹, which was an exploration of the knowledge, skills and attitudes (KSAs) of resident rural and remote South Australian psychologists (Sutherland, 2012). The published paper resulting from this thesis (Sutherland & Chur-Hansen, 2014) is included in Appendix A. The studies presented in this thesis are attempts to triangulate the findings of the previous study from the perspectives of other key stakeholders, and to expand this exploration of individual practitioners' competencies (KSAs) to a broader perspective of what is required for successful rural psychological service delivery. The research firstly set out to explore the experiences of psychologists based in metropolitan Adelaide providing services to rural and remote South Australian communities (fly-in, fly-out (FIFO), and drive-in, drive-out (DIDO) psychologists). The second and third studies explore the perspectives of rural general practitioners, and rural and urban community members.

This thesis is undertaken in publication format (a portfolio of papers published and/or submitted for publication and written in publication style). There is a total of four papers in this thesis, with one paper reporting results from the first qualitative study with FIFO/DIDO rural and remote psychologists, two papers reporting on the second qualitative study (interviews with GPs), and one paper reporting results from the quantitative survey of rural and urban community members. Each paper forms a chapter

¹ A minimum six-year sequence of training and education in psychology is required for eligibility for general registration as a psychologist in Australia, involving a three-year accredited undergraduate sequence, accredited fourth year studies, and completion of an internship or masters or doctorate degree. Accredited fourth year studies include a Postgraduate Diploma or Honours degree. The Honours degree, referred to here, requires completion of a research project (Honours thesis).

of the thesis. This introductory chapter contextualises the research topic and outlines the research questions and methods. The concluding chapter synthesises and discusses the main findings of this thesis.

1.2 Terminology

Some key terms used in this thesis are clarified at the outset.

Rural and remote

Throughout this thesis, rurality and remoteness are defined using the Australian Standard Geographical Classification (ASGC, Australian Bureau of Statistics [ABS], 2011). The ASGC determines five categories of remoteness: Major cities, Inner Regional, Outer Regional, Remote and Very Remote (ABS, 2011). The terms ‘rural and remote’ or ‘rural’ used throughout this thesis therefore refer to those living outside the ASGC classification of Major Cities. Further background and conceptual issues in defining rurality will be explored in Section 1.3.2.

Fly-in, fly-out (FIFO) and drive-in, drive out (DIDO)

The terms FIFO and DIDO will be used to describe psychologists based in metropolitan areas who provide visiting services to rural and remote communities. Overlapping terms such as “hub and spoke”, “visiting” and “outreach” service provision have been used to refer to this field (Hanley, 2012). Further background regarding the use of these terms will be explored in Section 1.3.9.

1.3 Background

1.3.1 Psychology in rural and remote Australia

Almost one-third (32%) of the Australian population resides in rural and remote areas, however only approximately 25% of Australian psychologists practice outside of

Major Cities (Australian Institute of Health and Welfare [AIHW], 2016b). Psychology in Australia has therefore been described as “urban-centric”, as there are also limited opportunities for psychology training and research outside of major cities (Roufeil & Lipzker, 2007). In South Australia (the location of the studies reported in this thesis), this figure is even lower, with only 11.5% of psychologists practising outside of Major Cities (Adelaide) (AIHW, 2014).

Since the ‘Millennium’ drought faced by rural Australia from the mid-90s to the official end declared in 2012, greater attention has been given to the impact of such events on the wellbeing of rural and remote Australians (Roufeil & Lipzker, 2007), with psychology as a profession increasingly paying attention to rural Australians’ mental health. In 2010, the Australian Psychological Society (APS) convened a Regional, Rural and Remote Advisory Group, reporting directly to the APS board, to ensure the prioritisation of issues relating to rural communities (Vines & Drent, 2010). In October 2011, an edition of the APS magazine, ‘InPsych’ was dedicated to issues in rural and remote psychology, and in 2014 the Australian Journal of Rural Health published a special edition focusing on rural and remote psychology, entitled ‘Psychology in the Bush’. The author of this thesis contributed to this edition (see Appendix A).

Limited published data exist regarding the number of psychologists working in rural Australia (Mathews, Stokes, Crea, & Grenyer, 2010). The 2010 Australian Psychology Workforce Survey (with a response rate of 48%, $N = 11,897$) indicated that approximately 5,300 fully registered psychologists worked in regional, rural, and remote Australia, comprising 21.5% of the psychology workforce, with 14% of psychologists working in rural areas, 6.6% in regional, and 0.8% in remote areas (Mathews, 2011). For this thesis, more recent data were obtained from the Health Workforce Australia 2014 dataset. This indicated that three-quarters of psychologists

are employed in Major Cities in 2014, the equivalent of 92 full-time equivalent psychologists per 100,000 population, and only 55 FTE in Inner regional, 41 in Outer regional, and 30 in Remote and Very Remote Areas (AIHW, 2016b). The AIHW is yet to publish rurality distribution statistics by state, however provides access to the psychology workforce dataset. Analysis of this dataset reveals approximately 11.5 % of psychologists in South Australia work rurally (AIHW, 2014), far below the Australian average of around 25%.

1.3.2 Defining rurality

While several classification systems have been developed for defining rurality in Australia, each approach has limitations, and there is no consensus on a standard definition of either rural or remote (Couper, 2003; Kulig et al., 2008). Major classification systems include the Rural Remote and Metropolitan Area (RRMA) classification, the Accessibility/Remoteness Index of Australia (ARIA), and the Australian Standard Geographical Classification (ASGC) (AIHW, 2004). The RRMA uses population size and direct distance from the nearest service centre to determine seven categories: Capital Cities, Other Metropolitan, Large Rural and Small Rural centres, Other Rural areas, Remote centres and Other Remote areas. The ARIA, since superseded in two reviews (ARIA + and ARIA ++) defines road distance to service centres with an index, values of which are allocated to one of five categories: Highly Accessible, Accessible, Moderately Accessible, Remote, and Very Remote (AIHW, 2004). The ASGC determines five categories of remoteness on the basis of the average ARIA score within a given Census district: Major Cities, Inner Regional, Outer Regional, Remote and Very Remote (Australian Bureau of Statistics [ABS], 2011).

The Australian Statistical Geography Standard (ASGS) (ABS, 2014) is similar to the ASGC in its use of the same remoteness categories (Major Cities, Inner Regional,

Outer Regional, Remote and Very Remote) however represents an update of the ASGC as it was based on 2011 Census population data (with the ASGC based on the 2006 Census data). During 2012 the ASGC and ASGS were both in official use, with the Australian Bureau of Statistics aiming to have the majority of their spatial data based on the ASGS by 2014 (ABS, 2014).

The RRMA does not take into account relative level of accessibility/remoteness, with capital cities defined as such regardless of population size and isolation (AIHW, 2004). Advantages of the ARIA include greater flexibility and precision compared to the RRMA (Vines, 2008); however the ARIA and the ASGC are limited by the assumption that persons living in rural areas have the same access to road transport and comparable road quality, and therefore dissimilar areas may be given the same classification. All systems are limited by population and accessibility changes leaving definitions less precise over time.

Defining rurality for the studies presented in this thesis was therefore challenging, given the multitude of classification systems being developed and refined during the period from 2011-2014. The ASGC was chosen as the classification used in this thesis, as the most widely available and understood system at the time, given the ASGS had only been recently introduced. Since the development and data collection phase of this thesis was conducted, another classification system, the Modified Monash Model (Australian Government Department of Health, 2016b) has been developed and recently employed by the Department of Health in its health workforce programs. The Modified Monash Model uses the ASGS as a base, however further differentiates areas in Inner and Outer Regional Australia based on local town size, to create seven instead of five categories. The model was announced in October 2014, and first applied to

health workforce programs (specifically recruitment and retention programs for rural doctors) in 2015.

1.3.3 Rural-urban disparities in physical and mental health outcomes

The disparities in health outcomes between rural and urban Australians are well documented (AIHW, 2010). Mortality rates increase with remoteness, and people living outside major cities are more likely to have chronic health conditions, be overweight or obese, and be admitted to hospital for potentially preventable conditions (AIHW, 2010; AIHW, 2012). Health risk factors, including smoking, high risk alcohol consumption, sedentary levels of physical activity, and poor diet are more prevalent in rural and remote communities (AIHW, 2010). In remote Australia, death rates from a range of diseases are significantly higher, with three times the number of deaths from diabetes, 40% more deaths from coronary heart disease, and 40% more deaths from lung cancer (NRHA, 2016).

In terms of disparities in mental health outcomes in rural and remote Australia, despite a similar prevalence in mental health conditions (Eckert, Taylor, Wilkinson, & Tucker, 2004; Judd et al., 2002), the suicide rate in rural communities is considerably higher, particularly for men (AIHW, 2010). In remote areas there are twice the number of deaths by suicide compared to major cities (NRHA, 2016). Personal vulnerability may be increased by isolation, unrecognised or untreated depression, and drug and alcohol use (NRHA, 2009b). Rural suicide risk factors include sociocultural, economic, and service-related factors, including vulnerability to economic and climate change (such as drought and the associated impacts on the social structure of farming communities), de-population and the withdrawal or merging of essential services (such as the closure of schools, banks and hospitals), which can affect the social fabric of

rural communities, and the availability of higher lethality means such as firearms (NRHA, 2009b).

Barriers to accessing help may also mean the burden of mental illness is higher in rural communities (NRHA, 2009a). Many barriers have been identified to rural help seeking and service utilisation, including stigma, lack of services, self-reliance, lack of awareness and misconceptions regarding mental illness and mental health services, and the ability of overburdened rural GPs to detect mental health problems (Collins, Winefield, Ward, & Turnbull, 2009). Rural mental health services are often underfunded, limiting opportunities to detect and treat mental health problems, and when accessing services involves travel, rural Australians may be more likely to postpone seeking help (NRHA, 2009b).

Indigenous Australians experiences higher rates of serious mental health problems (in metropolitan and in rural and remote areas), and comprise a considerably larger part of rural and remote communities (Hunter, 2007). Rates of suicide are up to six times higher for young Indigenous men and women in remote areas compared to other Australians (NRHA, 2009b). The effects of colonisation and government policies such as the forced separation of children from their families have resulted in enduring patterns of disadvantage that continue to impact upon Indigenous Australians (Griffiths, Coleman, Lee, & Madden, 2016; Halloran, 2007). Rates of high or very high levels of psychological distress among Indigenous adults are nearly 3 times that of non-Indigenous adults, and rates of intentional self-harm among young Indigenous people are 5.2 times that of non-Indigenous young people (Dudgeon et al., 2014).

Rural people may also be affected by the unique and unpredictable nature of rural stressors, including weather events, long hours, a lack of leisure time, and higher levels of unemployment, poverty, and financial stressors (Barbopoulos & Clark, 2003;

Roufeil & Lipzker, 2007; Vines, 2011). Rural Australians are more likely to experience the effects of severe weather events, and “live with the threat of natural disasters on a more or less continuous basis” (Morrissey & Reser, 2007, p. 120), with this burden and the associated anxiety and impact on wellbeing likely to increase in the context of climate change. Rural Australians may also face these challenges in the context of media criticism and a lack of understanding from non-rural people (Roufeil & Lipzker, 2007).

Rural communities face health and wellbeing disparities with far less access to psychological services than their urban counterparts (Mathews et al., 2010; Roufeil & Lipzker, 2007). The lack of psychological services may contribute to low rates of help-seeking and increased stigma in rural areas, as lack of exposure to services may result in a lack of understanding of the services psychologists can provide (Roufeil & Lipzker, 2007).

1.3.4 Professional and personal challenges for rural psychologists

In addition to challenges faced by rural communities, there are also numerous professional and personal challenges for rural psychologists. The low population density, distance from urban centres, and lack of access to resources mean that psychologists working in rural areas face unique ethical challenges (APS, 2010). As Malone (2011) highlights, “although the underlying ethical issues may be similar between rural and urban settings they may well manifest in different ways in rural and remote communities” (p.291). Oxnam and Griffiths (2005) note that although the ethical challenges faced by rural and remote psychologists may also arise in urban settings, the difference is the constancy of these experiences in rural psychological practice. In recognition of the ethical challenges associated with working in rural areas, the Australian Psychological Society has published guidelines for ethical practice in

rural and remote settings which address dimensions of difference between rural and urban practice, and which have been recently revised (APS, 2016a).

Ethical challenges for psychologists practising in rural and remote areas include professional isolation, which has implications for access to supervision, self-care and professional development. Rural psychologists may have fewer opportunities to consult with peers than urban psychologists (Werth, Hastings, & Riding-Malon, 2010), however the increasing use of technology (such as videoconferencing supervision) has contributed to reducing isolation (Gibson, Miller, & King, 2007). In addition to having fewer opportunities to consult with other psychologists on complex cases, professional isolation may mean reduced opportunities to engage in collaborative work with other psychologists or to conduct research (Malone & Dyck, 2011).

Tensions between acknowledging limits to professional competence and the lack of other services available create ethical challenges for rural psychologists. The ethical guidelines acknowledge the need for psychologists in rural and remote areas, while being conscious of limits to their capacity, to consider the implications of providing a service themselves, or making an appropriate referral which may cause a delay in a client receiving a service (APS, 2016a). This may be a particular issue for early career psychologists, who may experience pressure to provide a service knowing they may be the only option available for their clients (Roufeil & Lipzker, 2007). Malone and Dyck (2011) highlight the need for rural psychologists to possess self-awareness about their competence, and to discuss this with clients and health care providers. The need for rural psychologists to work as ‘generalist-specialists’ (Roufeil & Lipzker, 2007; Sutherland & Chur-Hansen, 2014) in meeting the needs of their communities has been well documented. Knowing how far one can “stretch” one’s

expertise is an ongoing challenge for rural psychologists (Helbok, Marinelli, & Walls, 2006).

Managing boundaries and multiple relationships is acknowledged as one of the most challenging aspects of practising as a rural or remote psychologist. The Australian Psychological Society ethical guidelines acknowledge that multiple relationships “are often unavoidable in rural and remote communities” (APS, 2016a, p. 166). Multiple relationships can include both social and business relationships (e.g. when a certain service in a rural community is only provided by a client or former client), and can also refer to situations in which rural psychologists’ family members have connections with clients (e.g. children attending the same school), or working with clients who are related in some way (e.g. clients who are from the same family or friendship group) (Schank & Skovholt, 1997). The APS ethical guidelines (2016a) highlight the need for rural and remote psychologists to determine whether the potential risks associated with a person receiving no service are greater than the potential risks of providing a service to a person the psychologist is connected to in some way.

The risks of burnout and occupational stress for rural psychologists are acknowledged. Managing boundaries can create personal stress for rural psychologists and their families, as their social opportunities (such as becoming involved in community organisations or clubs) may be limited by the need to avoid multiple relationships (Helbok et al., 2006). Ironically, avoiding multiple relationships (such as not joining a social or sporting club) can also limit self-care opportunities, which can also lead to burnout. A survey of rural psychologists and counsellors in Australia found that burnout was a significant issue for nearly half of respondents (Pelling & Butler, 2015).

Managing confidentiality is acknowledged to be a challenge for rural psychologists. The ethical guidelines discuss the need for psychologists in rural areas to be mindful of “inadvertent disclosures” (APS, 2016a, p. 167) of clients’ information due to the possibility of hearing information from others in the community, and highlight the need for psychologists to discuss ways of handling encounters outside of the psychological consultation in advance. As Oxnam and Griffiths (2005) highlight, managing confidentiality does not only mean managing verbal disclosure of a client’s information, but “protecting the knowledge that the client had sought services from the psychologist” (p. 7), and may therefore need to include consideration of context in which psychologists see clients (for example, the location of the psychologist’s practice being obvious or integrated with other health services).

Managing visibility (the lack of anonymity and separation of work and personal lives) is another ethical challenge for rural and remote psychologists. As Helbok et al. (2006) explain, in rural communities clients may be familiar with psychologists and their families from living in the same community, and may therefore possess information about the psychologist before attending the first appointment. As such, in addition to professional isolation, rural psychologists may experience social isolation, particularly given ethical concerns with socialising with members of the community in protecting their privacy and that of their families (Barbopoulos & Clark, 2003). The increased visibility also has implications for psychologists in terms of representing the profession, with rural psychologists aware that their conduct in the community reflects on the profession as they are always seen as ‘the psychologist’, even in non-work time (Oxnam & Griffiths, 2005; Sutherland & Chur-Hansen, 2014).

1.3.5 Professional and personal advantages for rural psychologists

While the literature has tended to focus on the challenges of rural practice, many personal and professional benefits of working as a health professional in a rural or remote area have also been highlighted. Hastings and Cohn (2013) identify four areas of opportunity in rural health care: ability to be a generalist, integrated care, potential financial incentives, and congruence with beliefs and values. Jameson, Blank, and Chambless (2009) suggest “the relative autonomy in clinical practice and the challenge of working with a wide variety of cases might be seen as attractive to many psychologists” (p. 725). While financial incentives for Australian psychologists practising in rural areas are limited (see Section 6.3.6, Recruitment and retention), Hastings and Cohn (2013) highlight several incentives for United States psychologists in rural practice, including government assistance with student loan repayment. Curtin and Hargrove (2010) suggest “many of the problems potentially associated with work in smaller, rural communities may be translated as opportunities for creative practice” (p. 549). While there are ethical challenges involved in living and working in a small community, being part of the community can provide rural psychologists with a unique understanding of social and community networks and provide an appreciation for the rural context that can increase rapport and contribute to the understanding of a client’s situation (Curtin & Hargrove, 2010). Chipp et al. (2011) found that the natural beauty of rural areas, access to outdoor activities and a sense of accomplishment in providing a service that ‘makes a difference’ were highlighted by practitioners as rewards of working in a rural area.

Much of the Australian literature on benefits of rural practice focuses on medical and nursing professionals, with limited research investigating psychologists’ perceptions of the benefits of rural practice. Sutherland and Chur-Hansen (2012, 2014)

found that rural psychologists highlighted the diversity of practice, opportunity to work as generalist-specialists and practice in a number of areas as professional benefits, and the positive aspects of the rural lifestyle (including slower pace, community connectedness and opportunity for leisure activities) as a personal benefit. Casey (2007) highlights opportunities to work with a diverse range of people, to visit and practice in different rural towns, and the pace of country living as advantages of rural practice.

Rural and remote placement opportunities have also been demonstrated to increase confidence and preparedness for practice in nursing students (Bennett, Jones, Brown, & Barlow, 2013) and medical students (Daly, Perkins, Kumar, Roberts, & Moore, 2013) with rural placements considered to better prepare students for practice given increased opportunities for autonomous practice and acquisition of advanced clinical and professional skills. In their outline of a psychology training program in rural Manitoba, Canada McIlwraith, Dyck, Holms, Carlson, and Prober (2005) highlight how the program prepares psychology trainees not only for working clinically with a diverse population, but for providing services their urban counterparts may not be exposed to as early in their careers, such as providing supervisory and leadership roles, participating in program development, policy evaluation and representing the psychology profession in other diverse ways. From an Australian perspective, rural and remote psychology clinical placements may offer the opportunity to develop culturally aware and sensitive practices in working with Indigenous Australians, to work flexibly and creatively, and to “think outside the realm of conventional psychological therapy” (Carey et al., 2011).

1.3.6 Rural psychology – an international perspective

Much of the international literature on rural and remote psychology practice arises from Canada and the United States. Both countries, particularly Canada, face

similar challenges to Australia in terms of rural and remote service provision, given their population dispersion and land mass. Scotland also faces challenges in psychology service provision, particularly in the rural and remote Highland regions where population density is the lowest in Europe (Freir et al., 1999). A focus on providing psychology services via telemedicine developed as response to the geographical isolation in this area, with Scottish mental health services early adopters of telepsychology as a model of service delivery (Freir et al., 1999; Simpson, Deans, & Brebner, 2001).

Similar to the Australian context, Malone (2011) highlights the urban-centric nature of psychology training, practice and research in Canada. Rural Canadians experience similar socioeconomic disadvantage to rural Australians (Barbopoulos & Clark, 2003), and Aboriginal Canadians experience social, cultural and economic disadvantage (Malone, 2011, 2012), as do Aboriginal Australians. Rural Canadian psychologists also experience similar ethical and professional challenges to Australian psychologists (Barbopoulos & Clark, 2003). Malone (2011) articulates a definition of Canadian rural psychology which highlights rural psychology as professional practice in a community where size, remoteness and resources are considered in determining rurality; where professional practice may be general as community needs do not support specialisation; where adaptation of professional practice norms (such as telephone services, travel to provide services, adopting a consultative model of service delivery, or adaptation of assessment and treatments) may be required; and where ethical issues may arise from any of the above. As outlined in Section 1.3.5, this definition is likely to apply to rural Australian psychological practice as well.

Similar issues are experienced in the United States, with significantly higher suicide rates in rural and urban areas, and a shortage of mental health professionals in

rural areas (Riding-Malon & Werth, 2014). Rural United States psychologists face similar ethical challenges to rural Australian psychologists, including managing limits to competence, multiple relationships, and confidentiality in small communities (Werth et al., 2010). As in Australia, primary care physicians in the United States deliver a greater proportion of mental health care in rural areas, given the lack of mental health professionals available (Harowski, Turner, LeVine, Schank, & Leichter, 2006).

Although the Canadian, Australian and United States health systems differ significantly, rural dwellers in all three countries experience generally poorer health and mental health outcomes (Meit et al., 2014; Pong, Desmeules, & Lagacé, 2009)

1.3.7 Competencies for rural and remote psychology

Previous research by the author (Sutherland, 2012; Sutherland & Chur-Hansen, 2014) focused on the need to develop competencies for rural and remote practice, given the unique features of rural practice for psychologists, and challenges faced by rural communities, as outlined above. Bourg, Bent, McHolland, and Stricker (1989) define competencies in psychological practice as the requisite knowledge, skills and attitudes (KSAs) for professional functioning. Competencies encompass knowledge of concepts and procedures, skills and abilities, behaviours and strategies, attitudes, beliefs and values, personal characteristics, and motivations required for effective performance of professional activities (Rubin et al., 2007), and can be enhanced through training (Kaslow, 2004). Competencies are elements of competence, “the professional’s overall suitability for the profession, reflecting his or her knowledge, skills, and attitudes and their integration” (Rubin et al., 2007, p. 453).

Prior to the research by Sutherland (2012) rural and remote competencies had been developed for other health professions, including medicine, nursing, allied health and social work, but not psychology. Competencies for other health professions had

included: maintaining confidentiality in small communities; demonstrating independence and self-reliance; demonstrating an understanding of Indigenous culture; maintaining work life balance; demonstrating electronic literacy skills (Bell, Walker, Allen, MacCarrick, & Albert, 2010); proficiency in technology required for service delivery and professional development; broad clinical skills in working with a diverse population; awareness of rural-urban disparities; awareness of services available in their area; willingness to engage in health education roles (Stanton, 2009); the ability to work with few resources, minimal supervision and without the anonymity of the city; a desire to live in the community where one works; sensitivity to the impact of difference in small rural communities; and the ability to drive long distances safely (O'Sullivan, Ross, & Young, 1997).

Reasons outlined for identifying rural competencies have included ensuring graduates are prepared for and supported in rural practice, facilitating quality teaching and learning, recognising the distinctive context of rural practice, and reinforcing the need to take holistic and interprofessional approaches in managing complex health challenges in rural areas (Bell et al., 2010). Given the lack of research with psychologists, practising rural psychologists' perspectives on the KSAs required or desirable to manage challenges and effectively provide psychological services, was identified as the focus of previous research by the author (Sutherland, 2012), which aimed to address these gaps in the literature through a qualitative interview study with rural and remote practitioners. A qualitative exploration was considered most appropriate given the limited research on the topic and the need to explore the perspectives of psychologists, with qualitative research suited to promoting a deep understanding of a particular setting as understood by participants (Bloomberg &

Volpe, 2008; Pope & Mays, 2006). A brief overview of this previous research is outlined here to provide context for the present PhD thesis.

A purposive sampling approach was employed for the former study, with participants recruited from the South Australian Rural Psychology Group, a forum organised by Country Health SA open to rural and metropolitan psychologists working in both government and private practice. Eligibility criteria included being a registered psychologist and living and working in a rural community (with those providing visiting services from a metropolitan base excluded). Rurality was defined using the ARIA ++ classification system categories of Accessible, Moderately Accessible, Remote and Very Remote, with communities classed as Highly Accessible excluded (AIHW, 2004).

Nine psychologists participated in semi-structured telephone interviews including questions about training, work history and current work setting, as well as perceptions of KSAs that were considered either required or desirable for rural practice, including perceived differences between working as a psychologist in a rural area compared to an urban area. Participants ($N = 9$), all women, ranged in age from mid 20s to early 60s ($M = 39$, $SD = 12.39$). All participants were Registered Psychologists: six had Masters level qualifications while three had qualified via either 5+1 or 4+2 supervision pathways. Years of experience as a psychologist ranged from six months to seventeen years ($M = 6.61$, $SD = 5.20$), with years of rural experience ranging from six months to sixteen years ($M = 5.83$, $SD = 4.82$). Four psychologists had experience working in both rural and urban areas, ranging from one to four years' urban experience. Participants represented almost all regions in South Australia and captured the full range of ARIA++ categories (Accessible, Moderately Accessible, Remote and Very Remote) included in the study.

Seven competencies were identified, relating to two broad themes: 'Professional Isolation' (competencies arising from being the sole psychologist or one of few in the community); and 'Rural Life' (competencies relating to the need to manage features of the rural context). The seven competencies were: managing continuing professional development (CPD); managing supervision; managing the lack of other services; managing dual relationships; managing visibility; managing confidentiality; and having an appreciation of the rural context.

Each competency consisted of corresponding and overlapping Knowledge, Skills and Attitudes (KSAs). Knowledge described as important by participants included knowledge of one's own limitations; having a diverse knowledge base; local knowledge; knowledge of Indigenous culture; and knowledge of rural presentations. Technology and networking skills were described as important, along with the ability to work outside psychology; generalist-specialist skills; the ability to set boundaries; self-care skills; strategies for managing accidental meetings; the ability to adapt interventions; community education skills; and the ability to compartmentalise information. Attitudes considered important were being willing to travel, proactive and resourceful, flexible, willing to step out of one's comfort zone, approachable and down to earth, community minded, appreciative of rural lifestyle, and passionate about rural psychology.

The competencies and KSAs identified were consistent with issues and challenges for rural psychologists previously identified in the literature (Barbopoulos & Clark, 2003; Oxnam & Griffiths, 2005; Roufeil & Battye, 2008; Roufeil & Lipzker, 2007; Vines, 2011). Furthermore, the competencies and KSAs identified were consistent with other health professions, including medicine (Bell et al., 2010), nursing (Stanton, 2009) and social work (O'Sullivan et al., 1997). While previous studies have

identified and described issues and challenges for rural psychologists, the previous study contributed to the existing literature through the development of a comprehensive checklist of KSAs identified by rural and remote psychologists as important to manage the challenges and unique features of rural psychology practice. The list of competencies developed could be used for training and professional development for rural psychologists, consistent with the competency-based training approach (Bourg et al., 1989; Lichtenberg et al., 2007). As highlighted by participants in the study, this could take the form of rural content in university courses (for example lectures highlighting KSAs required by rural psychologists) and increased support for rural placements, with rural placements considered by participants to be the optimal method of developing the KSAs required for rural practice. The published paper resulting from this thesis (Sutherland & Chur-Hansen, 2014) is available in Appendix A.

As the first in-depth exploration of rural psychologists' perceptions of the competencies required to provide services in rural Australia, the previous study provided an important 'first step' in developing competencies for rural and remote psychology practice. It was clear upon completion of this study that further research was required to triangulate the findings of this study by exploring the perspectives of other key stakeholders, to provide a broader understanding of the factors involved in successful rural psychological service delivery. This was the basis for the current PhD project, which will be explained in the following sections.

1.3.8 Triangulation and further exploration of previous findings

Triangulation refers to the concept of analysing a research question from different perspectives. This can involve different methods, different researchers, or different data sources. This can help find overlapping and different facets of the phenomenon of interest, or even contradictions (Tashakkori & Teddlie, 1998). As highlighted by

previous research (Sutherland, 2012; Sutherland & Chur-Hansen, 2014), in order to develop competencies for rural and remote psychology practice and a greater understanding of the delivery of rural and remote psychology services more generally, further perspectives are required beyond that of resident rural psychologists (i.e. those both living and working in their rural community). Three areas identified as requiring future research and examined in the present PhD thesis were the perspectives of three other key stakeholders: psychologists who provide visiting ‘fly-in, fly-out’ or ‘drive-in, drive-out’ services to a rural community from a metropolitan base; the perspectives of other health professionals in rural areas, namely rural and remote GPs; and the perspectives of rural clients and rural community members. Background for each of these areas is outlined below.

1.3.9 Fly-in, Fly-out (FIFO) and Drive-in, Drive out (DIDO) psychology

Fly-in fly-out (FIFO) and drive-in drive-out (DIDO) work practices have been central to the Australian resource sector for many years (House of Representatives Standing Committee on Regional Australia, 2013). The terms FIFO and DIDO refer to workers who travel for work, stay a pre-determined number of days and then return to their home location for a set ‘break’ time (Lifeline WA, 2013). In health settings, FIFO may also be referred to as ‘hub and spoke’ or ‘outreach’ service provision (Hanley, 2012). Wakerman, Curry, and McEldowney (2012) suggest that the FIFO/DIDO label covers “a multitude of sins” (p. 1), and may refer to specialist outreach services; ‘hub-and-spoke’ or outreach arrangements; “orbiting staff” who spend significant periods of time (12 months or more) in one or two specific communities; long term shared positions, such as month-on/month-off, where the same practitioners service the same

communities; and short term locum or agency staff who visit numerous rural locations on a short term basis.

While studies examining the psychosocial effects of FIFO/DIDO work practices in the mining and resource sector are emerging (Carter & Kaczmarek, 2009; McLean, 2012; Taylor & Simmonds, 2009; Torkington, Larkins, & Gupta, 2011), published research on the effects of human or social service delivery through FIFO-DIDO is almost non-existent (Guerin & Guerin, 2009). The recent House of Representatives Standing Committee Inquiry into the use of FIFO services (2013) highlighted the need to examine the growing use of FIFO/DIDO models not only in the resource sector, but in health service delivery (Hanley, 2012; Wakerman et al., 2012).

The use of a FIFO/DIDO workforce in health service provision, as with mining, is a contentious issue, and has been described as a “necessary evil” (Hanley, 2012, p. 48). In their submission to the Senate Inquiry, the National Rural Health Alliance (NRHA) argued that “fly-in fly-out or drive-in drive-out health services should never be seen as adequate or satisfactory replacements for personal, ‘hands-on’ healthcare and related services” (2013, p. 3). Hanley (2012) suggests that FIFO and DIDO health service provision “should not be seen as a replacement for local health care, but as part of the necessary compromise between the tyranny of distance and equity of access to health services” (p. 48).

Guerin and Guerin (2009) provide an outline of the potential benefits and drawbacks of FIFO/DIDO health services for both service providers and community members. Potential drawbacks for community members include inconsistencies in service provision; difficulty in accessing consistent care for long-term conditions; possibly younger, inexperienced staff; lack of options for services between visits and emergencies; and difficulty building long-term relationships. There are also concerns

for the wider community, as according to Hanley (2012) “a FIFO workforce makes temporary demands on local infrastructure and services, but does not contribute in the usual way to the local community or ‘social capital’” (p. 48).

Potential drawbacks for service providers include: travel time, which can be considered a waste of the individual service provider’s expertise and thus a waste of resources; frustration with the irregular nature of visits, particularly when a service user misses an appointment; lack of coordination between services and opportunities for multidisciplinary work; little time to take clients through long-term therapies; and difficulty arranging alternative styles of meeting (e.g. meeting with a client’s family or school) (Guerin & Guerin, 2009). There are concerns for employers as well, including the high cost of travel, pressure on accommodation and unproductive driving time (Hanley, 2012).

There are also potential benefits of FIFO/DIDO health service provision for both community members and service providers. For community members potential benefits include: less travel to access services; social benefits e.g. through meeting new people who travel to the community; and the possibly beneficial nature of “stranger relationships” (p.18) (when the service provider is not known to the community) in some circumstances (e.g. when confidentiality is very important to the community member). Potential benefits for service providers include: being able to experience country life without having to give up their city home, family commitments, and professional networks (Hanley, 2012); easier access to professional development in the city (compared to resident professionals); and avoiding the challenges of finding suitable spouse employment and schooling for children (Margolis, 2012).

The unique nature and challenges of FIFO/DIDO health service delivery described above may mean that this work requires practitioners to have certain unique

competencies or require particular supports. Sutherland and Chur-Hansen (2014) explored the experiences of psychologists who live and work in the same rural community; however, did not explore the perspectives of psychologists who are based in urban areas and provide FIFO/DIDO services. According to Guerin and Guerin (2009), “these types of services are markedly different from those in urban and town environments in which service users go to the service providers and usually have more choices” (p. 7) While providing FIFO/DIDO services in a rural area may also require competencies as described by rural psychologists, the unique nature of FIFO/DIDO service provision and the challenges and potential benefits outlined above may mean that this kind of work may also require competencies or may highlight specific professional issues that may differ to resident psychologists in rural and remote communities. There is a dearth of research in this area hence the need for an in-depth qualitative exploration of the experiences of psychologists who provide FIFO/DIDO services was identified. Study 1 of this thesis (Chapter 2) therefore focuses on the experience of FIFO/DIDO psychologists.

1.3.10 General Practitioners’ perceptions of psychology

Examining the perspectives of other rural health professionals, particularly GPs who are likely to be the main referral source for psychologists, was considered another vital step in triangulation of previous research in understanding the competencies required or desirable to work as a psychologist in rural and remote Australia, and developing a greater understanding of the requirements of successful rural psychology service delivery. Investigating GPs’ perceptions of psychologists’ competencies is particularly important given that GPs are the first professional contact for most Australians with mental health problems (Beel, Gringart, & Edwards, 2008), and are therefore often considered the ‘gateway’ to accessing psychological services. In

recognition of this role, the Australian Government has developed several policies over the last two decades to better integrate the services provided by GPs with specialised mental health care professions, including psychologists (Dempsey & Donaghue, 2009). This has included the Better Outcomes in Mental Health Care (BOIMHC) scheme, introduced in July 2001, and the 'Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS' scheme. Introduced in November 2006, under this plan patients can receive rebates through Medicare from sessions with clinical and non-clinical psychologists, as part of a GP mental health care plan (Dempsey & Donaghue, 2009).

These changes to the Medicare system have led to interest in GPs' perceptions of the changes and in the working relationship between GPs and psychologists. Dempsey and Donaghue (2009) interviewed nine GPs from a large regional city in Queensland regarding the provision of mental health care services in Australia, particularly with regards to working with psychologists under the Medicare schemes. GPs expressed frustration with the bureaucratic requirements of completing the mental health care plans, and commented on the importance of 'matching' patients with an appropriate psychologist, which included consideration of age, gender, the type of mental health concern, and financial considerations. GPs also indicated that they were more likely to refer to a psychologist that they knew and considered 'trustworthy'. Dempsey and Donaghue (2009) suggest that this indicates that GPs are unlikely to refer to a psychologist solely on the basis of their professional identity, without having an existing relationship. This was reinforced by the lack of understanding demonstrated by GPs of the professional requirements and registration standards of psychologists, with some participants unaware that psychologists are required to be registered by law, or that accreditation bodies existed for psychology training. Although most GPs were

aware that psychologists are required to have a university degree with further training including placements or postgraduate study, “GPs were rarely in possession of the full facts with regard to this issue” (p. 286).

In another qualitative interview study, Beel et al. (2008) interviewed 12 GPs in Perth, Western Australia regarding their perceptions of psychologists. GPs expressed generally positive attitudes towards psychologists, particularly their capabilities for treating a wide range of problems including relationship issues, anxiety, depression, phobias, stress, personality disorders, post-traumatic stress disorder, obsessive-compulsive disorder, eating, sleeping and dissociative disorders. In terms of what constituted a ‘good’ psychologist, GPs indicated they considered treatment endpoint, feedback provided by the psychologist, and the psychologist’s acceptance of their own limitations. Most of the GPs, however, were dissatisfied with the level of communication and feedback provided by psychologists outside of their practice.

Other studies have investigated the circumstances in which GPs are likely to refer to psychologists. In a qualitative study with GPs in the United Kingdom, Stavrou, Cape, and Barker (2009) found that in deciding whether to refer to a psychologist, GPs considered patients’ wishes for and interest in referral to a psychologist; the patient’s capacity to benefit from psychological therapy; and their own capacity to help the patient. GPs therefore balanced the likelihood of psychological therapy being effective with their own capacity to help the patient.

In a quantitative study, Pryor and Knowles (2001) investigated GPs’ attitudes towards psychologists and the relationship of these attitudes to their referral behaviours. GPs’ attitudes towards psychologists were generally favourable, although as with previous studies participants tended to underestimate the amount of training required to become a psychologist. GPs from a regional city and from metropolitan Victoria were

surveyed, with no significant difference found between groups, however as with Dempsey and Donaghue (2009) the perceptions of more rural and remote GPs were not investigated.

The previous studies outlined focused on GPs in either metropolitan areas or large regional centres. Rural and remote GPs' perceptions of psychologists appear to be an unexplored area in the literature. Study 2 of this thesis (Chapters 3 and 4) therefore addresses this gap in the literature by exploring rural GPs' perceptions of psychologists and experiences working with psychologists in rural areas.

1.3.11 Community perceptions of psychologists

In addition to investigating the perspectives of FIFO/DIDO psychologists and rural GPs, another important step identified in the development of rural and remote psychology competencies and in developing a greater understanding of rural psychological service delivery was to investigate the perceptions of rural community members. The perception of service users is essential in any health service delivery, with the need for consumer participation increasingly reflected in government policy (Lammers & Happell, 2003).

According to Benjamin (1986), the public image of psychology is a two dimensional issue, comprising of popularity (how the public feels about psychology) and understanding (what the public knows about psychology). Historically, psychology has been a profession poorly understood by the public (Benjamin, 1986). Studies conducted in the US as early as the 1940s found that "...the public seems to think that the psychologist deals only with abnormal individuals, and that professional work with normal individuals is beyond his province" (Guest, 1948, p. 137). Wood, Jones, and Benjamin (1986), in a review of unpublished and published surveys in the US until this

time, found that although the public generally held favourable attitudes towards psychology, most showed limited understandings of the field.

In Australia, early research by Small and Gault (1975) found that the general public had limited understanding of the role of psychologists and their competencies, and preferred to seek the help of other professionals, such as GPs, social workers, and psychiatrists, in obtaining services deemed by the study authors to be within psychologists' capabilities. A decade later, in investigating public perceptions of psychologists, psychiatrists, social workers and counsellors, Sharpley (1986) found that psychologists were perceived to be of less value to the community than psychiatrists, social workers, or counsellors, with 31.7% of respondents indicating that they did not know of any benefits, or thought that psychologists provided no benefit to the community. Franklin, Foreman, Kyriakou, and Sarnovski (1998) conducted a survey (N = 307) of GPs (GP; n = 83) and their patients (P-GP; n = 100), psychologists (PSY; n = 61) and their clients (P-PSY; n = 63) examining their awareness of psychologists' qualifications, professional associations and registration. Overall 58.3% of respondents did not know the qualifications of the psychologist they were seeing or referring to (P-PSY 68%, GP 82%, PSY 39%), most had difficulty in understanding the degree titles of psychologists or professional association abbreviations, and only a small majority knew that practising psychologists were required by law to be registered (P-GP 28%, P-PSY 65%, GP 64%, PSY 95%).

Aside from a study by McKeddie (2013) investigating lay attitudes towards and knowledge of counselling psychologists, there has been limited recent work in Australia examining the public perception of psychologists. In surveying a convenience sample of 114 adult members of the Victorian general public (predominantly known to the investigator as friends or family members), McKeddie (2013) assessed respondents'

perceptions of counselling psychologists across domains including previous client/non-client status, perceived need for counselling psychologists, value of counselling psychologists, respect for counselling psychologists, preparedness to consult a mental health care professional, personality traits of counselling psychologists, and confidence in various mental health care professionals (including counselling psychologists, clinical psychologists, social workers, psychiatrists, and general practitioners) to treat various clinical conditions. Results indicated that counselling psychologists were reported to be highly needed, valued and respected, and a high level of confidence was reported in counselling psychologists to treat various mental illnesses. However, qualitative data collected by the survey indicated that counselling psychologists were understood to be less qualified, less skilled, and to work with less severe or complex presentations compared with clinical psychologists.

In addition to the lack of recent research, the perceptions of rural community members regarding psychologists have been neglected in the literature. Hartwig and Delin (2003) surveyed 178 South Australians from both rural and metropolitan Australia regarding their perceptions of psychologists using both direct (i.e. specific questions about the usefulness of psychologists, or how willing people are to consult them) and indirect (e.g. overall favourability ratings) methods, however did not examine whether there were differences between rural and metropolitan groups. The study conducted by McKeddie (2013) also consisted of a predominantly metropolitan sample (86.8%) and did not examine rural-urban differences in public perceptions of psychologists, and Franklin et al. (1998) investigated an entirely metropolitan Australian sample.

The third study of this thesis, the survey of both rural and urban community member attitudes and understandings of psychologists, therefore addresses an important

gap in the literature. Examining rural community attitudes towards psychologists is important given that barriers identified to rural help seeking and service utilisation, including stigma, lack of services, self-reliance, lack of awareness and misconceptions regarding mental illness and mental health services (Collins et al., 2009) which may indicate possible differences between the views of rural and urban consumers of psychological services.

In addition, previous surveys have focussed on public understanding of psychology and public opinion of psychology (i.e. popularity), and have neglected to examine community members' experiences of accessing psychology services. The third study, provided an opportunity for community members, as key stakeholders in the provision of rural psychological services, to have input into understanding the gaps and requirements of rural psychological service delivery.

1.4. Research questions

Despite calls for further understanding and investigation as demonstrated in the literature review, research regarding rural psychological service delivery is limited and large gaps remain. Therefore, this thesis aims to qualitatively explore the following questions in investigating what is required of rural and remote psychology services from the perspective of three key stakeholders: psychologists, GPs, and community members.

1. What are the knowledge, skills and attitudes (KSAs) identified by psychologists providing fly-in, fly-out (FIFO) or drive-in, drive-out (DIDO) services to rural and remote communities as required or desirable for rural and remote FIFO/DIDO psychology practice?

2. What are the challenges and advantages of FIFO/DIDO psychology as opposed to working as a resident psychologist in rural areas?
3. How do rural and remote GPs see the relationship between psychologists and GPs in rural and remote areas?
4. How well do rural and remote GPs understand psychologists?
5. What are the barriers for rural and remote GPs in working with psychologists?

The final study of this thesis aims to answer the following research questions using quantitative survey methods

6. How well do rural community members understand psychologists? (and does this understanding differ from urban community members?)
7. What are the preferences of rural community members regarding psychologists? (and do these differ from urban community members?)
8. What are the barriers to rural community member accessing psychologists? (and do these differ from urban community members?)

1.5. Significance/contribution of the study

While many health professions (including medicine, nursing and social work) have developed competencies for rural and remote practice, there has been comparatively little work investigating competencies that may be required of rural and remote psychologists. This study provides a significant contribution in examining the perspectives of three key stakeholders (FIFO/DIDO rural psychologists, rural GPs, and rural community members), building upon research previously conducted with resident rural psychologists, as to the competencies that may be required of rural and remote psychologists.

This information may be used in the development of competencies for working as a rural or remote psychologist that could be used for training and professional development for rural psychologists, consistent with the competency-based training approach. A greater understanding of the competencies required to work as a psychologist in a rural or remote area may ultimately inform recruitment and retention, in both providing appropriate training for rural and remote practice, and assisting psychologists to identify whether they are suited to working in rural and remote areas.

In addition, through exploring the perspectives of not only psychologists, but GPs and rural community members, the thesis will provide insight into the views of these groups on the provision of psychological services in rural areas and may have implications for service delivery, for example support for the provision of resident or visiting (FIFO and DIDO) psychological services. The findings of this thesis may have implications for the promotion of psychology in rural and remote areas, as a lack of exposure to psychology services may result in a lack of understanding of the services psychologists can provide (Roufeil & Lipzker, 2007). Finally, the findings of this thesis may have implications in terms of interprofessional education and collaboration between psychologists and general practitioners in rural and remote areas, in exploring GPs' perceptions of psychologists.

1.6. Research approach

1.6.1 Theoretical framework

1.6.1.1 Competency based training and education for health professionals

The project draws on theories of competency-based education for health professionals. Competency based training is widely used and accepted in health professional education, for example in medicine (Leung, 2002). Psychology is also

moving towards an emphasis on competency based models of assessment and training (Falender et al., 2004; Rubin et al., 2007). The focus on psychologists attaining competency, rather than simply assessing that specified domains of education and training are undertaken, is reflected in the development of the recent Australian Psychology Accreditation Council (APAC) standards that specify “core capabilities” (2010, p. 48) that must be demonstrated before psychologists are considered fit to practice (Von Truer, Sturre, Keele, & Feenstra, 2011; Voudouris, 2009, 2010). Competency benchmarks have also been developed for different stages of professional development for psychologists (Fouad et al., 2009).

As well as identifying competencies for general psychology practice (APAC, 2010), competencies have been outlined for each area of practice endorsement (Psychology Board of Australia, 2012). Competencies have also been developed in specific areas of psychology including clinical supervision (Falender et al., 2004), geropsychology (Karel, Knight, Duffy, Hinrichsen, & Zeiss, 2010) and clinical health psychology (France et al., 2008). The need for competencies for rural and remote psychology practice was the focus of previous research (Sutherland, 2012; Sutherland & Chur-Hansen, 2014) and is an important focus of this thesis.

1.6.1.2 Interprofessional education (IPE) and collaboration

In exploring the perspectives of rural GPs on working with rural psychologists, this thesis also draws upon theories and perspectives of interprofessional education (IPE) and collaboration (IPC). IPE is defined as “occasions when two or more professionals, learn with, from and about each other to improve collaboration and the quality of care” (Centre for Advancement in Interprofessional Education (CAIPE), 1997). Interprofessional education among health professionals has been a recent focus in Australia and overseas. In the United States, core competencies for Interprofessional

Collaborative Practice (Interprofessional Education Collaborative, 2011) reflect the current emphasis on both competency-based learning and interprofessional learning in health professional education. In their report to Health Workforce Australia presenting an analysis of pre-registration interprofessional education (IPE) in Australia, The Interprofessional Curriculum Renewal Consortium Australia (2013) note that IPE as a core component of health professional education is considered critical in educating health professionals with well-developed interprofessional, collaborative and team-based capabilities, and the “preparedness of health professional graduates to engage in interprofessional practice (IPP) has been identified as essential to designing and delivering health services that are patient responsive, safe, effective, efficient and as a consequence, sustainable” (p. 12).

IPE is considered to be a key strategy in improving outcomes and delivery of increasingly complex health care by promoting interprofessional collaboration (IPC) (Gum et al., 2013). Given the complex nature of rural health and mental health issues, the lack of services and other professionals and the tyranny of distance as previously described, interprofessional education and practice has been argued to be of particular importance in rural areas (Gum et al., 2013). Therefore, in investigating rural GPs’ perceptions of psychologists, including GPs’ understanding of psychology and psychologists (such as when GPs would refer to psychologists, or any barriers to doing so) this thesis also draws upon theories of IPE and IPC in developing a greater understanding of the interprofessional relationship between these two professions in rural and remote areas. In addition, exploring the perspectives of GPs as key stakeholders in the provision of rural and remote psychological services in developing competencies for rural and remote psychologists, promotes the importance of interprofessional collaboration.

1.6.1.3 Models of rural health service delivery

In its focus on the perspectives of FIFO and DIDO psychologists and GPs, the present project also draws upon models of rural health and mental health service delivery, including FIFO and DIDO models and the role of psychology in primary health care. According to Wakerman and Humphreys (2011) there is no ‘one size fits all’ approach to rural health service delivery, and Roufeil (2011) outlines several innovative ways in which psychologists are providing services to rural and remote communities. Technological advances have allowed telepsychology initiatives, including telephone and video counselling to be used in rural and remote communities, both standalone and as an adjunct to face-to-face services. In addition to these methods of psychological service delivery in rural areas, much has been written about the place of psychology in rural primary health care. According to Roufeil (2011), rural communities and the organisations that service those communities have been “early adopters” (p. 1) of the principles of primary health care, recognising the value of integrated care due to the challenges of isolation, distance, staff shortages and complex care needs of rural communities.

In describing FIFO/DIDO psychology in remote areas the thesis therefore draws upon theories and models of rural health services delivery in exploring the competencies required to provide such services. The thesis also draws upon the literature relating to psychology and primary health care in its focus on the perspectives of rural general practitioners, and of both resident and FIFO/DIDO psychologists in working with rural general practitioners. The thesis also examines models of rural health services delivery from a consumer perspective, via the third study examining the perspectives of rural and remote community members. This study incorporates questions regarding the desirability and acceptability of service delivery in various

models (e.g. resident psychologists, FIFO/DIDO psychologists, psychologists working in primary health care).

1.6.2 Methods

The project employs a mixed-methods approach in triangulating previous research (Sutherland, 2012; Sutherland & Chur-Hansen, 2014). Triangulation is “a methodological approach that contributes to the validity of research results when multiple methods, sources, theories and/or investigations are employed” (Farmer, Robinson, Elliott, & Eyles, 2006). Triangulation refers to the idea of analysing a research question from different perspectives. This can involve different methods, different researchers, or different data sources. This can help find overlapping and different facets of the phenomenon of interest, or even contradictions (Tashakkori & Teddlie, 1998). In examining the research questions from three different perspectives, that of: 1) FIFO/DIDO psychologists; 2) rural GPs; and 3) rural community members, the proposed project aims to triangulate the findings of the previous study with resident rural practitioners (Sutherland, 2012; Sutherland & Chur-Hansen, 2014) using what Farmer et al. (2006) describe as “data triangulation” – the use of multiple data sources or respondent groups. In addition, this study applies methodological triangulation (Farmer et al., 2006), in the use of two qualitative interview studies and a quantitative survey.

Qualitative studies

A qualitative research approach was considered appropriate for answering the first five research questions (see Section 1.4). Qualitative methods allow for rich, detailed exploration of data. Given the lack of previous research regarding the perceptions of FIFO and DIDO rural psychologists and rural GPs, a qualitative

approach was therefore undertaken. The qualitative studies in this thesis follow the approach to Thematic Analysis as described by Braun and Clarke (2006, 2013). There are six phases to Braun and Clarke's (2006) approach, the first being familiarisation with the data. This involves transcription of all interviews by the researcher, (with lines numbered so that data extracts can be cross-checked back to the interview), reading and re-reading transcripts to become familiar with the data set, and taking note of initial ideas and preliminary themes. In the second phase, initial codes are generated through systematically working through the entire data set, taking account of exceptions and inconsistencies. These codes are then collated into potential themes and sub-themes, which are checked against coded extracts across the entire data set. The specific procedure for each of the qualitative studies is outlined below.

1.6.2.1 Study 1

Participants

Participants were Registered Psychologists based in metropolitan Adelaide who provided FIFO/DIDO services to rural communities in South Australia. Ethical approval was given for this study by the Human Research Ethics Committee at The University of Adelaide (HREC no. 13/72). FIFO/DIDO was defined as regularly (e.g. weekly, fortnightly, or monthly) travelling to a rural or remote community (or communities) to provide psychological services. 'Rural' was defined using the Australian Standard Geographical Classification (ASGC) rural and remoteness classes of Outer Regional, Remote and Very Remote, excluding Major Cities (AIHW, 2004). Exclusion criteria were psychologists who are based (live and work) in a rural community (i.e. resident practitioners).

Participants were recruited via the Country Health SA Rural Psychology Forum; a professional development group open to both rural and metropolitan psychologists with

an interest in rural practice. Attendees of the Forum were invited to participate through a short presentation at a meeting of the group and an email sent by the convenor of the group on behalf of the researchers. Additional participants were recruited through snowball sampling.

Methods

Interviews were conducted in person in Adelaide or via telephone if the participant was currently working in a rural location. Interviews were semi-structured, but open-ended to allow the participant to direct the interview. Some specific prompt questions were asked (in no particular order) if they were not discussed during the course of the interview. Interviews were audio recorded with the participant's consent. The researcher transcribed all interviews.

Data analysis

The data were analysed using thematic analysis, as outlined by Braun & Clarke (2006), an accepted qualitative technique to search for relevant themes. Participants received a transcription from their interview and were informed they could change or delete sections of the transcript as they wished. Only one participant made a minor change to their transcript in the interest of maintaining confidentiality. Participants were offered a summary of the project's findings.

1.6.2.2 Study 2

Participants

Participants were General Practitioners (GPs) and General Practice Registrars practising in rural and remote South Australia. Ethical approval was given for this study by the Human Research Ethics Committee at The University of Adelaide (HREC

no.13/42). Participants were recruited through the Rural Doctors Workforce Agency (RDWA), a not-for-profit rural workforce agency that supports and recruits doctors, locums, specialists, nurses and allied health professionals to work in rural and remote South Australia. The researcher attended the RDWA Annual Conference, held at the Adelaide Convention Centre on the 24th-25th May 2013, and invited attending GPs to participate through flyers and a sign-up sheet at the conference registration desk. Members of the RDWA board of directors were also invited to participate via an email sent out by the RDWA CEO on behalf of the researcher. Further participants were recruited via snowball sampling and via a bulk email sent on behalf of the researchers by the RDWA to their mailing list of rural and remote GPs in South Australia, inviting participation.

Methods

The study involved individual interviews using the same methods as Study 1, however interviews tended to be of a shorter duration given the time demands faced by most rural GPs. Interviews were semi-structured, but open-ended to allow the participant to direct the interview. Some specific prompt questions were asked (in no particular order) if they were not discussed during the course of the interview.

Data analysis

As with Study 1 the data were analysed using thematic analysis, as outlined by Braun & Clarke (2006, 2013).

Quantitative study

A quantitative approach was considered most appropriate for the third study, to allow for comparison of the perspectives of rural and urban community members (an

identified gap in the literature). A quantitative approach was also considered most appropriate to capture a broad range of community views.

1.6.2.3 Study 3

Participants

Participants were a community sample of rural and urban residents of South Australia recruited from the general population. A diverse sample representative of the general population was sought. Participants were adults aged over 18 years.

Methods

The survey utilised an online format using Survey Monkey software. Participation was promoted to a cross-section of the general public through snowball sampling methods and sending the survey link to family, friends and colleagues (e.g. through social media websites and email). Rural media promotion was also sought, in addition to circulating links through rural networks and organisations (see Appendix B for media release).

The survey included the collection of demographic information including gender, age, ethnicity, level of education, household income, occupation, marital status, degree of rurality, time spent living in a rural location, and whether the participant had previously lived in an urban location. Information was also collected regarding whether participants had previously seen a psychologist or engaged with any other mental health services.

The survey included questions regarding both participants' understandings of the roles of psychologists, and psychologists' popularity among participants (in line with Benjamin's (1986) two dimensional model of public perceptions of psychologists). This included examining understandings of the difference between psychologists and other

health professionals, the relationships between psychologists and GPs, and psychologists training and registration requirements. Questions examining the popularity or acceptability of psychologists included questions examining when participants would see a psychologist, for what concerns, and what method of service delivery (e.g. resident psychologist, FIFO/DIDO psychologist) participants would prefer.

Data analysis

Data were analysed using IBM SPSS Version 22. Data were screened for errors in normality, outliers, skewness, and homogeneity of variance. Demographic information of the participants was reported, as well as descriptive statistics for all measures, using means, standard deviations, Chi-square and t-tests. Demographic characteristics was compared to the normative data for an Australian population, to assess the representativeness of the sample. Quantitative data were analysed using Chi-square analysis and binary logistic regression using. A content analysis (Jackson, 2009) was undertaken on the qualitative comments.

1.7 Academic and scientific rigour in qualitative research

Tracy (2010) outlines a number of criteria for ensuring excellence in qualitative research. The first, 'worthy topic' argues that qualitative research should be relevant, timely, significant or interesting. Interest in rural and remote psychology in Australia has increased since 2011, where an edition of the Australian Psychological Society publication 'In Psych' was dedicated to rural and remote psychology. Since then, the Australian Journal of Rural Health published a special 'Psychology in the Bush' edition in 2014, focusing on rural and remote psychology. Tracey's criteria of 'rich rigour' requires enough data to support significant claims. Both qualitative studies (Study 1 and

2) in this thesis achieved data saturation. Rigour is also demonstrated by the criteria of ‘transparency’ and ‘sincerity’. An audit trail was maintained throughout the study to document decisions made during the research process: this is an accepted practice to enhance rigour (Tracy, 2010). The audit trail documented relevant material in addition to the interview transcript, including correspondence with participants, as well as notes taken during and after the interviews. The audit trail also contained themes noted immediately following each interview and preliminary synthesis of themes. Also to enhance the rigour and trustworthiness of findings (Pope, Ziebland, & Mays, 2006) for each of the qualitative studies the primary supervisor checked themes against the raw data. According to Tracy, sincerity also requires self-reflexivity from the researcher, considering the researcher’s interest and level of involvement. Reflexivity is addressed in Section 1.7.2 of this thesis. Finally, a key component of Tracy’s criterion of credibility involves ‘member reflections’ which “allow for sharing and dialoguing with participants about the study’s findings, and providing opportunities for questions, critique, feedback, affirmation, and even collaboration” (Tracy, 2010, p. 844). This process of participant validation was followed by providing participants with a copy of their interview transcript and allowing the opportunity for feedback.

1.7.1 Ethical considerations

The research followed the principals of the NHMRC National Statement on ethical conduct in human research (NHMRC, 2007). All three studies received approval from the Human Research Ethics Committee at The University of Adelaide (HREC no. 13/76, 13/42, 15/26). Ethical considerations for the qualitative and quantitative studies are outlined below.

1.7.1.1 Qualitative studies

Study 1 and 2 were both qualitative interview studies, involving individual interviews with health practitioners, therefore both had similar ethical considerations. Participants in both studies were fully informed consenting adults who volunteered to be interviewed. Participants were given full and adequate verbal and written information about the nature, purpose, possible risks and benefits of the study. Participants were given time to consider the information, to ask questions and to seek advice prior to being asked whether they wished to participate in the study. Participants were assured that their participation in the study was voluntary, and withdrawing from the study would not in any way negatively impact them. Expected uses of information provided by participants in the course of interviews (the write-up of the PhD thesis and publications) were fully disclosed to participants. A consent form was provided and participants were given the option of returning this via mail, email or fax, or providing verbal consent at the time of interview. It was not anticipated that the interview would cause any adverse reactions or trauma. A protocol was devised in the case of a participant becoming distressed during the interview, including ceasing the interview and providing necessary supports, however no participants reported distress during or following the interviews.

The main potential ethical considerations related to anonymity and confidentiality. The level of detail necessary to support and situate qualitative research claims, as well as the use of single settings and small numbers of participants often complicate simple anonymisation, as the interview transcript may contain multiple clues to a person's identity (e.g. name, employment details, place of residence and events that have occurred in their community) (Goodwin, 2006). These issues are particularly salient in the context of the research setting, as South Australian

psychologists providing FIFO/DIDO services and rural and remote South Australian GPs are both relatively limited in number.

Issues of confidentiality and anonymity were addressed by the following measures: 1) full disclosure of intended use of information provided by participants (the write-up of the PhD thesis and possible publications); 2) the use of pseudonyms and ensuring that potential identifying information (employment details, place of residence, events unique to community) was anonymised or excluded; and 3) participants were provided with the opportunity to see and approve transcripts to be used in the final report (Goodwin, 2006).

All participants provided consent for their interviews to be recorded. The researcher transcribed all interviews verbatim. Digital recordings have been kept on a university, password protected computer. The transcribed, de-identified data have been similarly stored on a university password protected computer to be kept for seven years, then destroyed.

1.7.1.2 Quantitative survey

Participation in the online survey was anonymous. An information sheet and consent form were presented to participants on the first screen of the online survey, which advised participants that participation was voluntary and information recorded would be kept secure and confidential following the procedures outlined above for qualitative data. The participant clicking on an 'Accept' icon to continue with the survey was considered consent from the participant. Data collected from the surveys has been similarly stored on a university password protected computer to be kept for seven years, then destroyed.

1.7.2 Reflexivity

Qualitative research requires transparency regarding the researcher's position in relation to the study and the data, with the need to highlight personal and intellectual biases to enhance the sincerity and credibility of findings (Mays & Pope, 2000; Tracy, 2010). Braun & Clarke (2013) describe reflexivity as “the process of critically reflecting on the knowledge we produce, and our role in producing that knowledge” (p. 37) and argue reflexivity is essential in ensuring quality in qualitative research. According to Tracy (2010), sincerity, where “the research is marked by honesty and transparency about the researcher's biases, goals, and foibles” (p. 841), is the “end-goal” of reflexivity. Jootun, McGhee, and Marland (2009) argue that aiming for “detachment” from qualitative research is unrealistic and this can negatively affect the qualitative process. They argue that by “incorporating their social selves” (p. 46) researchers can enhance the quality of their research by engaging with their participants. Personal and professional experiences have influenced my reasons for writing my PhD thesis in this area, and these experiences may have influenced my attitudes and assumptions towards the topic. These experiences, and my position as a researcher, will be explored below.

1.7.2.1 My rural background

My interest in this area arises from my own rural background, growing up in Birdwoodton, a small community near Mildura in the Sunraysia region of rural Victoria. Mildura is a ‘rural city’ on the border between Victoria and New South Wales, approximately 110 kilometres from the South Australian border. Mildura is defined as an Outer Regional area according to ASGC and ASGS criteria (ABS, 2011; 2014). The Mildura Rural City Council area covers approximately 22,000 square kilometres and

has a population of approximately 50,000 people. Mildura is approximately 550km from Melbourne and 400km from Adelaide (the nearest capital city), and relies primarily on agriculture (predominantly the wine, citrus and dried fruit industries) to support its economy as Victoria's 'Food Bowl'.

My experiences growing up near Mildura, a relatively isolated regional area, have influenced my perceptions of rural health service delivery. As with many rural communities, Mildura experiences disadvantage in health and social outcomes compared to the Victorian state average (Mildura Rural City Council, 2013). These disparities in outcomes are experienced in the context of limited access to medical specialists, and significant community concern regarding the management and services provided by the local hospital, the only privately owned and managed 'public' hospital in Victoria, reflected in the development of numerous community advocacy groups. In terms of personal experiences with inequity in access to services, I have experienced family members being unable to access treatment locally due to the lack of specialist services, and the personal and financial costs associated with the need to travel to capital cities for treatment. Moving to Adelaide to commence my university studies following secondary school highlighted this disparity in access, as I began to understand how readily (in my relative experience) services were available in Adelaide in comparison to Mildura. On a more positive note, I have also been privileged to experience the many positive aspects of growing up in a rural area. I have a strong appreciation of the resilience demonstrated by rural communities and the benefits of community connectedness, and value the lifestyle benefits of living in a rural community.

1.7.2.2 My experiences and professional development as a psychologist

During the writing of this thesis I was also undertaking my professional training as a psychologist through the Combined PhD/Master of Clinical Psychology² program. As my thesis has progressed I have also progressed in my clinical training, thus my understandings of clinical aspects of psychological service delivery have developed throughout the writing and development of this thesis. I conducted the qualitative interviews for Study 1 and 2 in 2013 (with rural fly-in, fly-out and drive-in, drive-out psychologists, and rural GPs) prior to commencing my first clinical placement. Although I did not have clinical experience as a psychologist prior to conducting the interviews with psychologists and GPs, I was undertaking the coursework requirements for the Masters program at the time and was therefore immersed in the culture of professional psychology practice. The survey design and data collection for Study 3, the quantitative survey of community members, took place in early 2015, as I was undertaking my second clinical placement. During the data analysis and writing stages of the thesis I undertook clinical placements in both metropolitan and rural areas, including at the Country Health SA Rural and Remote Inpatient Service, and the South East Integrated Mental Health Team. My rural placement experiences, being my first opportunity to directly experience some of the practical and ethical issues experienced by the psychologist and GP participants in the research, have undoubtedly shaped my views and understandings in the writing of the thesis, hence I will discuss these placements briefly here.

² The Combined PhD/Master of Clinical Psychology program involves completion of both a PhD and a Master of Psychology (Clinical) degree leading to eligibility for registration as a psychologist in Australia. The program involves completion of a full PhD, a minimum of 1200 hours of clinical placements, and coursework over four years.

The Rural and Remote Inpatient Service is a 23-bed mental health unit in metropolitan Adelaide for patients from rural and remote areas. During my placement at the Rural and Remote Inpatient Service I provided psychological services for rural and remote patients while they were admitted to the service based in Adelaide, many of whom had limited access to psychological services in their home community. Part of my role included arranging psychological follow up for patients, which in many cases was not available. My placement with the South East Integrated Mental Health team was based in Mount Gambier. The South East region has a population of approximately 62,000 people and covers an area of 21,000 square kilometres. During my time with the service I was based in Mount Gambier, the largest centre within the South East (population approximately 25,000) and provided visiting services to Naracoorte (population approximately 5000). The South East Integrated Mental Health team, at the time of undertaking the placement, had one full time Clinical Psychologist for the region, with regular placements for provisional psychologists.

In the final year of writing this thesis (2016), I gained registration as a psychologist and commenced part-time employment as a Mental Health Psychologist with the Riverland Integrated Mental Health Inpatient Unit (IMHIU), part of Country Health SA. The Riverland region has a population of approximately 42,000 people and is located approximately three hours' drive (250km) from Adelaide. The Riverland, similar to Mildura, relies heavily on agriculture, particularly the wine and dried fruit industries, to support its economy. The Riverland IMHIU is a six-bed rural inpatient unit based in Berri, South Australia, one of three rural inpatient units in South Australia established in the last two to three years. Prior to the establishment of the country units, all country patients requiring inpatient treatment in a mental health facility were required to travel to the Adelaide Rural and Remote Inpatient Unit for treatment.

My position as a 0.2 FTE psychologist in the Riverland IMHIU is, at the time of writing, the only public mental health psychologist position in the region. In providing psychological assessment and brief intervention, a large part of my role involves making recommendations for further psychological intervention. As in my placement experiences in the South East and Rural and Remote Inpatient Unit, often there are few options for outpatient psychological intervention for IMHIU patients. With no psychologists in the public community mental health system, the inpatient unit relies heavily on the small number of psychologists in private practice in the Riverland (a mix of visiting and local psychologists) working under the Better Access scheme to provide psychological intervention. The complexity of the client group means that often the ten sessions available under this scheme are insufficient.

1.7.2.3 Considerations of potential impact of these factors on the research

I have reflected on the experiences outlined above throughout my candidature, and the potential influence of these experiences on my choice of topic, my approach to the interviewees, the questions asked during interviews, and the questions included in the design of the survey. I have particularly reflected on my position as a provisional psychologist with a rural background at the time of conducting interviews. My position may have enhanced rapport with the psychologist participants in Study 1, as someone with an interest in their work. In terms of the GP interviews for Study 2, my position as a psychologist asking questions about psychology is acknowledged in terms of the potential impact on participants' willingness to share negative views or experiences of psychology. I found that the GPs did tend to relate to me, understandably, as a member of the psychology profession, rather than a student, often using the term 'you' to refer to psychologists. In terms of the relevance of my rural background to the conduct of the research, I generally did not highlight my own rural background unless asked, however

there was a general appreciation from participants that I must have some personal interest in the area and most participants asked if I had a rural background. My rural background was explicitly referred to in media attention for the survey (see Appendix B), particularly in rural media coverage, and may have influenced rural community members' willingness to participate.

In terms of the impact of my experiences on the broader writing of this thesis, clinical supervision, in addition to research supervision, has also been an important part of the reflective process. Learning to manage ethical challenges of being a rural psychologist myself, particularly with regards to managing limits to competence in working in an area with limited services, has provided me with a different perspective in relation to the data as I have made the transition from student researcher to practising psychologist. Working as a drive-in, drive-out (DIDO) psychologist, providing a visiting service to the South Australian Riverland while based in Adelaide, has provided me with the opportunity to experience the advantages, challenges and support needs of FIFO/DIDO practice as highlighted by the participants in Study 1. The writing of the thesis has also shaped my clinical practice and professional development particularly in regards to managing burnout associated with working in an underserviced rural area, with the writing of the thesis and papers serving as a way for me to contribute to the literature with the hope of contributing to practice and policy developments in rural psychology.

As the topic of the PhD overlaps with both personal and clinical interests for me, in the interest of reflexivity it is important to acknowledge this thesis has been developed and conducted with the wish to further understand and contribute to knowledge regarding the delivery of health services in rural areas, specifically psychology services, in light of a wish to contribute to improving health and mental

health outcomes for rural Australians. Through reflection and supervision throughout my candidature, and adhering to the principles of quality in qualitative research outlined in Section 1.7 including the involvement of my supervisors in checking themes against the raw data, I believe I have been able to remain faithful to the data while addressing these aims.

Chapter 2 – Experiences of Fly-in, Fly-out (FIFO) and Drive-in, Drive-Out (DIDO) rural and remote psychologists

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Authors and affiliations:

Carly Sutherland¹, Anna Chur-Hansen¹, Helen Winefield¹

¹School of Psychology, Faculty of Health Sciences, University of Adelaide, Adelaide, South Australia, Australia

2.1 Statement of contributions

Statement of Authorship

Title of Paper	Experiences of Fly-in, Fly-out (FIFO) and Drive-in, Drive-Out (DIDO) Rural and Remote Psychologists
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Principal Author

Name of Principal Author (Candidate)	Carly Rose Sutherland
Contribution to the Paper	Conducted literature review, designed study, collected data, analysed data, wrote manuscript, acted as corresponding author, and revised manuscript during the submission process in consultation with co-authors.
Overall percentage (%)	85%
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature	Date <u>18/10/16</u>

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Anna Chur-Hansen
Contribution to the Paper	Supervised development of the work, reviewed analysis of the qualitative data as a measure of rigour, helped to evaluate and edit the manuscript.
Signature	Date <u>18.10.16</u>

Name of Co-Author	Helen Winefield
Contribution to the Paper	Supervised development of the work, helped to evaluate and edit the manuscript.
Signature	Date <u>18/10/16</u>

2.2 Paper

2.2.1 Abstract

Objective: Fly-in, fly-out (FIFO) and drive-in, drive out (DIDO) work practices have been central to the resource sector in Australia for many years. While research considering the impacts of this lifestyle on mining workers is emerging, comparatively little is known about the experiences of FIFO/DIDO health professionals. The lack of information on FIFO/DIDO psychologists may be detrimental to both the communities serviced by them and the profession in terms of developing appropriate workforce planning and training for psychological service delivery in rural and remote areas. This qualitative study therefore aimed to explore the experiences of FIFO/DIDO psychologists.

Method: Semi-structured qualitative interviews were conducted with ten psychologists living in metropolitan South Australia and working in rural and remote areas. Interviews were conducted by telephone, face-to-face, or in a group. Data were analysed using thematic analysis.

Results: While participants reported experiencing similar challenges as resident rural psychologists, including diverse and complex cases and a lack of referral options, they also reported unique challenges, advantages and support needs as FIFO/DIDO psychologists. These were encompassed by the themes of ‘Living away from home’ and ‘Working away from home’, which included two sub-themes: ‘Limited time’ (referring to the limited time spent in the rural setting) and ‘Professional Isolation’ (factors associated with working away from professional supports).

Conclusions: This study may assist in recruitment and retention of FIFO/DIDO psychologists by providing insight into what is required in the role, and inform training and models of rural and remote psychological service delivery.

Key words: rural, remote, FIFO, outreach, psychology workforce, psychology training

2.2.2 Introduction

Fly-in fly-out (FIFO) and drive-in drive-out (DIDO) work practices have been central to the Australian resource sector for many years (House of Representatives Standing Committee on Regional Australia, 2013). The terms refer to workers who travel for work, stay a pre-determined number of days and then return to their home location for a set 'break' time (Lifeline WA, 2013). In health settings, FIFO may also be referred to as 'hub and spoke' or 'outreach' service provision (Hanley, 2012). Wakerman et al. (2012) suggest that the FIFO/DIDO label covers "a multitude of sins" (p. 1), and may refer to: specialist outreach services; 'hub-and-spoke' or outreach arrangements; "orbiting staff" who spend significant periods of time (12 months or more) in one or two specific communities; long term shared positions, such as month-on/month-off; and short term locum or agency staff who visit numerous rural locations on a short term basis.

While studies examining the psychosocial effects of FIFO/DIDO work practices in the mining sector are emerging (Carter & Kaczmarek, 2009; McLean, 2012; Taylor & Simmonds, 2009; Torkington et al., 2011), published research on the effects on human or social service delivery workers through FIFO/DIDO is almost non-existent (Guerin & Guerin, 2009). The recent House of Representatives Standing Committee Inquiry into the use of FIFO services (2013) highlighted the need to examine the growing use of FIFO/DIDO models in health service delivery (Hanley, 2012;

Wakerman et al., 2012). The lack of information available regarding FIFO/DIDO health services, including the experiences of FIFO/DIDO health professionals, may be detrimental to both health professions and rural and remote communities, in developing appropriate training and service delivery may be enhanced by the perspectives of those providing the services.

The use of a FIFO/DIDO workforce in health service provision, as with mining, is a contentious issue, and has been described as a “necessary evil” (Hanley, 2012, p. 48). In their submission to the Senate Inquiry, the National Rural Health Alliance (NRHA) argued that “fly-in fly-out or drive-in drive-out health services should never be seen as adequate or satisfactory replacements for personal, ‘hands-on’ healthcare and related services” (2013, p. 3). Hanley (2012) suggests that FIFO and DIDO health service provision “should not be seen as a replacement for local health care, but as part of the necessary compromise between the tyranny of distance and equity of access to health services” (p. 48).

The benefits and disadvantages of FIFO/DIDO health services for the community have been acknowledged (see Guerin & Guerin, 2009, for more information) however the benefits and disadvantages to the service providers themselves are relatively unknown. Guerin and Guerin (2009) provide an anecdotal outline of the potential benefits and disadvantages of FIFO/DIDO health services for service providers. Potential disadvantages for service providers include: travel time, which can be considered a waste of the service provider’s expertise and thus a waste of resources; frustration with the irregular nature of visits, particularly when a service user misses an appointment; lack of coordination between services and opportunities for multidisciplinary work; little time to take clients through long-term therapies; and difficulty arranging alternative styles of meeting (e.g. meeting with a client’s family or

school) (Guerin & Guerin, 2009). There are concerns for employers as well, including the high cost of travel, pressure on accommodation and unproductive driving time (Hanley, 2012).

Potential benefits for service providers include: being able to experience country life without having to give up their city home, family commitments, and professional networks (Hanley, 2012); easier access to professional development in the city (compared to resident professionals); and avoiding the challenges of finding suitable spouse employment and schooling for children (Margolis, 2012).

There has been limited empirical work investigating the experiences of FIFO/DIDO health professionals. In a recent qualitative study investigating the experiences of seven non-resident nurses providing services in remote regions of the Northern Territory, Heidelbeer and Carson (2013) found that the personal benefits of non-resident work include higher incomes, more time off, and avoiding the challenges of living and working in a remote community (such as those mentioned above). Challenges included committing to regular activities outside of work, missing important family events, and the high levels of fatigue arising from both the intensity of work and travel. Professional benefits included being able to ‘disengage’ from the stress of work when at home (however it was noted that work stressors may be felt more intensely when at work, given the intensity of work). Professional isolation was highlighted as of concern, including the pressure to undertake work for which the nurses were not qualified or trained due to the lack of other services. In contrast, some participants found that working in remote communities allowed them to use specialist skills less in demand in urban areas. Professional challenges included ‘fitting in’ to the community and getting to know different communities when working across several locations, and high levels of resident staff turnover.

Previous research (Sutherland & Chur-Hansen, 2014) has investigated the experiences of resident rural and remote psychologists (those living and working in a rural or remote community), finding that these psychologists required specific competencies to manage the challenges of resident rural practice; however no studies have examined the experience of FIFO/DIDO (non-resident) rural and remote psychologists. According to Guerin and Guerin (2009), FIFO and DIDO services “are markedly different from those in urban and town environments in which service users go to the service providers and usually have more choices” (p.7), in that FIFO/DIDO services are provided according to particular time limitations, and a choice of practitioners may not be available. While providing FIFO/DIDO services in a rural area may share some similarities with practising psychology in a rural area as a resident psychologist, the unique nature of FIFO/DIDO service provision, with its inherent need for practitioners to travel and work outside their own community, may involve challenges and benefits that differ to resident psychologists in rural and remote communities.

Developing a greater understanding of the experiences of FIFO/DIDO psychologists may be important for both rural and remote communities and the psychology profession, in informing models of training and service delivery. A greater understanding of the benefits, challenges and support needs of FIFO/DIDO psychologists may inform training to ensure psychologists are adequately resourced and supported to work in FIFO/DIDO arrangements, and assist psychologists to provide appropriate and acceptable services for rural communities. The aim of the present study is therefore to provide an in-depth qualitative exploration of the experiences of psychologists who provide FIFO/DIDO services in rural and remote Australia, in terms of benefits, challenges and support needs.

2.2.3 Method

Participants

A qualitative methodological approach was considered most appropriate given limited previous research and the need to elicit detailed, rich data. The University of Adelaide Human Research Ethics Committee approved this study on the 8th July 2013 (HREC no. 13/76). Seven semi-structured interviews were conducted with ten participants (six individual interviews and one focus group with four participants). Six of the seven interviews (including the focus group) took place in person, and one was conducted by telephone. Interviews took place between July and September 2013. Eligibility criteria included being a fully registered psychologist based in Adelaide providing FIFO/DIDO services to rural communities in South Australia. FIFO/DIDO was defined as regularly (e.g. weekly, fortnightly or monthly) travelling to a rural or remote community (or communities) to provide psychological services, including therapy, assessment and consultation. Rurality was defined using Australian Standard Geographical Classification (ASGC) rural and remoteness classes of Inner Regional, Outer Regional, Remote and Very Remote, excluding Major Cities (AIHW, 2004). Psychologists who were based (live and work) in a rural community (i.e. resident practitioners) were excluded from the present study.

A purposive sampling approach was employed, with participants recruited from a professional development group open to rural and metropolitan psychologists with an interest in rural psychology. The first author attended a meeting of the group, and an invitation to participate was subsequently sent via email to the group mailing list. One participant volunteered at the initial meeting, with eight responding to the group email. One participant was recruited through the second author. Two other psychologists expressed interest in participating but did not respond to follow up emails.

Participants ($N = 10$) ranged in age from late 20s to early 70s ($M = 48.30$, $SD = 17.55$). Six were women and four were men. Three had qualified via supervision pathways to practice while seven had a Masters or PhD level qualification. Five participants had Clinical endorsement, one Health, one Forensic and one Educational and Developmental. Years of experience as a registered psychologist ranged from two to thirty-six years ($M = 13.70$, $SD = 13.30$).

Years of experience providing FIFO/DIDO psychological services ranged from six months to seventeen years ($M = 5.94$, $SD = 5.14$). Five participants worked in public settings, and four in private (with one participant working in both). The majority of participants ($n = 6$), visited rural communities fortnightly, with three visiting weekly and two monthly. Five participants visited only one rural community, and five visited several different rural communities. Three psychologists also had experience working as resident rural practitioners. All participants worked in metropolitan settings in addition to their rural FIFO/DIDO work. The locations visited by participants represented almost all regions in rural and remote South Australia, and captured the full range of ASGC categories included in the study of Inner Regional, Outer Regional, Remote and Very Remote (AIHW, 2004).

Six participants identified as having a rural background, with one other participant having a partner with a rural background. Three participants had no pre-existing or partner connections to rural areas. Reasons highlighted by participants for working as a FIFO/DIDO psychologist included wanting to make a difference to rural communities, with some citing their own rural backgrounds as influencing this, and being valued and appreciated by the rural community. Several participants were in their role through chance or circumstance, rather than a particular desire to seek out FIFO/DIDO work. Financial advantages were highlighted by some. Only one

participant indicated they would be willing to work as a resident rural psychologist. Reasons cited for not wanting to live and work in rural areas included ethical dilemmas faced by resident rural psychologists, and the lack of services and opportunities (personally and professionally). Two participants indicated they were considering discontinuing FIFO/DIDO work in the near future. Both indicated this was not due to dissatisfaction with the work, but in order to seek new professional opportunities.

Procedure

All interviews were recorded using a digital voice recorder and transcribed verbatim by the interviewer. The first author conducted all interviews, which ranged from 27 to 87 minutes in length ($M = 61$). The interview was semi-structured and included questions about participants' FIFO/DIDO work arrangements (such as scheduling), the challenges and advantages of the work, experiences of ethical issues, and reasons for working FIFO/DIDO. A copy of the interview schedule may be obtained by the authors upon request.

Transcripts were emailed to participants, allowing for a process of participant validation. Data saturation was achieved, with no new themes emerging by the final interview. Interviews were analysed using a method of constant comparison, with each interview transcribed and subjected to preliminary analysis before the following interview. The process of constant comparison allows for the point of data saturation to be identified (Baker & Edwards, 2012). Data were analysed using thematic analysis as outlined by Braun and Clarke (2006, 2013). The first author conducted the analysis. A theoretical approach, involving engagement with the literature regarding experiences of FIFO/DIDO health professionals was employed. There are six phases to Braun and Clarke's (2006, 2013) approach, the first being familiarisation with the data. This involved transcription of all interviews by the first author and taking note of initial ideas

and preliminary themes. In the second phase, initial semantic codes were generated through systematically working through the entire data set, taking account of exceptions and inconsistencies. These semantic codes were then collated into potential themes and sub-themes, which were checked against coded extracts across the entire data set.

An audit trail was maintained throughout the study to document decisions made during the research process: this is an accepted practice to enhance rigour according to the principles of sincerity and transparency (Tracy, 2010). The second author coded an interview transcript, and checked all transcripts against themes identified in the analysis, as a further method of increasing rigour and trustworthiness. There was considerable overlap between the two analyses with minor discrepancies resolved through discussion, resulting in consensus of the final themes.

2.2.4 Results

Many of the types of knowledge, skills and attitudes required for rural and remote FIFO/DIDO psychology were similar to those reported by resident rural psychologists in the previous study (Sutherland & Chur-Hansen, 2014) such as having a high level of skills in a broad range of areas to work with complex and diverse presentations, being able to adapt interventions developed in an urban context, the ability to set personal and professional boundaries and manage confidentiality in small communities, and being adaptable, flexible and ‘down to earth’, with an appreciation of the rural lifestyle. The results of the present study will therefore focus on the unique features of FIFO and DIDO rural and remote psychology practice.

Two themes were identified that differentiated FIFO/DIDO work from resident rural psychological practice: ‘Living away from home’ and ‘Working away from home’. The theme of ‘Living away from home’ encompassed challenges, advantages and support needs associated with travelling and being away from family, friends and

home. The theme of 'Working away from home' encompassed factors associated with working as a psychologist away from home, and was comprised of two sub-themes: 'Limited time' and 'Professional isolation'. 'Limited time' captured challenges, advantages and support needs of only working for a limited amount of time in the one rural location. 'Professional isolation' encompassed challenges, advantages and support needs associated with working in rural areas with few other psychologists or health professionals to provide support. An overview of themes and sub-themes is provided in Table 1.

Living away from home

Challenges

Missing family

Missing important family events like birthdays and family dinners due to travel delays was described as a challenge of FIFO/DIDO work schedules.

...the pull of home is strong and you just want to get home and when your flight's delayed you're just like - oh. And then you know sometimes you can be planning oh well when I get back I'll go to that family dinner.... missed the family dinner. (Participant 4).

Caring for dependents

Caring for dependents, including children, elderly relatives and pets, was described as challenging when working a FIFO/DIDO schedule. FIFO/DIDO work was considered difficult with young children. One participant indicated they would stop FIFO/DIDO work when they had a family.

I really enjoy it and I think - you know three years is a while but I've still got stamina left in me so while I am childless I don't see a problem - I don't envisage it stopping anytime soon... certainly when the time comes to have a family and things like that definitely I would reconsider and most likely would stop doing FIFO... for obvious reasons...

(Participant 2)

Managing fatigue

The early starts and long days required (often exacerbated by limited flight options) was another challenge. Many participants highlighted the impact of fatigue in conjunction with the necessary intensity of the work, with FIFO/DIDO schedules often designed to see as many clients as possible during limited time in the rural area.

... because of the intensity of the fly in fly out drive in drive out you're often actually more tired than you would be if you were working in a metro area... so some of the flights are really early, some of the flights are late but [we] just rock back to work the next day because the report's due.... but in the meantime [we're] carrying this debt of accumulating tiredness just from the fatigue of travelling (Participant 4)

Managing safety

While FIFO/DIDO work was described as potentially advantageous in terms of personal safety, in that psychologists do not live in the same area as their clients, psychologists may be at higher risk when staying in rural locations.

So whilst that is an advantage on the one hand.... the flip side of the same coin is that while we're in country locations we are at higher risk compared to our metropolitan counterparts who come home to their own

houses where they're happy with the security, so at times we've had security issues with our accommodation, or we could be staying in the same accommodation as clients who've had to come in for the assessment (Participant 4)

Access to health care

Given the limited availability of health professionals in rural communities, participants described having to attend the same health services as their clients, leading to concerns about ethics and confidentiality. Catering for special health needs such as dietary requirements when visiting a rural community was also described as challenging.

...we had a team member that had a medical condition and she'd have to find the local hospital, go and have a blood test before work but lining up with clients whereas in a metro region you'd find [another] hospital (Participant 5)

Financial implications

Financial implications of living away from home were also highlighted, such as the cost of services not used when away.

There are a lot of personal costs in terms - even in terms of like gym memberships people have to cancel personal training sessions... to do the work (Participant 6)

Unable to return home in emergencies

Due to restrictive flight schedules in rural communities, the inability to return home quickly in case of emergencies was highlighted as a challenge of FIFO/DIDO work. This included when psychologists themselves were unwell.

If you are away, and you have a family issue or something, you've got to keep focused, the plane is only tomorrow you can't just drive back

(Participant 8)

Advantages

Financial compensation

Financial compensation was described as an advantage of FIFO/DIDO work for some, but not all participants. Financial compensation was considered appropriate given the lifestyle impact, and a reflection of the work being valued by the organisation.

...there was a um financial.... incentive to do the fly in fly out work um in recognition that it has a lifestyle impact which it does [have] in terms of your personal life outside of work so that sort of made me cheerful and happy to do this work knowing that it was valued by the [organisation] (Participant 6)

Personal space/time away from family

While missing family when away was described as a challenge, an advantage of time away was the opportunity for personal space, and time away from one's family and partner.

I kind of like my personal space - I'm not in a relationship at the moment but my last relationship - it was actually quite nice um having that time

away from each other...because we lived together and we'd see each other every day, and having that separation of me going away every - you know every fortnight for a couple of days was quite nice (Participant 2)

Support needs

Appropriate compensation for lifestyle impacts

The need for appropriate compensation for the lifestyle impacts of the FIFO/DIDO schedule was identified, including the need for organisations to appreciate that providing equitable services to rural communities may therefore cost more than equivalent services in metropolitan areas. It was indicated that the need for such support was not always recognised by metropolitan psychologists.

It would be nice for other psychologists to recognise that as well you know people might make the choice to not do this work but it would be nice to actually be validated that because we do make that choice to do this work - there is - we are deserving of some sort of compensation to make up for the impacts that has on our lives. We don't always get that support from other psychologists (Participant 6).

Working away from home

Limited time

Challenges

Developing relationships with resident rural health professionals

Developing professional networks with resident rural practitioners was another challenge, particularly given the reliance on locums and the high turnover of resident health professionals in many rural communities. The need for FIFO/DIDO

psychologists to make time to introduce themselves to local professionals was highlighted, to maximise opportunities for their clients to access other services. This was considered particularly important in working with local GPs and building up a referral base in the rural community. Ensuring resident clinicians are aware of FIFO/DIDO psychologists' schedules was also important. FIFO/DIDO services were generally considered to be valued by resident rural practitioners, however with resident practitioners generally accustomed to services 'coming and going', the importance of consistency in providing FIFO/DIDO services was emphasised.

...a lot of people come up and they'll think - oh yeah this is good I'll come and do this, but they can't actually sustain the work....if you drive in, you've got to keep driving in.... you know they're waiting to see - are you going to turn up next week (Participant 3)

Greater intensity of work

The intensity of FIFO/DIDO work was highlighted. Many participants described working much longer days when in the rural location than they would in metropolitan work, due to the need to fit in as many clients as possible.

...when I'm up there I usually work about thirty hours over the three days...and yeah - it's intensive, quite full on (Participant 2)

Scheduling challenges

Having longer times between appointments on a FIFO/DIDO schedule was described as challenging for both psychologists and clients. Longer times between sessions may mean that clients have difficulty relying on self-practice when learning new skills.

.... the other challenge then is on the four-week basis of being able to.... get [clients] to do the work and being able to review that.... I tell them this, you're trying to learn skills here and it's like riding a bike if you don't practice them, you can't ride it.... but if you practice riding a bike, [it] becomes automatic.... and what you've got to do is practice this - those ways of coping those new skills become automatic and you do it without actually thinking... and if you don't practice it then you're not going to get there now if you're seeing a person on a weekly basis you can keep reinforcing that input... you can't reinforce it as well once every four weeks ... so - rural and remote [clients] miss out on the fact that they don't have that - regular input from a psychologist (Participant 1)

Scheduling visits as a FIFO/DIDO psychologist was described as a balance between what is best for clients and what causes least disruption to the psychologist's personal life. Several participants acknowledged that while weekly visits may be best for their clients, the impact of weekly travel may be too great for some psychologists. It was noted that the disruptive impact of frequent travel was a significant difference between FIFO/DIDO and metropolitan work.

Conducting psychological assessments as a FIFO/DIDO psychologist was described as another scheduling challenge. Being able to develop rapport quickly was described as important as psychologists may only have limited opportunities for assessment sessions, whereas in a metropolitan or resident rural setting there may be more opportunities for follow up.

...your assessments can be trickier because um there's...time issues, you can't really - well you can but it's harder to arrange an assessment that involves checking them out and going back and seeing what

happens in response to interventions or how things change over time, so you're a bit stuck with one-off stuff (Participant 10)

Advantages

Increased flexibility of working hours/time on leave

Greater flexibility in working hours, either through 'flexitime' offered for working overtime, or by working longer hours when away and shorter days in metropolitan practice, was described as an advantage of the FIFO/DIDO schedule.

I work more in two days [FIFO/DIDO] than in [metropolitan] private practice but it means I don't have to work every day...and I prefer that timetable - working really hard and just taking some time off after that (Participant 8)

Avoiding ethical challenges

Being able to 'escape' some of the ethical dilemmas faced by resident rural psychologists, such as having dual relationships or accidentally meeting clients in social situations, was considered an advantage of FIFO/DIDO psychology as opposed to resident rural psychology. It was acknowledged that FIFO/DIDO psychologists may not need to socialise with members of the community, avoiding potential ethical challenges faced by resident rural psychologists, who are required to live and interact with the community in which they work.

I'm lucky in the fact that from an ethical [point of view] I don't have the dual relationship problem that my [resident rural] colleagues have up there.... the trouble is there that um there's not a big town there's not a lot to do, so consequently you ah would have a very

much a dual relationship problem seeing them in a clinical setting and then you see them in a social setting. I go up there - I fly up on the Monday, I work there, when I've finished I just go to my motel room.... the only time I'll go out socially is I might have a meal with my colleague.... but I don't tend to do much with - well nothing pretty well with anybody else (Participant 1)

For psychologists who enjoy working in the country but are concerned about these aspects, FIFO/DIDO work was described as 'the best compromise'.

I actually don't know how our [resident] social work colleagues succeed so well in living and working... in small towns....you know on a Friday night they will find themselves drinking at the same waterhole as their clients you know and then - what do they do with that information...So for that reason I probably wouldn't do it [resident rural work]....But - I find this [FIFO/DIDO] the best compromise... because I love the country side of things.... not doing country work is unappealing, and doing it in a country location is unappealing (Participant 4)

Greater support than resident rural practitioners

One participant also highlighted that FIFO/DIDO psychologists based in Adelaide may feel more supported than resident rural psychologists working for the same organisation, such as in accessing professional development in Adelaide.

I think living in the remote location [for a resident rural psychologist] was quite a different experience to what I had as a resident of Adelaide travelling up there regularly.... It was quite hard for [resident rural psychologist] to come down to Adelaide for professional development

purposes... [the organisation] weren't really supportive of flying her and would expect her to kind of - come down very early morning and drive back late at night (Participant 2)

Work is valued

Feeling valued by the rural community was also highlighted as an advantage of FIFO/DIDO work. It was highlighted that FIFO/DIDO psychologists may feel valued for providing a service that would not otherwise be available.

I think they appreciate our time and they appreciate that we've travelled a really long way just to see them...that's a very direct contrast to what I noticed working in metro you're just one of anyone who could be around (Participant 5)

Avoiding burnout

Avoiding burnout associated with living and working in a rural community was highlighted as an advantage, as was avoiding burnout associated with working in the one metropolitan job role. Many participants described their FIFO/DIDO work as a challenging and interesting addition to their metropolitan work that kept them engaged. Avoiding burnout associated with dealing with tragedy in small communities was also highlighted as an advantage for FIFO/DIDO psychologists, who are able to seek support from their own community outside the affected rural community.

...one advantage is you can actually escape... if you're not there all the time you can – one of the most difficult things in the country, you can be very closely connected with tragedy... and I've had a few successful suicides so know them you know the family, um, so I think in that sense

it's ah good to be able to – not necessarily escape but at least remove yourself from the environment (Participant 9)

Support needs

Appropriate induction into rural community

Being introduced to relevant professionals and services by someone familiar with the rural community was described as important, but not always practised.

....to go there and have somebody to introduce you to those services and often there's nobody.... there's no induction of what is available... you are pretty much left on your own to discover who can do what
(Participant 8)

Professional isolation

Challenges

Working across locations with different organisational procedures

Negotiating requirements across work locations, including policies and management procedures, was described as a challenge when these differed between country and metropolitan locations.

.... because I go between [metropolitan location], [rural SA town] and [other metropolitan location], and each institution is very different... and we'll have different office spaces and um - yeah - everything's slightly different, management processes.... It's quite chaotic!
(Participant 2)

Less access to supervision and peer support

Less access to professional supervision ‘on the job’ was highlighted as another challenge for FIFO/DIDO psychologists that may lead to ethical dilemmas.

.... being away from your professional supports.... you can feel ethically compromised with less peer supervision and support than you would normally have just to run something by someone else and you’re kind of forced to make decisions in the moment and then reflect on them later
(Participant 5)

The need to manage at risk clients when away from the rural community was another challenge. Developing close relationships with GPs and asking resident clinicians to see higher risk clients were two strategies used.

Advantages

More collaborative relationships with resident practitioners

It was suggested that FIFO/DIDO psychologists may also have more collaborative relationships with local health professionals in the rural location compared to their work in metropolitan areas, because they felt the services they were providing were valued by resident practitioners.

I tend to find them more collaborative the relationships are more collaborative than what I experienced in metro [Participant 5: Definitely] because our services are valued (Participant 6)

... There’s a sense of all pitching in.... which helps (Participant 7)

Support needs

Appropriate office facilities

This included practical support, such appropriate office, consulting and waiting room facilities, and administrative support in the rural or remote area.

...providing equipment would be good, providing your base office with telephones.... basically trying to make it as much like the city as possible (Participant 10).

Appropriate training

The limited opportunities available for psychology trainees to experience FIFO/DIDO work were highlighted, particularly the lack of FIFO/DIDO rural placements but also the lack of rural placements generally. Rural placements were considered important in highlighting the opportunities and advantages of FIFO/DIDO work for students and thus assisting with the supply of psychologists in rural areas.

....we used to offer student placements and that was withdrawn.... which is really disappointing because the hope in us offering those placements would be that it would be an incentive for students to go and later work in rural and remote areas or do outreach work and - that exposure I think is really important in supplying psychologists to the field and I think it's worth the - you know few hundred dollars you might have to spend over a placement (Participant 6)

In addition to placements, increased rural and remote content in university courses was highlighted as potentially helpful in preparing psychologists for FIFO/DIDO work. In terms of the suitability of FIFO/DIDO work for new graduates,

one participant highlighted that working in the country could be advantageous for psychologists ‘learning their trade’, as the limited services and close-knit nature of the communities assists psychologists to develop understandings of how services work together. In addition to professional psychology training, it was highlighted FIFO/DIDO psychologists may benefit from training such as First Aid and Driver Safety courses, particularly for psychologists travelling on their own for long distances.

Appropriate supervision

For both new graduates and more experienced psychologists, adequate supervision and on the job training were considered essential for FIFO/DIDO work, with an emphasis on supervision appropriate for the rural context.

I think you need um at least supervision in how you deal with these crossover [ethical] dilemmas of – how far you go in a country area...um in some senses right of refusal (Participant 9)

Availability of local health professionals

The availability of local health professional support and supervision was also identified as a support need of FIFO/DIDO psychologists.

...in terms of psychology I’m the only one up there at any given point in time.... however there is always other social workers and professional staff around... if I ever need supervision or a bit of guidance (Participant 2)

Personality for FIFO/DIDO work

In addition to themes described above, several participants described FIFO/DIDO work being suited to a certain personality ‘type’

I guess it's not for everybody.... I don't necessarily know what the commonality is between um the FIFO workers....but I can see that certainly a lot of people aren't geared towards it and I'm very keen to hear the outcomes of your study because....it's a unique kind of subset of people that do it I mean maybe we're all slightly mad I don't know
(laughs) (Participant 2)

Personality characteristics highlighted included having a sense of adventure, being flexible and adaptive and enjoying travel, being approachable, down to earth, practical and resourceful, having confidence in working independently yet also having the ability to seek support when required, and being able to sustain working in isolation.

Local vs. FIFO/DIDO services

In addition to their own experiences of providing FIFO/DIDO psychology services, participants also commented on their perceptions of rural community members' experiences of receiving FIFO/DIDO psychology services. It was noted that some clients may perceive FIFO/DIDO to offer increased confidentiality over seeing a resident rural psychologist.

...it's a big advantage for them because of confidentiality. The further away I'm coming from the better it is for them. So it's a bonus for them
(Participant 8)

There was a sense that rural clients were generally appreciative of having access to services, regardless of the background (resident or FIFO/DIDO) of the psychologist.

I haven't had that sense of you - guys wouldn't know what it's like to live here you don't understand the context which I was kind of

expecting....it's more an appreciation of shit you actually came!

(Participant 7)

Participants suggested that FIFO/DIDO psychologists should take the time to get to know the local community. It was noted that having travelled to see clients can help build rapport. FIFO/DIDO services were seen to be valued by rural clients, with some participants observing fewer no-shows compared to their metropolitan work. It was however noted that FIFO/DIDO services may be less appropriate for Indigenous communities, given the importance of developing long-term relationships with communities which often experience inconsistent services.

...we are not appropriate for remote areas.... because of the fact that we fly in fly out so we don't have credibility. I mean even if we were culturally vouched for it would be touch and go I think (Participant 4)

2.2.5 Discussion

This study employed qualitative methods to investigate the experiences of psychologists providing FIFO/DIDO services to rural and remote communities. While many of the challenges of FIFO/DIDO rural work were consistent with challenges for resident rural practitioners (Sutherland & Chur-Hansen, 2014) such as having a high level of skills in a broad range of areas to work with complex and diverse presentations, the participants in this study suggested there were unique challenges, advantages and support needs for FIFO/DIDO psychologists, encompassed by the themes of 'Living away from home' (associated with travelling and being away from family, friends and home) and 'Working away from home'. 'Working away from home' was comprised of two sub-themes: 'Limited time' (encompassing challenges, advantages and support

needs of only working for a limited amount of time in the one rural location) and ‘Professional isolation’ (challenges, advantages and support needs associated with working in rural areas with few other psychologists or health professionals to provide support).

Many of these challenges and advantages described were consistent with previous research with nurses (Heidelbeer & Carson, 2013), suggesting some features of FIFO/DIDO work may apply across professions. However, several points of difference which may be specific to the provision of rural and remote psychology services, as opposed to other health services, were noted. Compared to the FIFO/DIDO nurses in Heidelbeer & Carson’s (2013) study who tended to work in ‘block time’, with this being their primary employment, all the participants in the present study conducted FIFO/DIDO work in addition to their metropolitan work, meaning that they tended to work a traditional ‘full time’ week, with some days per week, fortnight or month spent in rural locations. Therefore, the benefits of ‘block time’ at home described for nurses (such as the opportunity to recuperate and spend extra time with family) may not be as applicable to psychologists working full time weeks.

The participants in this study suggested FIFO/DIDO psychologists may also face specific challenges given the often longer term nature of therapeutic work, and the difficulty of conducting psychological assessments in a limited time frame. Participants described scheduling difficulties in balancing the need to see clients regularly in order to reinforce skills learnt in therapy sessions and maintain rapport, and minimising the impact of travel on the psychologists.

Participants in this study identified support required for successful FIFO/DIDO work, including appropriate practical support, induction to the community, and local support. For psychologists and health professionals working in organisations, the

importance of FIFO/DIDO work being valued by the organisation and the lifestyle impact appropriately compensated was emphasised.

A need for increased training opportunities for FIFO/DIDO psychologists was also identified. As with resident rural psychologists (Sutherland & Chur-Hansen, 2014) a lack of rural placement opportunities for psychology students was identified as problematic, with a particular lack of FIFO/DIDO options. Rural FIFO/DIDO placements were considered important in highlighting opportunities for new graduates and therefore assisting with the supply of psychologists in rural and remote areas. Consistent with the previous study (Sutherland & Chur-Hansen, 2014) increasing rural content in university courses, including information about FIFO/DIDO rural work, was considered an important strategy in encouraging students to consider rural work and providing insight into the opportunities and challenges. With appropriate supervision, FIFO/DIDO work was considered beneficial for new graduates, enhancing their understanding of integration of health services in small communities. FIFO/DIDO work, with the benefits of easier access to professional development and peer support when based in the city, may therefore be an appropriate introduction to rural work for new psychology graduates uncertain about their readiness for resident rural work.

This study provides some insight into community members' views on FIFO/DIDO psychology services. Participants felt that they were not perceived negatively or as having less understanding of the community when practising as a non-resident psychologist. Some rural community members may see FIFO/DIDO as advantageous in terms of confidentiality if the psychologist is not a member of their community. Further research is required to directly explore the views of rural community members on FIFO/DIDO psychology service delivery.

This study included participants with a wide range of experience, expertise (including generalist psychologists and those with endorsements in Clinical, Health, Forensic, and Educational and Developmental psychology), training (supervision, masters and doctorate trained) and work settings (public and private). All participants were currently practising FIFO/DIDO psychologists, and the majority intended to continue in the foreseeable future.

The finding that personality factors may be important in working as a FIFO/DIDO rural psychologist is consistent with previous research with rural psychologists (Sutherland & Chur-Hansen, 2014) and rural doctors (Eley, Young, & Shrapnel, 2008). Further research is required to examine the role of personality in recruitment and retention of both FIFO/DIDO and resident rural and remote psychologists.

This study adds to previous work exploring what is required to work as a psychologist in a rural area (Sutherland & Chur-Hansen, 2014), as psychologists in the present study had, by definition, worked in both rural and urban areas. This paper therefore provides further insight into differences between working in rural and urban areas as well as insights into FIFO/DIDO. Further research is still required to directly compare experiences of urban and rural psychologists.

Qualitative research does not aim for representativeness of data in the same way that quantitative research does, but rather, seeks transferability. Given that the experiences of the participants in this study are consistent with previous research with other health professionals, and given that saturation was achieved, it is likely that the findings of this study would resonate with many - but not necessarily all - FIFO/DIDO psychologists. In only investigating the experiences of rural psychologists in South Australia, findings of this study may be state-specific, and further work is required to

explore the experiences of FIFO/DIDO psychologists from other states. South Australia's unique population characteristics may result in differences in experience of service delivery, as the state is characterised by a smaller, more dispersed rural population than the Eastern states. The use of a focus group in addition to individual interviews in the present study, while having the advantage of capitalising on group members' interactions and shared experiences of FIFO/DIDO work, means that limitations associated with the use of focus groups (including the possible inhibition of some participants' responses if they held views inconsistent with the group view) may apply (Kitzinger, 2006).

FIFO/DIDO health service provision in rural communities, having previously been described as a "necessary evil" (Hanley, 2012, p. 48), is a contentious issue. The present study suggests there may be advantages for practitioners in psychological service delivery through FIFO/DIDO models, although there are still significant challenges for practitioners and support is required for psychologists to successfully provide FIFO/DIDO services. The present study also indicates that health profession-specific research may be required. Professions such as psychology, where longer-term therapy relationships may be important, as opposed to professions which may deliver more 'one-off' or short term services, may face unique challenges in delivering their services

2.2.6 Table

Table 1. Themes and sub-themes

Living away from home		Working away from home			
		Limited time	Professional isolation		
<i>Challenges</i>	<i>Advantages</i>	<i>Challenges</i>	<i>Advantages</i>	<i>Challenges</i>	<i>Advantages</i>
Missing family	Financial compensation	Developing relationships with resident rural health professionals	Increased flexibility of working hours/time on leave	Working across locations with different organisational procedures	More collaborative relationships with resident practitioners
Caring for dependents	Personal space/time away from family	Greater intensity of work	Avoiding ethical challenges	Less access to supervision and peer support	Appropriate training
Managing fatigue		Scheduling challenges	Greater support than resident rural practitioners		Appropriate supervision
Managing safety			Work is valued		Availability of local health professionals
Access to health care			Avoiding burnout		
Financial implications					
Unable to return home in emergencies					

Chapter 3 – Rural and Remote General Practitioners’ perceptions of psychologists

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Authors and affiliations:

Carly Sutherland¹, Anna Chur-Hansen¹, Helen Winefield¹

¹School of Psychology, Faculty of Health Sciences, University of Adelaide, Adelaide, South Australia, Australia

3.1 Statement of contributions

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Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Anna Chur-Hansen
Contribution to the Paper	Supervised development of the work, reviewed analysis of the qualitative data as a measure of rigour, helped to evaluate and edit the manuscript.
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Name of Co-Author	Helen Winefield
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Signature	Date <u>18/10/16</u>

3.2 Paper

3.2.1 Abstract

Objective: As the first professional contact for most Australians with mental health concerns, General Practitioners (GPs) are often considered the ‘gateway’ to accessing psychologists. Understanding GPs’ views of psychologists is therefore of great importance to the profession. GPs serve a particularly important role in mental health in rural and remote areas given the lack of other services; however there has been limited research investigating the relationship between psychologists and GPs in rural areas. This study aimed to investigate rural GPs’ perceptions of rural psychologists.

Method: Semi-structured qualitative telephone and in-person interviews were conducted with thirteen GPs working in rural and remote South Australia. Data were analysed thematically.

Results: Three main themes were identified: Psychologists are useful/helpful; working with psychologists can be challenging; and psychologists are not well understood. Rural GPs held mostly positive views about psychologists and their value in providing professional support and reducing GP workloads. However, GPs’ understanding of psychologists’ training and expertise varied considerably, with most reporting gaps in their knowledge. Challenges included limited access to psychologists and communication barriers. Communication was considered to be enhanced by co-locating psychology services within the GP practice, which was also considered to be a valuable educational opportunity for GPs.

Conclusion: While rural GPs held largely positive views of psychologists, they may require further support in understanding what psychologists can offer and promoting psychology to their patients. Results may assist in improving communication

between rural psychologists and GPs and inform strategies to improve rural GPs' understanding of psychologists' skills and training.

Key words: access to health care; general practice; interprofessional communication; psychology; rural; remote

3.2.2 Introduction

GPs are the first professional contact for most Australians with mental health problems (Beel et al., 2008), and are therefore often considered the 'gateway' to accessing psychological services. Approximately one in eight GP consultations are mental health related (Britt et al., 2015), representing an annual increase of 7% in the estimated number of GP mental health related encounters since 2009-2010. Data from the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity indicates that medication is the most common form of GP management of mental health related problems (63.3 per 100 mental health related problems managed), with referrals given at a rate of 15.1 per 100 mental health problems. Referral to a psychologist was most common (7.4 per 100) followed by psychiatrists (1.9 per 100) (Britt et al., 2013).

In recognition of the role of GPs in mental health care, the Australian Government has developed several policies over the last two decades to increase access to psychological treatments through GP assessment and referral (Dempsey & Donaghue, 2009). This has included the Better Outcomes in Mental Health Care (BOIMHC) scheme, introduced in July 2001, and the 'Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS' scheme, introduced in November 2006 (Dempsey & Donaghue, 2009). The Better Access scheme in particular has seen a significant increase in the uptake of psychological services since its

inception, with the estimated population treatment rate for mental disorders in Australia increasing from 37% in 2006-2007 to 46% in 2009-2010, with this increase being attributed to the introduction of the scheme (Whiteford et al., 2014). The Australian Government's 2011 review of the program demonstrated similar increased treatment rates and concluded that the Better Access program was playing an important role in meeting previously unmet need for mental health care in Australia (Pirkis, Harris, Hall, & Ftanou, 2011).

These changes to the Medicare system have led to increased interest in GPs' perceptions of the working relationship between GPs and psychologists. Dempsey and Donaghue (2009) interviewed nine GPs from a large regional city in Queensland regarding the provision of mental health care services in Australia, particularly with regard to working with psychologists under the Medicare schemes. GPs expressed frustration with the bureaucratic requirements of completing the mental health care plans required to refer to a psychologist, and commented on the importance of 'matching' patients with an appropriate psychologist, which included consideration of age, gender, the type of mental health concern, and financial situation. GPs also indicated that they were more likely to refer to a psychologist that they knew and considered 'trustworthy'. Dempsey and Donaghue (2009) suggest that this indicates that GPs are unlikely to refer to a psychologist solely on the basis of their professional identity, without having an existing relationship. This was reinforced by the lack of understanding demonstrated by GPs of the professional requirements and registration standards of psychologists, with some participants unaware that psychologists are required to be registered by law, or that accreditation bodies exist for psychology training. Although most GPs were aware that psychologists are required to have a

university degree with further training including placements or postgraduate study, “GPs were rarely in possession of the full facts with regard to this issue” (p. 286).

Beel et al. (2008) interviewed 12 GPs in Perth, Western Australia regarding their perceptions of psychologists. GPs expressed generally positive attitudes towards psychologists, particularly their capabilities for treating a wide range of problems including relationship issues, anxiety, depression, stress, personality disorders, post-traumatic stress disorder, and eating, sleep and dissociative disorders. In terms of what constituted a ‘good’ psychologist, GPs considered treatment endpoint, feedback provided by the psychologist, and the psychologist’s acceptance of their own limitations. Most of the GPs, however, were dissatisfied with the level of communication and feedback provided by psychologists outside of their practice.

Other studies have investigated the circumstances in which GPs are likely to refer to psychologists. In a qualitative study in the United Kingdom, Stavrou et al. (2009) found that in deciding whether to refer, GPs considered patients’ wishes for and interest in referral to a psychologist; the patient’s capacity to benefit from psychological therapy; and their own capacity to help the patient. GPs therefore balanced the likelihood of psychological therapy being effective with their own capacity to help.

In a quantitative Australian study, Pryor and Knowles (2001) investigated GPs’ attitudes towards psychologists and the relationship of these attitudes to their referral behaviours. GPs’ attitudes towards psychologists were generally favourable, although as with previous studies participants tended to underestimate the amount of training required to become a psychologist. GPs from a regional city and from metropolitan Victoria were surveyed, with no significant difference between groups found, however as with Dempsey and Donaghue (2009) the perceptions of more rural and remote GPs were not investigated.

The previous studies outlined focused on GPs in either metropolitan areas or large regional centres. There is a lack of research investigating the views of rural and remote GPs towards psychologists. The unique challenges and features of rural practice for psychologists, including professional isolation, the lack of access to specialist services, ethical challenges such as managing dual relationships and confidentiality in small communities, and difficulties accessing professional development and supervision (Roufeil & Lipzker, 2007) may mean that the relationships between psychologists and GPs in rural and remote areas differ compared to metropolitan GPs and psychologists. Rural GPs of course experience similar challenges (Hays, Wynd, Veitch, & Crossland, 2003; Larkins & Evans, 2014). Previous research with rural psychologists (Sutherland & Chur-Hansen, 2014; Sutherland, Chur-Hansen, & Winefield, 2016) has highlighted the importance of the relationship between psychologists and GPs in rural areas, suggesting rural psychologists rely on GPs' professional support in managing complex cases and crisis situations, and on positive relationships with GPs to facilitate referrals in private practice. The support provided to psychologists by rural GPs is particularly relevant given the well-documented shortage of psychiatrists in rural areas, with almost 9 out of 10 psychiatrists working in Major Cities in 2014 (AIHW, 2016).

The Better Access program has been criticised for failing to reach those in rural and remote areas (Meadows, Enticott, Inder, Russell, & Gurr, 2015). There is a lack of psychologists in rural areas, with three-quarters of psychologists employed in Major Cities in 2014, the equivalent of 92 full-time equivalent psychologists per 100,000 populations, and only 55 FTE in Inner regional, 41 in Outer regional, and 30 in Remote and Very Remote Areas (Australian Institute of Health and Welfare, 2016b). Given lack of psychologists in rural areas nationally, and that only approximately 11.5 % of psychologists in South Australia work rurally (AIHW, 2014), rural GPs may also have

less exposure to psychologists, which may affect their perceptions of the profession. These features of rural practice, particularly psychologists' reliance on GPs in rural areas, mean that it is important to investigate the relationship between GPs and psychologists. The present study aimed to explore rural GPs perceptions of psychologists and experiences working with psychologists in rural areas.

3.2.3 Method

Participants

A qualitative design was considered most appropriate given limited previous research and the need to elicit detailed, rich data. Following ethics approval from University of Adelaide Human Research Ethics Committee (HREC no. 13/42), semi-structured interviews were conducted with thirteen participants (eight rural general practitioners and five rural general practice registrars) between May 2013 and August 2014. Rurality was defined using Australian Standard Geographical Classification (ASGC) rural and remoteness classes of Inner Regional, Outer Regional, Remote and Very Remote, excluding Major Cities (AIHW, 2004).

A purposive sampling approach was employed. Participants were recruited from the Rural Doctors Workforce Agency (RDWA) Annual Conference, held in Adelaide in May 2013. The first author attended the conference, with participants invited to take part by RDWA staff at the registration desk. Follow up emails were sent on behalf of the researchers to RDWA members on three occasions. Four participants were interviewed in-person at the conference, with three conference attendees participating in telephone interviews at a later date. One participant responded to the post-conference email. The remaining four participants were recruited via snowball sampling and via contacts of the first and second author, and were all interviewed by telephone. The first

author conducted all interviews, ranging in length from 13 to 47 minutes ($M = 26$, $SD = 10.08$). Data saturation was achieved by the thirteenth interview, with no new themes emerging (Baker & Edwards, 2012).

Participants ($N = 13$) ranged in age from 28 to 65 ($M = 43.58$, $SD = 12.35$). Six participants were women and seven were men. Eight were fully qualified General Practitioners and five were General Practice registrars. Years of experience as a registered medical practitioner ranged from two to thirty-six years ($M = 13.7$, $SD = 13.3$). Registrars ranged in experience from first to third year registrar training. GPs ranged in experience from 4 to 35 years as fully qualified GPs. Eleven participants were trained in Australia, and two were overseas trained (one completing GP training in Australia as an international medical graduate, the other having completed GP training overseas). Participants' locations represented almost all regions in rural and remote South Australia, including the Eyre Peninsula, Yorke Peninsula, the Riverland, Murraylands, South East, Mid-North, Far North and Fleurieu regions, and captured the full range of ASGC categories included in the study of Inner Regional, Outer Regional, Remote and Very Remote (excluding Metropolitan) (AIHW, 2004).

Procedure

All participants gave verbal consent at the time of interview. A series of open-ended prompt questions were asked flexibly (being omitted, adapted or elaborated as necessary). A focus group was conducted with fifth year medical students to pilot the prompt questions before commencing interviews. Demographic questions including participants' training and work history (including rural and urban experience) were included in all interviews. Interview questions focussed on GPs' experiences working with psychologists, including barriers and facilitators to referral, GPs' views on psychologists' skills, and GPs' own training and expertise in mental health.

All interviews were digitally recorded and transcribed verbatim by the interviewer. Transcripts were emailed to participants, allowing for a process of participant validation. Data saturation was achieved, with no new themes emerging by the final interview. Data were analysed using thematic analysis as outlined by Braun and Clarke (2006, 2013). The first author conducted the analysis. A theoretical approach, involving engagement with the literature regarding the relationship between psychologists and GPs was employed. There are six phases to Braun and Clarke's (2006, 2013) approach. In the first phase, familiarisation with the data, the first author transcribed all interviews, taking note of initial ideas and preliminary themes. Initial semantic codes were then generated through systematically working through the entire data set, with exceptions and inconsistencies noted. The semantic codes were then collated into themes and sub-themes, which were checked against extracts across the entire data set. Interviews were analysed using a method of constant comparison, with each interview transcribed and subjected to preliminary analysis before the following interview. The maintenance of an audit trail enhanced rigour and trustworthiness of findings. The second author checked themes against the raw data, as a further method of increasing rigour and trustworthiness.

3.2.4 Results

Three main themes were identified in terms of how rural GPs perceived rural psychologists: Psychologists are helpful and useful, Working with psychologists can be challenging, and Psychologists are not well understood (see Table 1).

Psychologists are helpful and useful

Support in reducing GP workloads

All but one of the thirteen GPs regularly referred to psychologists when available. Psychologists were largely considered to be a support for rural GPs, particularly in reducing large mental health workloads.

.... before they [psychologists] were there.... in the past I've had to do CBT myself which is a pain in the bloody arse because it takes a lot of time.... psychologists just make for much easier management and I think – doctors can't do all things to all people, it's not possible, and the psychologist certainly allows us to get on and do our job, triage, to help, and to plan.... I find it really difficult to practice medicine without them
(Participant 12)

Psychologists were also considered to be of value in working together with GPs as a 'team' where psychiatrists were not available.

...because as I say because of the limited resources - the psychologists are of of ah a real help and real support. At the same time the psychologists because of the unavailability of the psychiatrists as well like - GPs - are good support for them as well in terms of the need to be on medication so the GP can at least administer the medication and organize further treatment as necessary or can expedite the referral to the psychiatrist....so they kind of work hand in hand....and they - they - their collaboration and interaction is really important and especially in country settings (Participant 2)

GPs with a special interest in mental health indicated they also used referral to psychologists as a way to manage their workloads, as even when

they may have had the interest or skills to work with clients, they may not have the time.

I do a lot of my own psychology work....I'm sort of fully trained in CBT, motivational interviewing and other sort of techniques, and I'm a sexual therapist so I actually do all my own ah - psychological work, if I'm overloaded well....then I'll certainly do a GP mental health plan and refer (Participant 1)

The GP who did not regularly refer reported that other local GPs had mentioned that psychologists in their rural area seemed unwilling to work with "challenging" presentations, hence the GP did not think it was worth referring and had only referred one patient [via the Medicare Local, now known as Primary Health Network] since recently commencing work in that rural area.

...the anecdotal experience that I have with discussion with other GPs - is that they seem very very reluctant, whether it's the psychologists or the Medicare locals that are - being the triage facility, the feedback that I'm getting over and over, and that's probably why I've only referred one patient....is that they are not keen or won't take on anything that's - I guess - perceived as a little bit hard.... (Participant 4)

Education for GP

Working with psychologists was considered a good educational opportunity for GPs, particularly new GPs and registrars, in enhancing their knowledge of psychological approaches.

.... [communicating with psychologists] is not only good for the patient and for me to know where they're up to but also sort of education for me.... so I can say oh ok so this is what you went though, and um this is what you think's important and that then informs me for next.... I'll say ah ok this is what psychologists do and this is um how they go about things (Participant 5)

Working with psychologists can be challenging

Barriers to access

A number of challenges with working with psychologists in rural areas were highlighted, including difficulty accessing psychologists and long waiting times. It was noted that long waiting times deterred GPs from referring patients needing more urgent support.

Generally [access is] fairly poor.... in in um - bigger areas obviously it's a little bit better but in remote areas it's ah often quite poor and ah variable.... Psychologists sit in the leafy green suburbs ah - of Australia by and large (Participant 1)

The inconsistency of access to psychologists was thought to mean rural GPs can become used to managing on their own, and even when there is a psychologist available they may not be in the 'habit' of referring. Therefore, a barrier to accessing psychologists was the GP 'thinking of it'.

...I guess having started out 20 years ago without having had access to those sort of supports, often the biggest barrier is me thinking of it.... that as a country GP you often get used to just battling along and doing the best that you can.... when there are additional resources you love

tapping into them but they sometimes come and go....and so you don't always necessarily think of it even when it is available because you've got used to not having it available....if that makes sense? (Participant 7)

Even when psychologists are available, the lack of referral choice compared to working in the city was considered problematic. Accessing specialised treatments in rural areas was also described as difficult.

...you have your – referring pathways, regardless of where you are – I suppose the beauty of the city is that you get to choose your referring pathways whereas in the country I just have to have a look at who I've got who is available to me....often you don't have those choices because you you know you take what you've got um and we're very grateful for what we've got, but we certainly don't have enough (Participant 11)

Fluctuations in availability of mental health practitioners including psychologists was considered to be challenging.

...also the high fluctuation not just psychologists but also other mental health workers there seems to be generally huge fluctuations there um – ah there's not an awful lot of continuity there (Participant 13)

The need to make the best use of often limited psychologists in rural areas was noted, with one GP reporting that some patients wouldn't be referred if they were thought to be 'beyond help' as they would 'burden the system'.

Some people - some people - there's a few people who are just beyond help so you don't want to burden the system down, you do what you

can for whoever you can. You've got to have some reality as well - um
- does a psychologist see three people over ten or twelve weeks or do
they get bogged down with one and get nowhere....so you - really
need to have a little bit of flexibility and common sense about referrals
(Participant 1)

Although GPs referred under the Better Access program, the ability of patients to pay gap fees (when applicable, as these were reported to be often waived) and to pay for further sessions if requiring more than ten, meant that cost was another barrier. Costs associated with travelling to see a psychologist were described as another barrier. Stigma associated with seeing a psychologist in a rural area was described as a reason some patients may prefer to travel.

...in [rural SA region] some people are a little bit reluctant certainly to see ah particularly psychologists that they see in the community or that they know....even though you know you assure them of confidentiality still sometimes people refuse to go to um psychologists in [rural SA region] and we might have to send them to [rural SA region closer to Adelaide] or a little bit further afield (Participant 10)

Referring to a visiting (fly-in, fly-out or drive-in, drive-out) psychologist was another way GPs managed the stigma perceived by some patients.

.... [some patients] would prefer to see someone who's not from town.... They like the idea of someone who's coming in who kind of they won't - won't see at the shopping centre (Participant 3)

While the Better Access program was noted to have increased access to psychologists in some areas, the bureaucratic requirements were noted to be tedious and at times unnecessarily time-consuming.

...it is a bit of a 'tick and flick' to meet the government's requirements... I suspect I probably do a less useful referral by using that template than if I was just writing a letter to a colleague

(Participant 7)

Finding time for the double appointment recommended to provide a GP mental health care plan was noted to be particularly challenging in rural areas

.... for [the] mental health care plan they would need a 20 to 30 minute appointment.... there is sometimes a delay to get that appointment so getting a thirty minute appointment well for me there would be a six week wait now....so that the patients now for the first consultation I would probably see them then probably five to six weeks later for a mental health care plan and then they have a longer wait even to get the first session um going (Participant 13)

It was noted that while the Better Access program had helped with increased access to psychologists in larger rural areas, GPs in more remote areas may struggle to find psychologists to refer to under the scheme due to the difficulty of recruiting and retaining psychologists in these areas.

... it's all very well for us here in [larger rural SA region] we've got you know psychologists in every town.... But if you lived in Roxby Downs or Ceduna or even in Renmark or Naracoorte I've got no idea how accessible psychologists are in those places. It's all very well to

have a federal government program here's the money for you to go and see a psychologist and if there's no psychologist what do you do? (Participant 9)

When psychologists were available, the lack of sessions under the Better Access program, capped at 10 at the time of interview, was described as problematic.

... there's only so much you can do in six to ten sessions (Participant 9)

Barriers to communication

Expectations and experiences of communication between GPs and psychologists was a prominent theme. Actual experiences of communicating with psychologists were mixed. Some GPs reported excellent communication and feedback from psychologists. However, many GPs had less consistent experiences.

...in our situation where we are in [rural SA town], communication is generally not that great and I think could probably be much better (Participant 13)

Expectations included being given a limited summary at the start of treatment and a full summary at the end, to ensure that both the psychologist and GP agree that the patient is receiving the appropriate treatment. The importance of the GP and psychologist being 'on the same page' early was emphasised. The inclusion of a plan for treatment and outline of what has been achieved was considered important.

...all of the patients that I refer to psychologist I actually expect the psychologist to write back what their assessment is.... because that

really helps immensely in um kind of following and managing the patient further....and to see which part should be going further like getting more sessions or um - referral to psychiatrist (Participant 2)

Good communication was also considered important in assisting the GP to reinforce the work the psychologist is doing with the patient.

Yeah I think a letter would be quite useful just in terms of um - it allows me to then sort of reinforce? so then if I'm getting a patient coming back in between, it's good for me to be able to tell them you know your psychologist is doing this this and this....and it's important and we need to keep doing that.... (Participant 3)

Having psychologists co-located in the same practice or building was considered advantageous in terms of communication and building relationships.

...certainly having psychologists working within the rooms has been great both with accessibility for patients and also with collegiate support, being able to discuss cases, either that we had both mutually seen or just to get some ideas around different approaches as well.... it's a little bit more distant um when the service is provided 50ks away.... I do get a summary of care but I don't get the casual corridor conversations that add a lot of depth to those sorts of clinical interactions (Participant 7)

Another benefit of co-location was the ability to share electronic notes to enhance communication between the GP and psychologist.

...in fact the good thing about her working in our clinic is that she can actually access our um clinical software and enter her notes in - directly into that. So I can actually see all of her notes um when she's seen a

patient so that I think helps with our continuity of care between visits

(Participant 6)

The challenges of communicating with visiting psychologists, compared to those who live and work in the rural area, were noted.

Oh haven't worked very closely with psychologists unfortunately I would like to be able to work a little bit more closely with them though...um it's hard I suppose when we're - I mean we're so busy in our work days to actually be able to meet up with them and perhaps have a chat about our patients - joint patients occasionally would be nice but um - time is such a limiting factor....with that so um - I mean I'd be lucky to catch up with our visiting psychologist in the corridor once a fortnight um at the moment (Participant 6)

While the problems associated with the Better Access program were noted, the requirement for psychologists to write a report back to the GP once treatment had commenced was considered to potentially enhance communication.

.... suppose the Better Outcomes in Mental Health actually makes things better to a degree because.... a psychologist will have to write to you to ask you to review the patient and see if you think they need another five visits....so at that point they'll often write a report so that's good (Participant 11)

Psychologists are not well understood

Understanding of training

GPs' understanding of psychologists' training varied considerably. Most were not confident in their explanation. Two GPs indicated they had very little idea regarding how psychologists were trained.

Um - it seems to be a little bit varied um - I've had a little bit to do with Australian trained psychologists and I've had a little bit to do with overseas trained....um - certainly the skill set is diametrically opposed, and some are very good and some are very not - look I haven't taken enough interest to be quite fair. I've got - I've got no idea. I don't even know how long they train for (Participant 4)

It was suggested by one participant that there are a 'spectrum' of courses one can undertake, from TAFE to university, in studying psychology.

Yeah um I guess probably I know that there's sort of a spectrum um for psychology in particular you can um - there are university um bachelor degrees, I believe that there's also probably TAFE sort of courses and certificates in you know counselling and psychology (Participant 5)

Most participants were aware a university degree is required to practice as a psychologist, although most thought three or four years of training in total were required.

Um how do you mean as in university or [CS: Yeah] what is it three or four years isn't it? Is it three years for a basic degree a year of honours and then a year of clinical? (Participant 11)

Two GPs acknowledged that psychologists may not necessarily do clinical work, and may work in research, or other areas of practice endorsement such as organisational psychology. The difference between clinical psychologists and other psychologists was not well understood.

I don't know the fine details between clinical psychologists and ordinary psychologists.... because some of them obviously operate in different environments (Participant 12)

Almost all participants reported that their exposure to information about psychologists, mental health and psychological treatment was limited in both medical school and their GP training. Most GPs (aside from two participants who reported having a special interest) reported having limited specific training in mental health, despite mental health being a reasonably large proportion of their workload. Most GPs mentioned the 6 hour General Practice Mental Health Standards Collaboration (GPMHSC) training enabling them to claim the higher rebate Medicare items for the GP Mental Health Care Plan as being the only specific training they had undertaken in mental health.

Um apart from what's um – what was required for us for GPs to um to be able to charge the mental health item numbers I haven't had any specialist training (Participant 9)

Explanation of psychology to the patient

GPs' explanation of psychology to the patient highlighted GPs' perceptions of psychologists' skills and knowledge. The detail and amount of information provided to patients being referred to a psychologist varied. It was acknowledged that the emphasis the GP places on seeing a psychologist may affect the patient's likelihood of seeing a psychologist.

...it does depend on their motivation to get help.... uh and it also comes down to how much emphasis we place on it for them.... if we say to the patient - I think this is very important for you.... and stress that then there's more chance that they will go and have that input (Participant 5)

Explanations included a focus on psychologists addressing thoughts and emotions and building skills. The importance of having a good 'match' between psychologist and client was also referred to in GPs' explanations to the patient. Many explanations involved distinguishing between psychology and psychiatry, which was described as a continuing source of confusion for patients. The need to explain that psychologists do not prescribe medication was emphasised. One GP employed the analogy of 'training for the mind' in his explanation of what psychologists do.

....when you tell them that there are exercises that psychologists can do, that can help you can control of those, and I use the analogy if you want to run a marathon, you may have to do three to six months' training to get in shape....if you want to get into shape from say OCD, you're going to have to do an intensive three to six months not physical but mental work....And most people like to use those analogies to sort of – I've had nobody question that (Participant 12)

Many of the GPs were not confident in their explanation of psychology, and acknowledged they had not spoken to a psychologist about what psychologists actually do.

Yeah um (laughs) you might say this is completely wrong....and I haven't actually talked to a psychologist about what they do.... I also then try and - I say sometimes a lot of it is just talking and you listening to themselves say stuff um - I'm not sure whether that - I'm not sure whether that's much of what you guys do!...I sort of say a lot of it is even if you know in the in between times from counselling and psychology if you have a good friend or someone that you can just talk to because a lot of it is just letting yourself say things and hearing it back yourself I guess (Participant 5)

How do GPs assess psychologists' skills?

Given the knowledge gaps in understanding of psychologists' training and expertise identified, it was highlighted that GPs rely on a number of factors in developing their own assessment of a psychologists' skills. This included the quality of correspondence, the patient's perspective of the encounter, and scores on outcome measures.

....at the moment all I'm relying on is the patient's point of view....and that happens with the medical specialties as well too.... if they come back from the cardiologist I'll say oh how did you get along with them were they nice? Oh yeah they were really good well you know I'll remember that.... (Participant 5)

Desired outcomes of seeing a psychologist included the patient having a better understanding of their situation and ability to cope, the GP being able to reduce medication use with a reduced risk of relapse, and the patient to be able to report strategies and skills they had developed to manage their particular issue.

....I've had them come and say oh I'm feeling better because I've seen the person....but if you ask in what way are you feeling better, they can't really define um what's betterbut if they come back and say well I've got strategies like if I'm going to the mall and I have a panic attack my psychologist says I should focus on this and that and the other – then I know they are actually doing something and they are retaining something out of those sessions (Participant 8)

3.2.5 Discussion

This study employed qualitative methods to explore the experiences of rural GPs regarding working with rural psychologists. Three key themes were identified in terms of how psychologists were perceived by rural GPs: Psychologists are helpful/useful; working with psychologists can be challenging; and psychologists are not well understood. Consistent with previous research with metropolitan GPs and GPs from larger regional cities (Beel et al., 2008; Dempsey & Donaghue, 2009; Pryor & Knowles, 2001), rural and remote GPs held generally positive attitudes towards psychologists. Psychologists were considered to provide support in reducing rural GPs' large workloads, with the team of a psychologist and GP thought to provide essential services where psychiatrists were unavailable. It was noted when psychologists are not available, GP workloads increase. Psychologists were also thought to be of value in

providing education to GPs about psychological approaches, both directly and indirectly through written communication and casual conversations. Only one GP did not regularly refer to psychologists, citing a perception among local GPs that psychologists may be unwilling to work with “challenging” presentations.

Consistent with previous research (Dempsey & Donaghue, 2009; Pryor & Knowles, 2001) most of the participants were uncertain about the qualifications and expertise of the psychologists they referred to, with some confusion about how psychologists are trained. Many GPs were not confident in their explanation to their patients of what psychology may involve. As highlighted by participants, the way in which GPs present psychology to their patients may directly influence the likelihood of the patient choosing to attend an appointment with a psychologist. In a recent survey of rural and urban community members regarding their perception of psychology, 28.7% of rural participants indicated their GP was a source of knowledge to them about psychology (Sutherland, Chur-Hansen, & Winefield, 2016b). It is therefore of benefit for psychologists to ensure GPs have access to relevant and up to date information about psychologists. This suggests a need for initiatives for GP education. Since completion of the present study the Australian Psychological Society (APS) has established a number of websites aimed at providing information about psychology and psychologists to the public (APS, 2016). A similar resource specifically targeted for GPs may assist in reducing these knowledge gaps.

Knowledge gaps also may reflect a lack of content relating to mental health and psychology in GP training. Despite their large role in the provision of mental health care, particularly in rural areas, most participants highlighted the limited specific training they had received in mental health (both in medical school and as general practice registrars). In 2004, Winefield and Chur-Hansen discussed the potential for

interprofessional education (IPE) and collaboration between medical students, interns, registrars and clinical psychology students as a method of increasing awareness of each other's professions, in the lead-up to the introduction of the Better Outcomes scheme. In terms of rural health professional education, initiatives such as the National Rural Health Student Network (NRHSN), which supports rural health clubs at each university, provide one of the few pathways for students from different health professions to interact through conferences and other learning opportunities. While many universities have established rural health schools, these tend to focus on the provision of training for rural medical students, and opportunities for psychology and other allied health students to engage with medical students in this setting are limited. Increasing opportunities for medical and psychology students to collaborate during their training could be one method of addressing these knowledge gaps.

In terms of barriers, consistent with the research demonstrating the lack of psychologists in rural areas, most participants perceived a lack of access to psychologists. It was noted that inconsistency in access can also be a barrier to referral, with GPs often becoming 'out of the habit' of referring to psychologists, even if a psychologist may be available. This reinforces the well-documented need for greater access to psychologists in rural areas, as well as findings from previous research with psychologists (Sutherland & Chur-Hansen, 2014; Sutherland, Chur-Hansen, et al., 2016) emphasising the importance of rural psychologists developing networks with rural GPs, as the current study suggests GPs may not always be aware of psychologists in their area. Also related was the finding that rural GPs may triage or screen patients as appropriate for psychology with the lack of access and concerns about wait lists in mind, with several GPs mentioning the need to not 'burden the system'. This reinforces

the importance of GPs having a thorough understanding of what psychologists can offer to make appropriate referral decisions.

Some challenges with communicating with psychologists in rural areas, particularly visiting rural psychologists, were noted. The mixed experiences of GPs regarding communication provides important information for psychologists regarding GPs' expectations. Suggested solutions regarding improving communication included co-locating psychologists in GP practices and sharing electronic case note systems. Collaborative care between psychologists and GPs and co-locating psychologists in GP practices has been demonstrated to result in positive outcomes for clients (Vines, 2008; Vines et al., 2004). The present study provides support for this model in also providing professional support for GPs. Other rural-specific considerations noted about working with psychologists as a rural GP included the possible increased importance of the relationship between psychologists and GPs to provide both 'arms' of treatment (medication and psychological intervention) in the absence of psychiatrists. This reflects findings from research with psychologists (Sutherland & Chur-Hansen, 2014; Sutherland, Chur-Hansen, et al., 2016) which has also highlighted the importance of the relationship between GPs and psychologists in providing professional support to each other in the absence of other services. The finding that GPs assess psychologists' skills on the basis of the perceived quality of their correspondence reinforces the need for consistent and thorough communication with GPs.

The bureaucratic requirements of GP mental health care plans under the 'Better Access' scheme have been highlighted as problematic for GPs (Dempsey & Donaghue, 2009). The present study suggests that while some GPs found the requirement of a mental health care plan useful in encouraging communication with psychologists, there were particular barriers for GPs in rural areas in meeting the requirements of the

program, including long wait times for the double appointment required to develop a mental health care plan. The Better Access program has been criticised for failing to reach those in rural and remote areas (Meadows et al., 2015), with a demonstrated lack of uptake compared to urban areas. This study suggests that the requirements of the scheme may be further restricting access to psychological services for rural and remote patients due to difficulties in obtaining a timely double appointment with a GP. This supports the recommendation of the Australian Government National Review of Mental Health Programmes and Services to make the provision of a GP mental health care plan optional, providing GPs with the option of referring via a letter (similar to referring to a medical specialist) (National Mental Health Commission, 2014). The findings of the present study suggest removing the requirement for GPs to prepare a mental health care plan could assist rural and remote patients to access psychology in a more timely manner given the often long wait for a double appointment to complete the plan before they can see a psychologist.

Limitations of the present study include that due to the convenience sampling method, GPs with more positive views of psychology or an interest in mental health may have chosen to participate, however at least one participant did not regularly refer to psychologists. The first author's position as a provisional psychologist at the time of interviewing may have inhibited participants from discussing more negative views towards psychology, however several participants did still share negative views, for example regarding poor communication from psychologists. The findings of this study may be state-specific, as South Australia has particularly limited access to rural psychologists and psychiatrists, with only 11.5% of South Australian psychologists working in rural areas, compared to the national average of approximately 25% (Australian Institute of Health and Welfare, 2014, 2016b). Future research should

investigate GP perceptions of working with psychologists across states. The study focused on GPs' experiences of working with psychologists in terms of direct mental health service provision. As findings suggested GPs may have limited understandings of the difference between 'clinical' and 'other' psychologists, future research may focus on GPs' understandings of psychology in other contexts. As a qualitative study the present study provides insight into rural GPs' experiences. Future quantitative research may directly examine whether there are differences between rural and urban GPs in terms of how they perceive psychologists (such as in terms of accessibility and helpfulness). While Pryor and Knowles (2001) did not find any significant differences between groups in their survey of metropolitan and regional GPs, their study did not include more rural and remote GPs, and was conducted prior to the introduction of the Better Outcomes and Better Access schemes.

Given rural GPs' significant workloads, and the fact that many indicated their training in mental health and time available for mental health consultations was minimal, it may be advantageous for rural GPs and psychologists to work more closely together. Previous research has demonstrated good outcomes for clients when collaborative models of care between psychologists and GPs are employed in rural areas (Vines et al., 2004). The present study suggests there may also be professional benefits for rural GPs, including reduced workloads and increased educational opportunities, although greater support for GPs in understanding what psychologists may offer their patients is required.

3.2.6 Table

Table 1. Themes and subthemes

Theme	Subtheme
Psychologists are helpful/useful	<ul style="list-style-type: none">- Support in reducing GP workloads- Education for GP
Working with psychologists can be challenging	<ul style="list-style-type: none">- Barriers to access- Barriers to communication
Psychologists are not well understood	<ul style="list-style-type: none">- Understanding of training- How GPs explain psychology- How GPs assess psychologists' skills

Chapter 4 – What do GPs need to know about psychologists? 6 top tips

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Authors and affiliations:

Carly Sutherland¹, Anna Chur-Hansen¹, Helen Winefield¹

¹School of Psychology, Faculty of Health Sciences, University of Adelaide, Adelaide, South Australia, Australia

4.1 Statement of contributions

Statement of Authorship

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Principal Author

Name of Principal Author (Candidate)	Carly Rose Sutherland
Contribution to the Paper	Conducted literature review, wrote manuscript.
Overall percentage (%)	85%
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature	Date 29/11/2016

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Anna Chur-Hansen
Contribution to the Paper	Supervised development of the work, helped to evaluate and edit the manuscript.
Signature	Date 30.11.16

Name of Co-Author	Helen Winefield
Contribution to the Paper	Supervised development of the work, helped to evaluate and edit the manuscript.
Signature	Date 30/11/16

4.2 Paper

4.2.1 Abstract

Background: Mental health care is an increasing component of GPs' workloads, with approximately one in eight GP consultations now mental health related. The Better Access program has increased access to psychologists and has increased GP-psychologist collaboration, but many GPs continue to report gaps in their knowledge about how to work with psychologists most effectively.

Objective: This article highlights 6 top tips for GPs for working with psychologists.

Discussion: We discuss practical tips and provide information including how psychologists are trained and regulated, how GPs can explain to their patients what psychologists do, how to communicate with psychologists under Better Access, and information on accessing psychologists, including in private practice.

4.2.2 Paper

The role of GPs in mental health care

GPs are the first health professional contact for most Australians with mental health problems (Beel et al., 2008). Approximately one in eight GP consultations are mental health related (Britt et al., 2015). Medication is the most common form of GP management (63.3 per 100 problems managed), with referrals given at a rate of 15.1 per 100 mental health problems. Referral to psychologists was most common (7.4 per 100) followed by psychiatrists (1.9 per 100) (Britt et al., 2013), although in rural and remote areas a severe workforce shortage for these professionals exists (Australian Institute of Health and Welfare, 2016a, 2016b).

In recognition of the role of GPs in mental health care, several policies have been developed to increase access to psychological treatments through GP assessment and referral including the 'Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS' (Better Access) scheme, introduced in November 2006 (Dempsey & Donaghue, 2009). The scheme has seen a significant increase in the uptake of psychological services, with the estimated population treatment rate for mental disorders in Australia increasing from 37% in 2006-2007 to 46% in 2009-2010 (Pirkis et al., 2011; Whiteford et al., 2014).

The first author is a psychologist working in a rural multidisciplinary mental health inpatient unit. As part of her training she completed a PhD involving interviews with rural GPs regarding their perceptions of and understanding about psychologists. From the research it became clear there was a need for updated and accessible information for GPs about working with psychologists, particularly for rural GPs who generally have less access to psychologists. The following article highlights 6 essential tips for GPs.

1. How are psychologists trained and regulated?

Although GPs tend to report positive attitudes towards the value of psychologists, GPs commonly report confusion regarding understanding psychologists' training and expertise (Beel et al., 2008; Dempsey & Donaghue, 2009; Pryor & Knowles, 2001; Sutherland, Chur-Hansen, & Winefield, 2016a). This can make explaining psychology to patients challenging. Since 2010, all psychologists in Australia are registered with the Australian Health Practitioner Regulation Agency (AHPRA) (previously psychologists were registered with state boards). All psychologists have a minimum of six years' training. Following four years' undergraduate study, psychology trainees may commence an internship program (a period of supervised practice) or a postgraduate

degree (Masters, Doctorate, or combined Masters/PhD), during which time they are referred to as provisional psychologists. Psychologists at present do not have specialist registration, but following completion of a specific postgraduate degree and a supervised registrar program may hold an *area of practice endorsement* in one of nine areas: clinical, clinical neuropsychology, community, counselling, educational and developmental, forensic, health, organisational, and sport and exercise psychology. The title *psychologist* is protected under national law. Psychologists may also be members of the Australian Psychological Society (APS), the main professional organisation (equivalent to the Australian Medical Association), but are regulated by the Psychology Board of Australia (equivalent to the Medical Board of Australia).

2. What is the difference between a psychologist and a counsellor?

There are no legal restrictions on the use of the titles counsellor, therapist or psychotherapist in Australia, hence experience and expertise may vary considerably (Australian Psychological Society, 2016b). Individuals using these titles are not bound by the same obligations as registered health professionals. It is therefore important for GPs to establish the credentials of any counsellor, therapist or psychotherapist. Counsellors and psychotherapists may be members of voluntary organisations such as the Psychotherapy and Counselling Federation of Australia (PACFA) or Australian Counselling Association (ACA) which hold membership standards. Counsellors and psychotherapists cannot provide services under Better Access. In addition to psychologists, appropriately accredited social workers and occupational therapists may provide services under Better Access, but must be certified as meeting specific mental health practice standards to be eligible.

3. When should I refer to a psychologist?

Research indicates that GPs consider their own skills and workload in referring to a psychologist (Sutherland, Chur-Hansen, et al., 2016a). General guidelines for when to refer to a psychologist include:

- When GPs do not feel they have the time or expertise to manage a patient
- When the patient is interested in engaging with a psychologist
- When the evidence suggests psychological intervention is needed

Current best practice indicates psychological intervention should be considered a first line treatment for most common mental health conditions seen in primary care, including anxiety (National Institute for Health and Care Excellence, 2014), posttraumatic stress disorder and acute stress disorder (Phoenix Australia: Centre for Posttraumatic Mental Health, 2013), sleep disorders (Cunnington, Junge, & Fernando, 2013), and mild-moderate depression, and should be used in combination with medication for moderate-severe depression (Malhi et al., 2015). For more severe mental health problems such as bipolar disorder and schizophrenia, there is an evidence base for psychological intervention in conjunction with appropriate medical management (Galletly et al., 2016; Malhi et al., 2015).

Under the Better Access scheme patients must have an ‘assessed mental disorder’ (the scheme excludes dementia, delirium, tobacco use disorder and intellectual disability) (Australian Government Department of Health, 2012). The guidelines are informed by the WHO ICD-10 Diagnostic and Management Guideline for Mental Disorders in Primary Care (World Health Organization, 1996) (see Box 1).

Box 1. Mental disorders eligible for treatment under the Better Access scheme

- Anxiety disorders (including obsessive compulsive disorder, phobias, and panic disorder)
- Adjustment disorder
- Attention deficit disorder
- Bereavement disorder
- Bipolar disorder
- Conduct disorder
- Co-occurring anxiety and depression
- Depression
- Eating disorders
- Substance use disorder (including alcohol and other drugs)
- Posttraumatic stress disorder (PTSD)
- Psychotic disorders (including schizophrenia)
- Sexual disorders
- Sleep problems

Examples of appropriate referrals under Better Access therefore include adjustment disorders, for example living with a chronic illness, bereavement disorders, sleep problems, and problems associated with disordered eating (including binge eating).

4. How do I explain to my patients what psychologists do?

Many GPs report uncertainty regarding how to explain psychology and psychologists to their patients (Sutherland, Chur-Hansen, et al., 2016a). The emphasis

GPs place on the importance of seeing a psychologist is related to the likelihood of the patient attending an appointment (Sutherland, Chur-Hansen, et al., 2016a). It is therefore important for GPs to have clear and relevant information about what psychologists do. It is important to emphasise to patients that psychological treatment:

- Is goal focused (with goals developed in collaboration with the client)
- Uses evidence based interventions such as Cognitive Behaviour Therapy
- Requires active participation from the client
- Focuses on problems in current functioning

It may be useful to explain how psychologists and GPs work together under Better Access, and to explain the difference between psychologists and psychiatrists, as confusion persists in the community. Box 2 is an example of how GPs could explain what psychologists do to a patient unfamiliar with psychologists:

Box 2. Example of how GPs can explain psychologists to their patients

Psychologists use evidence-based interventions to help people experiencing difficulties in their lives. This means their treatments have been researched and demonstrated to work with people experiencing the problem(s) you are experiencing. The psychologist will work with you to develop goals and help you learn and practice skills and strategies to help you function better in your life. Psychologists have at least six years' training and are skilled in helping people manage their thoughts, emotions and behaviours. Psychologists are different to psychiatrists in that they are not medical doctors and do not prescribe medication.

5. How do I communicate with psychologists?

GPs report confusion regarding expectations for communicating with psychologists under Better Access (Sutherland, Chur-Hansen, et al., 2016a). A summary of the requirements for psychologists is provided in Box 3.

Box 3. Summary of communication requirements for psychologists seeing clients under the 'Better Access' initiative.

The psychologist must provide a report back to the referring practitioner:

- On completion of the initial course of treatment (a maximum of six services, but may be less depending on the nature of the referral)
- On completion of any subsequent course of treatment which forms the end of an episode of treatment.

The psychologist's report should include information about:

- Assessments carried out
- Treatment provided
- Recommendations for the future management of the client's disorder

GPs may find psychologists' reports useful for enhancing their own understanding of psychological treatments (Sutherland, Chur-Hansen, et al., 2016a). Similarly, psychologists value GPs' thoughts and feedback about their patients' progress, particularly in rural areas where GP support is considered vital in managing professional isolation and challenging cases (Sutherland & Chur-Hansen, 2014; Sutherland, Chur-Hansen, et al., 2016). Collaborative care between psychologists and GPs, and co-locating psychologists in GP practices, have been demonstrated to result in positive outcomes for clients (Vines et al., 2004).

Previous research with GPs has indicated mixed experiences of communicating with psychologists, with some GPs reporting receiving limited information back, or not in a timely manner (Beel et al., 2008; Sutherland, Chur-Hansen, et al., 2016a). While both GPs and psychologists experience challenges with increasing workloads and professional requirements, good communication is essential to improving patient outcomes. GPs and psychologists may find brief telephone conversations enhance communication.

6. How can my patients access a psychologist? Where can I find them?

The number of sessions patients are eligible for is summarised in Box 4.

Box 4. Summary of sessions available under the 'Better Access' initiative.

- Up to 10 individual sessions in a calendar year (1 January – 31 December), with a GP review after the initial 6 sessions to determine if a further 4 sessions are required.
- Up to 10 group therapy sessions in a calendar year (1 January – 31 December) where such services are available and seen as appropriate by the referring doctor and psychologist.

The provision for an additional 6 sessions under 'exceptional circumstances' ceased on 1 January 2013.

Currently, the rebate for psychologists under Better Access is \$84.80 per consultation for registered psychologists and \$124.50 for clinical psychologists. The APS recommended fee is \$238 for a standard psychological consultation of 45-60 minutes. So although many psychologists bulk bill, some patients may be charged a gap fee. Patients may choose to see a psychologist without a Better Access referral and pay the full fee. Some private health funds also cover psychological treatment. Some

psychologists may provide services under other Medicare items, including the Chronic Disease Management, Helping Children with Autism, Better Start for Children with Disability, and Pregnancy Support Counselling items.

GPs may also be able to refer patients to psychologists under the Access to Allied Psychological Services (ATAPS) program. ATAPS is intended to target population groups that have difficulty accessing mental health treatment, including rural and remote patients, hence patients must not be referred to both Better Access and ATAPS in a calendar year unless their circumstances (e.g. financial) have changed (Australian Government Department of Health, 2015). Patients are eligible for a maximum of 12 individual sessions and 12 group sessions per calendar year (six sessions with an option for a further six following GP review). ATAPS is funded through the Primary Health Networks (PHNs) hence access will vary in different regions.

Reliable information regarding psychologists can be accessed via the APS website www.wearepsychology.com (Australian Psychological Society, 2016c). The 'Find a Psychologist' service for locating psychologists in private practice can be accessed at <http://www.psychology.org.au/FindaPsychologist/> or by telephone 1800 333 497. In addition to private practice, psychologists work in public community and inpatient mental health and health settings, and access to psychologists may be possible through community mental health teams, although this varies considerably across Australia. Research indicates GPs tend to refer to psychologists they know and consider trustworthy (Dempsey & Donaghue, 2009; Sutherland, Chur-Hansen, et al., 2016a). While this is an excellent way to build collaborative professional relationships, the Find a Psychologist service may be of particular use for GPs who have yet to develop

relationships with psychologists in their area, or new GPs and registrars who would like to build referring relationships with psychologists.

Summary

Previous research has demonstrated good mental health outcomes for clients when psychologists and GPs collaborate (Vines et al., 2004). GPs report the value of psychologists in reducing GP workloads and providing professional education and support. The tips presented provide a concise and up to date summary for GPs of the essential information needed to work effectively with psychologists to improve patient outcomes.

Chapter 5 – Rural and urban Australian community members’ knowledge and understanding of psychologists

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Authors and affiliations:

Carly Sutherland¹, Anna Chur-Hansen¹, Helen Winefield¹

¹School of Psychology, Faculty of Health Sciences, University of Adelaide, Adelaide, South Australia, Australia

5.1 Statement of contributions

Statement of Authorship

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Principal Author

Name of Principal Author (Candidate)	Carly Rose Sutherland
Contribution to the Paper	Conducted literature review, designed study, collected data, analysed data, wrote manuscript, acted as corresponding author.
Overall percentage (%)	85%
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature	Date <u>18/10/16</u>

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Anna Chur-Hansen
Contribution to the Paper	Supervised development of the work, helped to evaluate and edit the manuscript.
Signature	Date <u>18.10.16</u>

Name of Co-Author	Helen Winefield
Contribution to the Paper	Supervised development of the work, helped to evaluate and edit the manuscript.
Signature	Date <u>18/10/16.</u>

5.2 Paper

5.2.1 Abstract

Objective: Rural Australians experience unique mental health challenges and barriers to help-seeking, in the context of limited access to psychologists. Rural Australians' views of psychologists have been neglected in the literature, with previous surveys of public opinion of psychologists focusing on urban populations. The present survey is the first comparison of rural and urban Australian community understandings and perceptions of psychologists.

Method: Participants were a convenience sample of 877 Australian adults from rural (34.6%) and urban (64.8%) areas. Participants completed an online survey which assessed 5 domains, including previous experience with psychologists, perceived likelihood of seeing a psychologist, factors and barriers associated with seeing a psychologist, knowledge of and understanding about psychologists, and preferences for seeing a psychologist.

Results: Rural participants were significantly less likely to have seen a psychologist, were more likely to perceive seeing a psychologist as helpful, were more likely to endorse travel time as a barrier to seeing a psychologist, scored significantly lower on a multiple-choice test of knowledge about psychologists, and were less aware of the Medicare rebate for psychological services.

Conclusion: There was a significant gap between rural and urban Australians regarding knowledge of and understanding about psychologists, and perceived accessibility and barriers to seeing a psychologist. Public awareness campaigns for psychological services should target rural areas.

Key words: access to health care; attitudes; health knowledge; practice; psychology; rural

5.2.2 Introduction

Historically, psychology as a profession has been poorly understood by the public (Benjamin, 1986). In an early review of unpublished and published surveys in the United States, Wood et al. (1986) found that although the public generally held favourable attitudes towards psychologists, most held limited understanding of the field. In Australia, early research by Small and Gault (1975) found that the general public had limited understanding of the role of psychologists and their competencies, and preferred to seek the help of other professionals, such as general practitioners (GPs), social workers, and psychiatrists. A decade later, Sharpley (1986) found that psychologists were perceived to be of less value to the community than psychiatrists, social workers, or counsellors. Franklin et al. (1998) conducted a survey of GPs (and their patients) and psychologists (and their clients), examining their awareness of psychologists' qualifications, professional associations and registration. Overall 58.3% of respondents did not know the qualifications of the psychologist they were seeing or referring to, and only a small majority knew that practising psychologists were required by law to be registered. Public confusion regarding the difference between psychologists and psychiatrists has also been well documented (Dempsey, 2007; Sharpley, 1986; Webb & Speer, 1986).

There has been limited recent work in Australia examining the public's perception of psychologists. Hartwig and Delin (2003) surveyed 178 rural and metropolitan South Australians regarding their perceptions of psychologists using direct (e.g. specific questions about the usefulness of psychologists) and indirect (e.g. overall favourability ratings) methods, finding that public impressions of psychologists were

more favourable using indirect methods. McKeddie (2013) investigated lay attitudes and understandings towards counselling psychologists in a survey of 114 Victorian adults, finding that while counselling psychology was generally positively regarded by the sample, there was a lack of understanding of the nature of counselling psychology as opposed to clinical psychology. There is a lack of recent research investigating the attitudes of the Australian general public towards psychologists more generally. The need for recent research is particularly relevant given changes in the profession over the last ten years, specifically the introduction of the 'Better Access' initiative in which access to (and uptake of) psychological services by the general public has risen dramatically (Australian Psychological Society, 2014).

The perceptions of rural community members regarding psychologists have been neglected in the literature. Hartwig and Delin (2003) did not examine whether there were differences between rural and urban groups. The study conducted by McKeddie (2013) consisted of a predominantly metropolitan sample (86.8%) and did not examine rural-urban differences. Franklin et al. (1998) investigated an entirely metropolitan Australian sample.

The present study of both rural and urban community member attitudes towards and understanding of psychologists therefore addresses an important gap in the literature. There are a number of reasons why rural Australians may have different attitudes towards or understanding about psychologists, including higher burden of mental illness due to barriers in accessing help (NRHA, 2009), more suicide deaths, particularly for men (AIHW, 2010), higher rates of serious mental health problems for Indigenous Australians, who comprise a larger proportion of rural and remote communities (Hunter, 2007), and the unique and unpredictable nature of rural stressors, such as drought and reliance on single industries (Barbopoulos & Clark, 2003; Roufeil

& Lipzker, 2007; Vines, 2011). Examining rural community attitudes towards psychologists is important given that barriers identified to rural help seeking and service utilisation, including stigma, lack of services, self-reliance, lack of awareness and misconceptions regarding mental illness and mental health services (Collins et al., 2009) may mean rural Australians have particular needs and perceptions of help-seeking, and in turn of psychologists, which need to be investigated and compared against urban attitudes.

It is well established that there is a maldistribution of psychologists across Australia, with only 21.5% of psychologists working in regional, rural and remote areas, despite approximately one-third of the Australian population residing in these areas (Mathews et al., 2010). Given that rural Australians may therefore be less likely to have exposure to psychologists, this lack of knowledge and understanding may further widen the disparity in access to psychologists and awareness of how to access psychologists and what psychologists can offer.

It was hypothesised that rural participants would be less likely to have experience with a psychologist, would be less likely to perceive seeing a psychologist as helpful, would be more likely to report that cost, travel time and waiting time were barriers to seeing a psychologist, would be less likely to perceive psychologists as accessible, and would be less likely to have an understanding of psychologists and what they do (as measured by both self-report and objective tests of knowledge).

5.2.3 Method

Participants

The study sample comprised 877 adult participants from the Australian general public (608 women and 271 men), ranging in age from 18 to 79 years ($M = 35.21$, $SD =$

12.73). The majority were born in Australia (85.3%), university graduates (61.4%), and in a relationship (51.6%). The majority (64.8%) were in full or part time employment, 12.3% were not working, and 23.1% were full or part time students. The majority of participants (37.0%) were from South Australia, with 26.7% from Victoria, 16.3% from New South Wales, 10.4% from Queensland, 5.1% from Western Australia, 2.5% from the Australian Capital Territory, and 2.0% from Tasmania. The Australian Standard Geographical Classification system (Australian Bureau of Statistics, 2011) was used to classify rurality, with 64.8% of participants from Major Cities (RA1), 16.3% from Inner Regional (RA2), 16.1% from Outer Regional (RA3), 1.8% from Remote (RA4) and 0.5% from Very Remote (RA5) areas. These were collapsed into two categories for the analysis, Urban (64.8%) and Rural (34.6%), which approximately reflects the Australian rural/urban population distribution of 71% of Australians living in Major Cities (ABS, 2015).

Materials

Participants completed an online survey using Survey Monkey software. The 32 item questionnaire was developed by the authors to assess the general public's perceptions towards and knowledge of psychologists. Similar to McKeddie's (2013) survey regarding counselling psychology, in addition to demographic questions (9 questions) the questionnaire assessed 5 domains, including previous experience with psychologists (8 questions), perceived likelihood of seeing a psychologist for 14 different presentations, factors and barriers associated with seeing a psychologist (4 questions), knowledge and understanding of psychologists (6 questions including 11-item multiple choice test), and preferences for seeing a psychologist (3 questions). In addition, participants were given the opportunity to provide a qualitative comment regarding their views of psychology and psychologists. Participants were asked to

maintain anonymity and avoid making specific comments regarding particular psychologists, to ensure confidentiality and anonymity of responses. A copy of the survey is available from the first author.

Procedure

The University of Adelaide Human Research Ethics Committee approved the study (HREC no. 15/26). Participants were recruited primarily using social media, with the survey promoted via a Facebook page, Twitter, and a post on Reddit. A University of Adelaide media release resulted in a radio interview and several print media articles promoting the survey. The survey was retweeted or shared by colleagues and contacts of the researchers as well as by psychology and mental health organisations. Participation in the survey was voluntary, with confidentiality and anonymity of participants assured. Informed consent was obtained via the information sheet and consent form incorporated into the first page of the online survey. The survey was pilot tested by three psychologists and four non-psychologists to ensure the average time required to complete the survey was less than 10 minutes. The majority (28) of questions were compulsory, with the final 5 questions made non-compulsory to avoid participant attrition in the event of participants becoming fatigued with the survey. Of the 887 total participants, 842 participants completed the entire survey including non-compulsory questions, with 235 participants providing a qualitative comment. Quantitative data were analysed using Chi-square analysis and binary logistic regression using IBM SPSS Statistics (Version 22). A content analysis (Jackson, 2009) was undertaken on the qualitative comments.

5.2.4 Results

Demographic information

Urban participants ($M = 33.16$, $SD = 11.83$) were significantly younger than rural participants ($M = 39.15$, $SD = 13.48$), ($t = -6.819$, $df = 882$, $p < .001$). They were more likely to be students ($\chi^2 (2, n = 882) = 42.09$, $p < .001$, $\phi = .218$) and university graduates ($\chi^2 (2, n = 882) = 17.762$, $p < .001$, $\phi = .142$). Rural participants were more likely to be in a relationship ($\chi^2 (2, n = 882) = 29.556$, $p < .001$, $\phi = .183$). Participants from NSW, Tasmania and Victoria were more likely to be from rural areas, while participants from South Australia were more likely to be from urban areas ($\chi^2 (7, n = 882) = 143.926$, $p < .001$, $\phi = .404$).

Experience with psychologists

Of the total sample, 64.7% had previously seen a psychologist. Significantly fewer rural participants had been to see a psychologist ($\chi^2 (1, n = 878) = 11.81$, $p < .001$, $\phi = .119$). Of those who had seen a psychologist (rural and urban), 22% were currently seeing a psychologist, 23.4% had seen a psychologist within the last year, 35.0% within the last 5 years, 10.3% within the last ten years, and 9.3% more than 10 years ago. Of the total sample, 8.3% had been referred to a psychologist, but had not attended an appointment. There was no significant association between having been referred to a psychologist and not attending and rurality. Of those who had not seen a psychologist, 81.7% indicated they would be willing to see a psychologist. There was no significant association between being willing to see a psychologist (having not seen one before) and rurality. Percentages of rural/urban participants who had seen a psychologist for specific presentations are outlined in Table 1.

Of those who had seen a psychologist, 79.3% found seeing the psychologist helpful or very helpful. Rural participants were more likely than urban participants to perceive seeing a psychologist as helpful ($\chi^2 (1, n = 567) = 5.481$, $p < .014$, $\phi = .103$). The following aspects of seeing a psychologist were endorsed as helpful by those who

had seen a psychologist, with no significant association between any of the aspects and rurality (see Table 2).

The total sample had sought help from the following mental health professionals (see Table 3).

Perceived likelihood of seeing a psychologist

The self-reported likelihood of seeing a psychologist for a range of presenting problems is outlined in Table 4.

Factors and barriers associated with seeing a psychologist

Of the total sample, 19.6% perceived psychologists as very accessible, 37.4% perceived psychologists as moderately accessible, 14.1% perceived access as limited and 1.1% perceived them as not accessible (4.2% ($n = 37$) did not answer this question). Rural participants were more likely to report that psychologists were limited or not accessible in their community, and urban participants were more likely to report psychologists were very accessible in their community ($\chi^2(1, n = 846) = 122.234, p < .001, \phi = .380$). Factors endorsed as important in seeing a psychologist are outlined in Table 5. Barriers to seeing a psychologist are outlined in Table 6.

Knowledge of psychologists

Performance on the multiple-choice test

The mean score on the 11-item test of knowledge of psychologists for the total sample was 9.73 ($SD = 1.34$), with a range of 3-11. Univariate linear regression was used to assess rurality in predicting total test scores on the multiple-choice test of knowledge of psychologists. There was a significant association between rurality and scores on test of knowledge of psychologists (global $p < .001$). The rural group had a

mean understanding score 0.53 units less than urban participants (95% CI: -.719, -.345). Multivariate linear regression was used to assess rurality in predicting total test scores, after controlling for education and previous experience with a psychologist. There was a statistically significant difference between mean test scores of rural and urban participants, after adjustment for education and previous experience with a psychologist (global $p < .001$). Rural participants had a mean understanding score 0.40 units less than urban participants (95% CI: -0.58, -0.22).

Minimum training requirements

The majority (73.5%) of the total sample correctly identified that psychologists must have a minimum of six years' training. There was no significant difference between rural and urban participants in knowledge of this test item.

Ability to prescribe medication

The majority (77.6%) of the total sample correctly identified that psychologists do not prescribe medication. Urban participants were more likely to correctly answer this (Odds Ratio = 1.88, 95% CI: 1.32, 2.68, $p < .001$). There remained a statistically significant association between knowing psychologists do not prescribe medication and rurality when adjusting for the education level of the participant and previous experience with a psychologist (OR = 1.6, 95% CI: 1.123, 2.339, $p = .010$).

Accessing psychologists through Medicare

The majority (83.3%) of the sample correctly identified that psychologists can be accessed through Medicare. Urban participants were more likely to correctly answer this item (Odds Ratio = 0.524, 95% CI: .343, .800). The significant association between knowing psychologists can be accessed through Medicare and rurality remained when

adjusting for the education level of the participant and previous experience with a psychologist (OR = .58, 95% CI: .337, .893, $p = .013$).

Training in research

The majority (82.2%) of the sample correctly identified that psychologists are trained in research. There was no significant association between rurality and correctly answering this test item.

Ability to read minds

The majority (93.9%) of the sample correctly identified that psychologists do not have the ability to read minds. There was no significant association between rurality and correctly answering this test item.

Use of cognitive-behaviour therapy

The majority (89.9%) of the sample correctly identified that psychologists may use cognitive-behaviour therapy. Urban participants were more likely to correctly answer this item (Odds Ratio = 2.2, 95% confidence interval: 1.171, 4.072), and the association between knowing psychologists use CBT and rurality remained when adjusting for the education level of the participant (OR = 1.98, 95% CI: 1.053, 3.716, $p = .034$), however did not remain significant when also adjusting for whether the participant had seen a psychologist (OR = 1.798, 95% CI: .951-4.401, $p = 0.71$).

Working with mental health problems

The majority (84.8%) of the sample correctly identified that psychologists do not work only with mental health problems. Urban participants were more likely to correctly answer this item (Odds Ratio= 2.1, 95% CI: .1.351, 3.246, $p < .001$), with the association between knowing psychologists do not only work with mental health

problems and rurality remaining when adjusting for the education level of the participant and previous experience with a psychologist (OR = 1.9, 95% CI: 1.205, 2.946, $p = .005$).

Working only with individuals

The majority (90.3%) of the sample correctly identified that psychologists do not work only with individuals. There was no significant association between rurality and correctly answering this test item.

Registration requirements

The majority (89.5%) of the sample correctly identified that by law psychologists must be registered. Urban participants were more likely to be aware of this (Odds Ratio = 1.9, 95% confidence interval: 1.055, 3.568), the association between knowing psychologists must be registered by law and rurality remaining when adjusting for the education level of the participant (OR = 1.9, 95% CI: 1.058, 3.624, $p = .032$), and when adjusting for education level and having seen a psychologist previously (OR = 1.9, 95% CI: 1.019, 3.518, $p = 0.43$).

Training pathways

The majority (92.4%) of the sample correctly identified that psychologists are not trained at TAFE. There was no significant association between rurality and correctly answering this test item.

Ability to help with physical conditions

The majority (70.1%) of the sample correctly identified that psychologists are able to help people with their physical conditions. There was no significant association between rurality and correctly answering this test item.

Self-reported understanding of what psychologists do

Of the total sample completing this question ($n = 860$), most participants (64.1%) self-reported they understood what psychologists do. Approximately one third (33.77%) indicated they knew “a little bit” about what psychologists do. Only 2.1% of the total sample reported they didn’t understand what psychologists do. Rural participants were significantly more likely to endorse “I know a little bit about what psychologists do” (28.7% urban, 42.8% rural) while urban participants were more likely to endorse “I understand what psychologists do” (69.3% urban, 54.5% rural) ($\chi^2 (1, n = 856) = 18.532, p = <.001, \phi = .147$). There was no significant difference between the groups with regards to endorsing the statement “I don’t understand what psychologists do” (2.0% urban, 2.7% rural).

Self-reported understanding of when to see a psychologist

Of the total sample, 81.6% agreed or strongly agreed they had a good understanding of when to see a psychologist, with no significant difference between rural and urban groups.

Self-reported understanding of how to get a referral to a psychologist

Of the total sample, 82.4% of participants agreed or strongly agreed they had a good understanding of how to obtain a referral to see a psychologist, with no significant difference between rural and urban groups.

Self-reported understanding of the difference between a psychologist and psychiatrist

Of the total sample, 77.1% agreed they understood the difference between a psychologist and psychiatrist. Rural participants were significantly less likely to agree that they understood the difference between psychologists and psychiatrists.

Specifically, 86.1% of urban participants reported they understood the difference, while 71.4% of rural participants reported they understood the difference ($\chi^2 (1, n = 841) = 25.796, p = <.001, \phi = -.178$).

Sources of knowledge about psychologists

Sources of knowledge about psychologists are outlined in Table 7.

Awareness of Medicare rebate

Of the total sample (rural and urban), 30% reported they were unaware they could obtain a Medicare rebate for seeing a psychologist. Urban participants were more likely to be aware of the Medicare rebate than rural participants ($\chi^2 (1, n = 846) = 18.140, p = <.001, \phi = .149$), with 73.6% of urban participants aware and 59.1% of rural participants aware.

Preferences for seeing a psychologist

Participants' preferences regarding GPs and psychologists are outlined in Table 8 and Table 9.

Qualitative comments

Participants were provided with an opportunity to provide general comments or suggestions regarding psychology or psychology services at the conclusion of the survey. Of the total sample, 26.49% ($n = 235$) provided a comment. There were no significant associations between rurality, gender, or education level and providing a comment. There was a significant association between employment and providing a comment on the survey, with those not currently employed more likely to make a comment ($\chi^2 (1, n = 887) = 6.87, p = .032, \phi = 0.88$). Those who had seen a

psychologist before were also more likely to provide a comment ($\chi^2 (1, n = 883) = 45.91, p = <.001, \phi = 0.231$).

A content analysis (Jackson, 2009) was conducted on the qualitative comments in response to the question ‘Do you have any other comments or suggestions you would like to make about psychology or psychology services?’ The qualitative comments were analysed and a coding frame was developed, with initial themes noted and similar grouped together. The qualitative data were then analysed using the coding frame. The second author checked the process of coding against the steps taken for analysis and cross-checked for rigour and trustworthiness. Basic descriptive statistics were generated to analyse the number of comments provided in each category by rurality. The second author cross-checked the codes and themes for reliability. Themes identified and quotes illustrating each theme are outlined in Table 10. Urban participants were significantly more likely to make a comment regarding a negative experience with a psychologist, or negative views of psychologists. There were no associations between rurality and the other categories of comments.

5.2.5 Discussion

The present study represents one of the largest surveys of public perceptions of psychologists conducted in Australia. As such, the study provides insight into overall attitudes towards and understanding of and knowledge about psychology in the Australian community, as well as differences between urban and rural Australians. Consistent with the first hypothesis, rural participants were significantly less likely to have seen a psychologist. Despite this, rural participants were significantly more likely to perceive seeing a psychologist as helpful. There was no significant association between rurality and having seen a psychologist for particular problems (or self-reported likelihood of seeing a psychologist in future for this problem) aside from self-

harm or suicidal ideation, with rural participants significantly less likely to have seen a psychologist (or to report it was likely they would) for this issue than urban participants. This is consistent with the literature demonstrating higher suicide rates in rural areas, particularly amongst rural men (AIHW, 2010).

Urban participants were more likely to report that cost and the type of therapy/treatment used by the psychologist would influence their decision to see a psychologist, which may reflect their greater knowledge of psychologists, and hence greater likelihood of being aware of different treatments/therapies used by psychologists. The finding that urban participants were more likely to report uncertainty regarding whether psychologists could help may suggest a lack of familiarity with the profession. Rural participants were more likely to report that travel time would be a factor (and a barrier) to seeing a psychologist. Inconsistent with the hypothesis, rural participants were not more likely to report cost and waiting time as barriers, and in fact urban participants were more likely to report cost as a barrier. It is possible that urban participants were more likely to indicate cost a barrier as more psychologists bulk bill in rural areas (Lindner & Stokes, 2007). Rural participants were more likely to perceive access to a psychologist as limited or non-existent in their community, suggesting rural participants are aware of this maldistribution, possibly due to experiencing difficulties in accessing psychological services.

The survey revealed a gap between rural and urban participants in terms of understanding of psychologists, consistent with the hypothesis that rural participants would be less likely to have an understanding of psychologists and what they do. This gap in understanding and awareness suggests a need for raising the profile of psychology in rural areas. Rural participants were significantly less likely to endorse school or university studies, or experience with psychologists, as sources of knowledge,

suggesting a lack of exposure to psychologists may be a key reason for this disparity in understanding and knowledge.

While the study indicated awareness and understanding of psychology and psychology services was greater in urban participants, it is important to also note that 30% of the total sample (rural and urban) were unaware they could obtain a Medicare rebate for seeing a psychologist. This suggests a need to raise awareness of this option, particularly with cost the most commonly cited barrier for seeing a psychologist in this survey (with 56.6% of rural and urban participants indicated cost would be a barrier). This may suggest a need for greater support for GPs, as the ‘gatekeepers’ of psychological services under the Better Access scheme (Dempsey & Donaghue, 2009) to inform their patients of the availability of the Medicare rebate.

The study also provides insight into community members’ preferences for seeing a psychologist. Previous research regarding rural health service delivery has highlighted controversies regarding visiting service delivery models, with FIFO/DIDO models of service delivery having been described a “necessary evil” (Hanley, 2012). The majority of rural participants in this survey preferred to see a local psychologist (75.1%), however 17.7% reported a preference for seeing a visiting psychologist, and 9.5% a preference to travel to see a psychologist. This is consistent with previous research with FIFO/DIDO psychologists (Sutherland, Chur-Hansen, et al., 2016), in which it was suggested that some community members may prefer to see a non-local psychologist for reasons of confidentiality. This suggests that while the majority of rural participants preferred to see a local psychologist, there may still be a role for visiting psychology services in rural areas in providing communities with choice regarding seeing a visiting or local psychologist.

The present study also provides insight into community members' views regarding the relationship between psychologists and GPs. The majority (72%) of participants (both rural and urban) indicated they would prefer to see a GP who refers to psychologists. Despite co-locating GP and psychology services being proposed as a method of reducing the stigma associated with seeing a psychologist and facilitating communication between psychologists and GPs (Sutherland, Chur-Hansen, et al., 2016a; Vines et al., 2004), only 34.4% of participants indicated they would prefer to see a psychologist who works in the same clinic in their GP, with no significant difference between rural and urban participants. This suggests that community members hold generally positive attitudes about GPs and psychologists working together, however many may prefer not to see a psychologist working within a GP practice. The present study did not explore participants' reasons as to why they would not prefer to see a psychologist co-located within a GP practice. While previous research has demonstrated good outcomes for clients using a collaborative model of care between psychologists and GPs in rural settings (Vines et al., 2004) future research may focus on rural community perceptions of the relationship between psychologists' and GPs, including clients' experiences of co-located services.

The present study also provides insight into the factors participants found helpful about seeing a psychologist, with 'Getting some strategies to help with my problem' (75.3%) the most commonly endorsed factor. There were no significant differences between rural and urban participants, suggesting that when they are able to access psychology services, rural Australians may perceive the same benefits from seeing a psychologist as urban Australians.

Methodological considerations

Overall the views towards psychologists in the sample could be described as mostly positive, with the majority (79.3%) of participants who had seen a psychologist describing the experience as helpful, and the majority (81.7%) of participants who had not seen a psychologist indicating they would be willing to. This is consistent with McKeddie's (2013) finding of a largely positive view of counselling psychologists. The nature of the convenience sampling method employed may have led to a bias with those with more positive views of psychology choosing to participate, however content analysis of qualitative comments revealed 13.9% of the comments provided were negative, indicating some participants with less positive experiences and views of psychology still chose to participate in the survey. A high proportion of the sample (64.7%) had seen a psychologist previously, therefore the results may have been biased towards higher ratings of knowledge.

There were some significant demographic differences between the rural and urban samples. Urban participants were more likely to be students, younger, and have a university degree. Rural participants were more likely to be in a relationship. These differences do however largely reflect differences in the rural-urban population in Australia, with a higher proportion of older people living in rural areas (Australian Bureau of Statistics, 2013) and generally lower education levels (Australian Bureau of Statistics, 2008). Overall, men were underrepresented in the survey, comprising 30.6% of the total sample. This is consistent with the literature suggesting men are generally underrepresented in mental health research (Ellis et al., 2014) however again reflects a need for future studies to employ more representative sampling methods, and the need for research focusing on men's perception of psychology and psychology services,

given that rural men are less likely to seek help for mental health concerns (Caldwell, Jorm, & Dear, 2004; Judd et al., 2006).

As the research was conducted in South Australia and employed a convenience sampling approach, the distribution of participants from each state did not reflect the Australian population distribution. Participants from New South Wales, Tasmania and Victoria were more likely to be from rural areas, with participants from South Australia were more likely to be from urban areas.

As with previous research, due to the fact a standardised measure of public perceptions and knowledge of psychologists does not exist, the survey used in the present study was developed in accordance with the research questions and adapted from previous survey research (Franklin et al., 1998; McKeddie, 2013) as well as employing insights obtained from research conducted by the authors with rural psychologists and GPs (Sutherland & Chur-Hansen, 2014; Sutherland, Chur-Hansen, et al., 2016a; Sutherland, Chur-Hansen, et al., 2016) to ensure the instrument was relevant.

The present study focused on psychology as a profession as applied to mental health settings, and it is acknowledged that the diversity of the profession was not fully captured in the survey. The focus on psychology in terms of mental health reflected the aims of the research to inform competencies for psychologists providing mental health services in rural areas, in order to address recruitment and retention strategies for this area of need. Public perceptions of psychology more generally, including both the science and practice of psychology as applied to mental health and non-mental health settings, should be explored further in future research.

The present study used direct methods of examining attitudes towards psychologists, which have previously been found to elicit more negative views of psychology and psychologists than indirect methods (Hartwig & Delin, 2003; Webb &

Speer, 1986). The finding of generally favourable attitudes towards psychology using direct methods perhaps suggests an improvement in psychology's status with the public, however, the potential limitations of using a convenience sample must again be acknowledged.

Significance and implications

The significant gaps in understanding and awareness of psychologists between rural and urban participants indicates a need for public health campaigns raising the profile of psychology in rural areas. The Australian Psychological Society has recently developed a 'We are Psychology' campaign with the aim of raising the public profile of psychology in Australia (Coghlan, 2015). The campaign, consisting at the time of publication of a website aimed at providing information regarding psychology and how to access psychologists, was launched after this survey was conducted, and does not specifically address psychological services in rural areas.

The present study indicates that the confusion between psychologists and psychiatrists persists in rural areas. Dempsey (2007) highlights two main reasons for the importance of clarifying the role of psychologists as to other mental health professionals: ethical reasons (the responsibility of each profession to accurately inform the public of the nature of their role); and professional, marketing and financial issues, such as the delineation of boundaries between the scope of practice of particular professions. Public awareness campaigns in rural areas may therefore include information from both professions regarding their similarities and differences.

Given the disparities between rural and urban understandings of psychologists highlighted in the present survey, initiatives specifically targeted for raising the profile of psychologists in rural areas may be warranted. The finding that rural participants were less likely to have experience with psychologists and less likely to highlight

experience with a psychologist as a source of their knowledge about psychologists suggests the knowledge disparity may unsurprisingly relate to a lack of access to psychologists. Addressing the knowledge and understanding gap therefore highlights the importance of increasing strategies for recruitment and retention of psychologists in rural areas.

5.2.6 Tables

Table 1: *Percentage of sample who had seen a psychologist for the following issues:*

Issue	Urban sample	Rural sample	Total sample
Depression	44.7%	37.8%	42.3%
Anxiety	45.7%*	35.2%*	42.1%*
Relationship problems	22.6%	18.9%	21.3%
Self harm/suicidal thoughts	17.6%*	11.4%*	15.4%*
Grief/bereavement	8.9%	6.5%	8.0%
Employment related concerns	7.0%	6.5%	6.9%
Eating disorders	5.2%	2.3%	4.2%
Trauma	4.9%	4.9%	4.9%
Substance use problems	4.2%	3.3%	3.8%
Child behaviour problems	2.8%	5.2%	3.6%
Serious/chronic illness	3.8%	2.0%	3.2%
Chronic pain	3.3%	1.6%	2.7%
Psychosis	3.0%	1.6%	2.5%
Learning difficulties	1.7%	0.7%	1.4%
Other (trauma, sleep problems, personality disorders, bipolar disorder, ADHD, and Autism Spectrum Disorder)	5.8%	5.6%	5.7%

**Significant at $p = .05$*

Table 2: *Percentage of sample who had seen a psychologist endorsing the following factors as helpful*

Factor	Urban sample	Rural sample	Total sample
'Learning some strategies to help with my problem'	74.6%	76.5%	75.3%
'Talking to someone about my problem (getting it off my chest)'	69.3%	65.1%	67.8%
'Getting a different perspective on my problem'	59.7%	53.0%	57.4%
'Getting advice on my problem'	44.2%	42.3%	43.5%
'Learning more about what might have caused my problem'	37.0%	33.6%	35.8%
Other	9.9%	9.4%	9.7%

Table 3: *Percentage of total sample who had seen the following mental health professionals*

Mental health professional	Urban sample	Rural sample	Total sample
Psychologist	68.9%	57.0%	64.7%
GP (for mental health reasons)	39.8%	35.8%	38.6%
Counsellor	30.4%	30.3%	30.4%
Psychiatrist	22.8%	18.2%	21.1%
Social worker	8.3%*	13.4%*	10.1%*
Mental health nurse	5.7%	9.1%	6.9%
Occupational therapist	2.4%	3.3%	2.7%
Other (psychotherapists, naturopaths, speech pathologists, and peer support workers)	1.7%	2.0%	1.8%
No other mental health professional	36.9%	38.4%	37.3%

* Significant at $p = .05$

Table 4: *Percentage of sample endorsing that it was 'likely' or 'very likely' they would see a psychologist for the following issues.*

Issue	Urban sample	Rural sample	Total sample
Depression	78.3%	77.7%	78.1%
Anxiety	76.8%	74.2	76.0%
Self-harm/suicidal thoughts	76.2%*	69.4%*	74.3%*
Psychosis	69.1%	64.1%	67.4%
Substance use problems	62.9%	61.8%	62.6%
Eating disorders	64.2%	57.7%	62.0%
Child behaviour concerns	56.1%	60.0%	57.4%
Grief/bereavement	55.3%	60.0%	57.0%
Relationship problems	49.2%	50.5%	49.6%
Dementia	45.2%	49.5%	46.6%
Serious or chronic illness	45.3%	46.7%	45.7%
Learning difficulties	25.9%	22.4%	24.7%
Career counselling	22.8%	21.2%	22.3%
Other (trauma, workplace conflict, stress, and life coaching/self improvement)	13.4%	13.8%	13.5%

* *Significant at $p = .05$*

Table 5: *Factors endorsed as important in seeing a psychologist by percentage of total sample*

Factor	Urban sample	Rural sample	Total sample
Cost	72.9%*	59.3%*	68.1%*
Type of therapy/treatment used	57.4%*	45.6%*	53.3%*
Recommendation of GP	45.2%	47.2%	45.9%
Recommendation of friends/family	36.2%	30.9%	34.4%
Waiting time	30.8%	36.2%	32.7%
Travel time	22.1%*	35.8%*	26.9%*
Other (perceptions of individual psychologist's competence and characteristics, time, and perceived privacy of seeing a psychologist)	8.7%	9.4%	9.0%

* *Significant at $p = .05$*

Table 6: *Barriers to seeing a psychologist*

Factor	Urban sample	Rural sample	Total sample
Cost (too expensive)	60.9%*	48.5%*	56.6%*
Uncertain if psychologist able to help	32.2%*	22.5%*	28.8%*
Waiting time too long	14.4%	18.2%	15.8%
Psychologist being too far away	10.4%	24.1%*	15.3%*
Uncertain what psychologist would do	15.8%	12.7%	14.7%
Uncomfortable talking with psychologist	14.8%	11.4%	13.6%
Stigma/concern about what others think	12.7%	15.0%	13.5%
GP unsure if psychologist could help	3.1%	4.2%	3.5%
Friends/family unsure if psychologist could help	1.0%	2.0%	1.5%
None of the above	16.3%	15.0%	15.9%
Other (having the time to go and see a psychologist, previous negative experiences with psychologists, and confidentiality concerns for those working in health or mental health fields)	7.3%	5.0%	6.8%

* *Significant at $p = .05$*

Table 7: Sources of knowledge of psychologists

Source	Urban sample	Rural sample	Total sample
Experience with psychologists	61.3%*	53.0%*	58.4%*
School/university studies	55.0%*	46.0%*	51.9%*
Common knowledge	42.3%	45.7%	43.5%
Friends or acquaintances	39.8%	43.3%	41.0%
Internet	31.9%	28.3%	30.7%
GP	30.1%	28.7%	29.6%
Books/magazines	20.3%	21.0%	20.5%
Movies/TV	12.9%	13.3%	12.9%
Newspapers	3.8%	6.0%	4.5%
Other	5.4%	3.0%	4.5%
“I don’t know anything about psychologists”	1.4%	2.7%	1.9%

* Significant at $p = .05$

Table 8: Preferences regarding GPs and psychologists ‘agree’ or ‘strongly agree’

Preference	Urban sample	Rural sample	Total sample
Preference for seeing a GP who refers to a psychologist	74.9%	78.8%	76.4%
Preference for seeing a psychologist in same clinic as GP	34.5%	39.3%	36.2%

Table 9: *Rural participants' preferences for seeing a psychologist*

Preference	Percentage of rural participants (n = 305)
See a local psychologist	75.1%
See a psychologist who visits	17.7%
Travel to see a psychologist	9.5%
Would not want to see a psychologist	5.2%

Table 10: *Content analysis of qualitative comments (N)*

Theme	Urban	Rural	Total	Quote
Barriers to accessing psychologists (limit to Medicare sessions, cost, access, stigma)	65	35	100	<i>10 visits via Medicare are generally not enough. Governments only say they want to remove the stigma around mental health, but restricting services for mental but not physical health services is a form of stigmatisation in itself and suggests that a short-term fix will suffice – Urban Female, 56</i>
Negative experiences/views of psychologists	38*	10*	48*	<i>I do not believe it can help me. It seems to help others at times but other times it seems to make the problem worse. I dislike the practice as while it uses scientific principles, it cannot garner independently verifiable results - Rural Male, 21</i>
Positive experiences/views of psychologists	22	10	32	<i>The one psychologist I had was brilliant. I was sceptical before going, though after it was worth every cent. It is helpful to overcome a large variety of issues. Urban Male, 38</i>

Preferences when seeing a psychologist	21	10	31	<i>I would prefer to see a psychologist who provides treatment in a structured and planned way, with a plan laid out at the first session, rather than planning it one session at a time. Urban Male, 24</i>
Problems with mental health system	15	9	24	<i>The current mental health system and Medicare rebate system sets you up to fail because of the lack of a continuity of care and time to explore and work through a complex history of trauma. That's why people get stuck in the system for most of their adult life. It really is a nightmare. We need more access to psychologists, not less. Rural Male, 47.</i>
Need to raise awareness of psychology	12	8	20	<i>... awareness is a big issue. In schools, teenagers and young adults are not aware of the services available, client/patient confidentiality or the problems that they or their friends may be experiencing. Education about mental health is important to raise awareness, lower the stigma surrounding it and to help diagnose patients. Urban Female, 19</i>
Relationship between GPs and psychologists	15	7	22	<i>I think having GPs as the referral "gate keepers" is an unnecessary barrier and deters a lot of people from seeing a psychologist who would benefit from their help. Urban Male, 24</i>

* Significant at $p = .05$

Chapter 6 – Conclusions

6.1 Summary of findings

In light of limited previous research, this thesis set out to explore rural psychological service delivery from the perspectives of FIFO/DIDO psychologists, rural and remote GPs, and rural and urban community members. The thesis builds upon previous work with resident rural psychologists (Sutherland, 2012; Sutherland & Chur-Hansen, 2014) in investigating the perspectives of other key stakeholders in psychological service delivery.

Study 1 (reported in the first paper, Chapter 2) employed qualitative methods to explore the perspectives of psychologists providing visiting FIFO/DIDO services to rural and remote communities. This study found that while FIFO/DIDO psychologists face similar challenges to resident rural and remote psychologists, they also face additional unique personal and professional challenges due to working away from home, including caring for dependents, managing fatigue and personal safety in rural communities, greater intensity of work and less access to professional support when away, and scheduling and logistical challenges. Study 1 highlighted how while FIFO/DIDO work arrangements are a contentious issue in the literature, there may be both personal and professional advantages for psychologists of providing services to rural communities according to this model. This may include financial and time compensation and greater work flexibility, as well as greater support and fewer ethical dilemmas compared to resident rural psychologists. The study identified particular support needs for psychologists working FIFO/DIDO schedules including an appropriate induction into the rural community, the availability of local support, and appropriate compensation for lifestyle impacts.

Study 2 (reported in Chapter 3 of this thesis) employed qualitative methods to explore the perspectives of rural and remote GPs regarding working with psychologists. The study found that while rural and remote GPs held largely positive views of psychologists and their value in reducing GP workloads, GPs experienced some challenges in working with psychologists in rural areas, including in terms of communication, and gaps in their knowledge of psychologists' training and expertise.

The third paper in this thesis, Chapter 4, was an article written for GPs in light of the finding of Study 2 that rural GPs possessed gaps in their knowledge of psychologists. The paper aimed to address these gaps in an accessible format for GPs, identifying '6 top tips' for GPs in terms of highlighting how psychologists are trained, the difference between psychologists and counsellors, when to refer to a psychologist, how GPs can explain to their patients what psychologists do, how to communicate with psychologists, and how to access them.

The fourth paper in this thesis (Chapter 5) focused on Australian community perceptions of psychologists. Quantitative survey methods were used to compare rural and urban perspectives of psychologists. Rural participants were significantly less likely than urban participants to have seen a psychologist, were more likely to perceive seeing a psychologist as helpful, were more likely to endorse travel time as a barrier to seeing a psychologist, scored significantly lower on a multiple-choice test of knowledge about psychologists, and were less aware of the Medicare rebate for psychological services. The findings of Study 3 therefore highlighted a gap between rural and urban Australians regarding knowledge of and understanding about psychologists

The three studies reported here have fulfilled the aims of this thesis in investigating what is required of rural and remote psychologists and psychology services from the perspective of three key stakeholders: psychologists, GPs, and

community members. Themes present across all three studies included the lack of psychologists in rural areas and the need for more psychologists, with the impact of the lack of psychologists in rural and remote areas felt by psychologists themselves, referring practitioners (GPs), and importantly, by rural communities. All three studies highlighted a need for greater awareness and initiatives to improve understanding of psychologists and psychology services amongst rural GPs and rural communities, and opportunities of alternative models of service delivery such as FIFO/DIDO services in addressing recruitment and retention problems in the rural psychology workforce. The significance and implications of the findings will be discussed in further detail below.

6.2 Significance of the findings and contribution to knowledge

6.2.1 Contribution to the literature regarding models of rural health service delivery

The thesis contributes to the literature on models of rural health service delivery, particularly the understanding of FIFO/DIDO models. Previous research with health professionals providing FIFO/DIDO services has been limited and mostly anecdotal in nature, and has tended to focus on the limitations and concerns regarding these models. One of the few studies exploring health professionals' perspectives focused on nurses working in 'block' rosters (e.g. week on, week off) (Heidelbeer & Carson, 2013). Study 3, in providing an in-depth qualitative exploration of psychologists' perspective on providing these services, contributes to the literature by exploring the perspectives of practitioners who incorporate FIFO/DIDO work into their regular work schedule, rather than in a 'block time' roster. The study highlights the need for profession-specific research in exploring FIFO/DIDO service delivery, as professions such as psychology, where longer-term therapy relationships may be important, may experience unique

challenges and needs in delivering their services compared to health professionals who may provide ‘one-off’ services.

The thesis also provides insight into resident health professionals’ (rural GPs) and community members’ perceptions of FIFO/DIDO service delivery. While the majority of participants in the community survey preferred to see a local psychologist, the findings indicated 17% of rural community members do prefer to see a visiting psychologist. This was consistent with findings of the qualitative study with FIFO/DIDO psychologists (Study 1), in which participants indicated that some community members preferred to see them, as visiting psychologists, for reasons of confidentiality. This was consistent with Study 2, which highlighted that some GPs also reported that some of their patients preferred to see a visiting psychologist for reasons of confidentiality. Potential implications of these findings will be discussed in Section 6.3.4.

The thesis also provides further insight into perceived access to psychological services in rural communities. Both rural and remote GPs and rural community members perceived they had limited access to psychologists in their communities, indicating that the statistical maldistribution of psychologists is experienced on a practical level as a gap in service by health professionals and community members. Implications of the findings of this thesis in terms of recruitment and retention of rural psychologists will be discussed in Section 6.3.6.

6.2.2 Contribution to the interprofessional education (IPE) literature

The findings of this thesis contribute to the IPE literature, specifically in terms of interprofessional collaboration and education in rural areas. The finding that GPs and psychologists hold largely positive views of the value of the other profession in supporting their workload in rural areas suggests each profession values

interprofessional collaboration. Findings from Study 3, the community survey, indicate that community members also value interprofessional collaboration from their treating professionals, with most participants in both rural and urban areas preferring to see a GP that worked with psychologists.

The findings of the thesis highlight gaps remaining in interprofessional education in psychology and medical curricula, and in terms of interprofessional collaboration and communication between psychologists and GPs. In 2004, Winefield and Chur-Hansen discussed the potential for interprofessional education (IPE) and collaboration between medical students, interns, registrars and clinical psychology students as a method of increasing awareness of each other's professions, in the lead-up to the introduction of the Better Outcomes scheme. The findings of this thesis suggest such initiatives may still be required, as GPs reported limited understanding of psychologists' training and expertise.

Similarly, GPs' concerns about the level of communication they had received from psychologists may reflect that psychology training also lacks focus on interacting with GPs. Fourteen years ago, prior to the introduction of Better Access, Wyman (2002) outlined how psychologists may be unaware of GPs' expectations (based on their experiences referring to medical specialists) that psychologists will follow the 'culturally appropriate procedure' of writing to GPs to thank them for a referral, describe their formulation and treatment plan, and describe the limits of their involvement in referring back to the GP. The experiences of GPs in Study 2 suggests interprofessional education may still need to also address the need for psychologists to be aware of GPs' expectations of communication. Implications of the findings of this thesis in terms of IPE will be discussed in Section 6.3.3.

6.2.3 Contribution to the training and professional development of rural and remote psychologists (including rural and remote competencies)

The findings of this thesis contribute to the literature regarding competencies for rural and remote health practice. Building on previous research (Sutherland, 2012; Sutherland & Chur-Hansen, 2014), Study 1 found that rural and remote FIFO/DIDO psychologists required similar competencies to rural and remote psychologists (such as having a high level of skills in a broad range of areas to work with complex and diverse presentations, being able to adapt interventions developed in an urban context, the ability to set personal and professional boundaries and manage confidentiality in small communities, and being adaptable, flexible and ‘down to earth’, with an appreciation of the rural lifestyle). The study highlighted, however, that FIFO/DIDO psychologists experience additional challenges, advantages and support needs to be able to practice effectively as a visiting rather than a resident psychologist. The findings of Study 1 therefore contribute to the literature on competencies for rural and remote psychologists by addressing the requirements for successful FIFO/DIDO rural psychology practice, which complements previous research with resident rural psychologists.

Similar to the findings of Sutherland (2012); Sutherland and Chur-Hansen (2014), rural FIFO/DIDO psychologists highlighted that rural placements were the most effective way to develop the skills required for rural and remote FIFO/DIDO psychology practice. The challenges, advantages and support needs of FIFO/DIDO psychologists could therefore be incorporated with previous findings regarding competencies of resident rural and remote psychologists to develop a list of competencies for FIFO/DIDO psychology practice, to be used in conjunction with rural FIFO/DIDO placements as part of a competency based training approach.

Most studies of health profession specific competencies have focused on the perspective of the profession only. Studies 2 and 3, in incorporating GP and community members' perspectives of psychology services, provide further insight into the competencies required of rural and remote psychologists, in terms of knowledge and skills required by rural psychologists to communicate and work effectively with GPs and the wider community. Skills in networking with other professionals, including GPs were identified as a competency required for rural and remote psychology by Sutherland and Chur-Hansen (2012, 2014). The findings of Study 2 provide further insight into the networking skills required of rural psychologists in terms of working with rural GPs, for example, being proactive with communication and explanation of what psychologists can offer to rural GPs, who may possess gaps in their knowledge.

The findings of Study 3 highlight a need for rural psychologists to be aware of rural and urban disparities in terms of knowledge and understanding of psychology, including that rural clients may be less likely to be aware of the availability of the Medicare rebate, less likely to be know psychologists are registered, and less likely to be aware of the differences between psychologists and psychiatrists. Rural psychologists may also need to be aware that rural clients are less likely to have seen a psychologist. The KSAs identified previously (Sutherland, 2012; Sutherland & Chur-Hansen, 2014) included 'Knowledge of rural presentations', which indicated that while the presenting problems in rural areas may not be different, the triggers behind them may be, such as the impact of drought. The findings of Study 3 suggest that awareness of disparities in understanding between rural and urban community members could be added as a 'Knowledge' competency for rural and remote psychology practice, and practically highlight the need for rural psychologists to discuss the role of psychology and their training and expertise with their clients.

6.3 Implications of the findings

The findings of this thesis have implications in terms of models of rural psychological service delivery, professional development and education for rural psychologists and general practitioners, mental health and Medicare policy in rural areas, recruitment and retention strategies for rural psychologists, and primary care psychology. These will be outlined below.

6.3.1 Psychology education and professional development

The findings of the thesis highlight the need for greater support for rural placements as part of psychology training. As with previous research with resident rural and remote psychologists (Sutherland, 2012; Sutherland & Chur-Hansen, 2014), rural placements were considered the best way for psychology trainees to develop the competencies required for rural practice. Rural placements were also considered valuable by psychologists in introducing trainees to the benefits of rural practice as a recruitment and retention initiative. Essential, however, to increasing rural placement opportunities is increasing the number of psychologists available in rural areas who are able to undertake training and then supervise psychology students. Greater support for FIFO/DIDO placements may assist in addressing this gap. FIFO/DIDO placements may also allow students who are unable to undertake a resident rural placement (for example, for financial or family reasons) to experience rural practice.

The findings of this thesis also highlight a need for psychology training to focus more on working with and communicating with GPs. As noted, the findings of Study 2 suggest many GPs remain dissatisfied with the communication they receive from psychologists. Depending on the placements undertaken during professional training, psychology trainees may vary in their experiences in working with GPs. Haley et al.

(1998) outline recommendations for psychologists to work effectively in primary care, including tips for developing relationships with doctors, the utility of a problem-focused approach in working in time-limited settings, the need for a generalist approach, and the need to be willing to both educate and accept education from doctors. Including specific content in psychology training such as tips in addressing communicating with GPs will be discussed further in Section 6.3.3 in the context of implications for interprofessional education.

6.3.2 Medical education and professional development

The findings of Study 2 indicate that as with previous research with metropolitan GPs and GPs from larger regional centres (Beel et al., 2008; Dempsey & Donaghue, 2009), there may be gaps in rural GPs' knowledge of psychologists' training and expertise. Chapter 4 was written in response to this finding and was designed to provide this information in an accessible format for busy GPs. Wyman (2002) highlights the need for psychologists to be aware of the time pressures and workloads faced by GPs and to present their skills and services in a way that is relevant and accessible. Chapter 4 represents a direct outcome of this thesis in attempting to provide this type of accessible and relevant education for rural GPs.

GPs in Study 2 highlighted the limited opportunities for mental health training in their medical and GP training, with most GPs indicating that the 6 hour General Practice Mental Health Standards Collaboration (GPMHSC) training enabling them to claim the higher rebate Medicare items for the GP Mental Health Care Plan had been the only specific training they had undertaken in mental health (aside from the two GP participants with a special interest in mental health). Programs such Better Access rely on GPs' ability to identify and diagnose mental health problems before referral to a psychologist. Adequate training for GPs to ensure mental health problems are

accurately identified is therefore essential to ensure Australians can access psychological services. Increasing opportunities for interprofessional education between psychologists and GPs is discussed in Section 6.3.3 as a way of addressing possible gaps in GP mental health training.

6.3.3 Interprofessional education (IPE)

Interprofessional education and practice has been argued to be of particular importance in rural areas given the lack of services, complex nature of rural health and mental health problems, and professional isolation (Gum et al., 2013). Findings from this thesis (Study 1 and 2) indicated that GPs held positive views about the value and support provided by psychologists, and psychologists held positive views about the support provided by GPs. Findings from the community survey (Study 3) indicated a preference from community members for psychologists and GPs to work together.

The theory behind IPE is that by learning together, and increasing understanding of roles of different health professionals in a team, complexity can be more effectively managed through collaboration (Teodorczuk, Khoo, Morrissey, & Rogers, 2016). Despite the need for IPE opportunities for psychologists and GPs being highlighted as early as 2004 by Winefield and Chur-Hansen, prior to the introduction of the Better Access scheme, actual opportunities for IPE within university health professional training remain limited. Morrissey et al. (2011) highlight barriers to the implementation of IPE in health professional education including insufficient support and resources from universities (and the relevant schools such as psychology, nursing, social work, occupational therapy, and medicine), and emphasis on “disciplinary integrity” (p. 3) from professional accreditation bodies, the potential for curriculum overcrowding, and the lack of guidelines and curriculum materials.

The findings of this thesis suggest a need for increased opportunities for IPE in improving collaboration between future psychologists and GPs. Queensland's Griffith University has developed an IPE framework incorporating three phases: establishing health professions literacy (increasing knowledge of the roles and theoretical underpinnings of each discipline) in early training; simulated IPE experience (including workshops, discussions, and reflection on team practices) in the middle stages of training; and a third phase (as students approach professional registration) where this learning is applied to patient care settings (Teodorczuk et al., 2016). While challenges of implementing such models are noted, the eight-step guide provided by Teodorczuk et al. (2016) offers a starting point for universities to adopt successful IPE models.

As mentioned, interdisciplinary practice is considered particularly important in rural areas. Initiatives such as the National Rural Health Student Network (NRHSN), which supports rural health clubs at each Australian university, provide one of the few pathways for students from different health professions with an interest in rural health to interact through conferences and other learning opportunities. A training curriculum involving collaboration between family medicine residents and doctoral psychology trainees in the US found that 83% of family medicine residents indicated they had learnt new information or techniques from working with the psychology trainees, 89% stated the collaboration had enhanced their patient care, and 89% indicated the collaboration had enhanced their ability to work as part of a team (Porcerelli, Fowler, Murdoch, Markova, & Kimbrough, 2013). Increasing opportunities for Australian medical and psychology students to collaborate during their training through initiatives such as the NRHSN could be one method of addressing these knowledge gaps.

6.3.4 Rural psychology service delivery

Having previously been described as a “necessary evil” (Hanley, 2012, p. 48), the present thesis provides some support for FIFO/DIDO service models as an alternative model of service delivery that is more acceptable to some psychologists and some community members than resident rural psychology services. For the FIFO/DIDO psychologists in Study 1, working as a visiting rather than a resident rural psychologist was a “compromise” that allowed them to work in a rural area, while avoiding the ethical challenges and lifestyle concessions that have been highlighted by resident rural psychologists. Study 3 highlighted that while most participants preferred to see a local psychologist, a percentage of participants (almost 18%) preferred to see a visiting psychologist. Given difficulties in recruitment and retention of rural psychologists, the finding that FIFO/DIDO models of service delivery are acceptable (and preferred) by a subsection of psychologists and community members, indicates that FIFO/DIDO models may be a valuable option for recruitment and retention of psychologists in rural areas. Many psychologists may have an interest in rural work, but have concerns about the lifestyle impacts and ethical challenges of resident rural work. FIFO/DIDO work, in being highlighted as an “ideal compromise”, may provide both a professional opportunity for psychologists, and an opportunity for communities to receive greater access to services.

Rural FIFO/DIDO work was also highlighted by participants in Study 1 as an excellent learning opportunity for new graduates, with the ability to learn how services work together in a smaller environment considered an advantage. This could be put to new graduates as a recruitment and retention strategy (see Section 1.7.2 on reflexivity for an overview of the experiences of a graduate psychologist providing FIFO/DIDO services). Study 1 also identified support needs for FIFO/DIDO psychologists,

including appropriate compensation for the lifestyle impacts, appropriate induction into the rural community, appropriate office facilities, training and supervision, and the availability of local health professionals. This information could be used by service providers in making FIFO/DIDO services more sustainable. The findings of this thesis also highlight a need to address communication difficulties between FIFO/DIDO and resident practitioners, as this was highlighted by both the FIFO/DIDO psychologist participants in Study 1, and the GP participants in Study 2. Previous research indicates FIFO/DIDO services work best where local primary health care resources are adequately resourced (Hussain et al., 2015), hence efforts to provide sustainable FIFO/DIDO services must also address gaps in local service provision.

While the disadvantages of FIFO/DIDO service provision for both community members and service providers are noted, including the potential erosion of local services (Hussain et al., 2015) the findings of this thesis suggest there may be a role for FIFO/DIDO services as an adjunct, rather than a replacement, to resident psychology services. FIFO/DIDO services may increase options for rural community members in offering a choice of visiting and local practitioners, and increase options for psychologists interested in rural work who may not be able to live in a rural area, for a variety of personal and professional reasons.

6.3.5 Mental health policy and Medicare

The finding that GPs were generally very positive about psychology being accessible through Medicare under the Better Access scheme is consistent with research indicating the success of Better Access generally in increasing access to psychological services (Pirkis et al., 2011; Whiteford et al., 2014). However, the thesis highlighted limitations of the Better Access scheme from the perspectives of both GPs and community members. Both GPs in Study 2, and community members in Study 3

highlighted how the 10 sessions provided under the scheme was insufficient for their needs (with this being the most prevalent theme of the qualitative comments).

Specifically of interest were rural GPs' views of mental health care plans under the scheme, and the finding that requirement for a double appointment to create a mental health care plan may mean access is further reduced for rural populations, given the long waiting times for a double appointment. Community members also commented on the role of GPs as 'gatekeepers' in the scheme, with some indicating this presented an unnecessary barrier to accessing psychological treatment. The Better Access program has been criticised for failing to reach those in rural and remote areas (Meadows et al., 2015), with a demonstrated lack of uptake compared to urban areas. The findings of Study 2 suggest that the requirements of the scheme may be further restricting access to psychological services for rural and remote patients due to difficulties in obtaining a timely double appointment with a GP, supporting the recommendation of the National Review of Mental Health Programmes and Services to make the provision of a GP mental health care plan optional (National Mental Health Commission, 2014). The findings of Study 2 suggest removing the requirement for GPs to prepare a mental health care plan and allowing GPs to refer to psychologists via a referral letter could assist rural and remote patients to access psychology in a more timely manner given the often long wait for a double appointment to complete the plan before they can see a psychologist.

The findings of Study 3, including both objective measures of knowledge and qualitative comments from participants, suggest a need for community awareness campaigns about psychology and psychologists. Given 30% of the total sample were unaware of the availability of the Medicare rebate under Better Access (particularly considering this was a sample with an overall high knowledge of psychologists), further

work is required to promote psychology and the availability of Medicare rebates in the community, as the rate of awareness in the general community may be even lower. For example, a survey conducted by the Royal Australian and New Zealand College of Psychiatrists revealed less than half (38%) of Australians were aware of their eligibility for a Medicare rebate when seeing a psychiatrist (RANZCP, 2014).

Since the survey in Study 3 was conducted in early 2015, the Australian Psychological Society has developed several resources aimed at promoting psychology to the general public, including the ‘We are Psychology’ website with information about areas of practice endorsement and how to access psychologists, and the ‘Psychlopaedia’ website which aims to make psychological research and practice more accessible to the general public (Australian Psychological Society, 2016c). Given the findings of Study 3, indicating a disparity between rural and urban Australians in terms of their knowledge of psychologists, rural-focused information may be an addition to these resources. Rural and remote residents should be engaged in the development of rural health promotion initiatives, to ensure information campaigns address challenges and issues rural communities face, and meet local needs (National Rural Health Alliance, 2011). An example of a successful rural health promotion initiative is the Country Cancer Support website, a South Australian resource developed in response to an identified gap in information and support services for rural and remote South Australians accessing cancer treatment in Adelaide, developed via qualitative interview research with rural South Australian cancer patients (Fennell et al., 2016; Gunn, Turnbull, McWha, Davies, & Olver, 2013). However, the need for greater access to psychological services, not just information relevant for rural areas, to address this disparity in knowledge between rural and urban community members is acknowledged.

This highlights a need for further focus on recruitment and retention initiatives for rural psychologists, discussed in Section 6.3.6.

6.3.6 Recruitment and retention of rural psychologists

A theme present throughout all three studies in this thesis has been the need for more psychologists in rural areas, noted by psychologists themselves, rural and remote GPs, and rural and remote community members. This suggests the statistical maldistribution of psychologists is experienced on a practical level as a gap in services by these three groups. Knowledge gaps between rural and urban Australians regarding psychology and psychologists may be related to a disparity in access. The findings of the thesis therefore support a need for increased recruitment and retention initiatives and incentives for rural psychologists.

While there has been substantial investment in recruitment and retention initiatives for medical practitioners, there has been limited focus on allied health professionals (Durey, Haigh, & Katzenellenbogen, 2015). In a review of extrinsic (such as salary and availability of professional development) and intrinsic motivations (such as the pleasure derived from autonomy or challenging work) for allied health professionals working in rural areas, Campbell (2012) found that although intrinsic motivations that contribute to job satisfaction were present, there were insufficient extrinsic incentives to mediate for the burden of extrinsic disincentives which contribute to high turnover of allied health professionals in rural areas. They highlight the need for extrinsic incentives (e.g. better access to professional development and supervision, and appropriate financial compensation) to be developed to address this mismatch.

Current recruitment and retention initiatives for rural psychologists are limited. Financial incentives such as those available for medical practitioners relocating to rural

areas, such as the Australian Government General Practice Rural Incentives program, which provides incentives for medical practitioners to relocate and remain in rural areas (Australian Government Department of Health, 2016a) do not exist for rural and remote psychologists. Scholarships for rural psychology students are also limited. The Nursing and Allied Health Scholarship and Support Scheme (NAHSSS), valued at \$15,000 per annum for two years full time equivalent for clinical psychology postgraduate students with a rural background has previously been available, however at the time of writing this thesis it had not been confirmed by the Australian Government whether these scholarships would be offered for 2017. There are few specific scholarships available for undergraduate psychology students, or psychologists completing training pathways other than postgraduate clinical psychology. Many scholarships available for rural students for other allied health disciplines requiring undergraduate degrees exclude undergraduate psychology as completion of an undergraduate psychology degree does not directly lead to professional registration (unlike, for example, social work or occupational therapy). However, the lack of options for undergraduate rural scholarships may mean that rural students with an interest in rural psychology may never progress to complete postgraduate psychology or professional training to enable them to obtain registration as a psychologist, as pathways may not exist to support them through undergraduate training.

The lack of training pathways for rural psychology is also problematic. The Australian Psychological Society Rural and Remote Interest Group (RRIG) sought information from its student members in 2014 regarding their experiences seeking postgraduate psychology training (Australian Psychological Society Rural and Remote Interest Group, 2014). Most students highlighted that the availability of postgraduate training in psychology in their rural or remote area was a significant problem, with most

reporting no local options for completing professional training. Some students who had been offered a place in a metropolitan postgraduate course either faced significant difficulties in commuting and/or relocating to take up their studies, especially those with children or other commitments, with many students having to give up places offered for this reason. Students completing the alternative 4+2 internship pathway to registration as a psychologist³ highlighted the failure of the requirements of the program, developed in an urban context, to consider challenges of rural and remote practice such as the distance required to travel to see clients. The lack of distance education options for postgraduate psychology was highlighted, with many students indicating they had been forced to change career paths and undertake further study in social work or counselling, given the availability of distance education options for these pathways.

Durey et al. (2015) highlight the opportunities of the development of ‘rural pipelines’ for allied health professionals, similar to those developed for doctors, which consist of initiatives from school through to graduation and rural practice for students with rural backgrounds. Students are targeted in secondary school with information about health careers. In universities students are exposed to rural opportunities throughout the curriculum, including placements. Graduates who choose rural practice are then supported in the system. Durey et al. (2015) highlight the opportunities for rural pipelines to include allied health professionals who enter rural work at different stages of their career including through FIFO/DIDO work, or those looking for a ‘sea or

³ The 4+2 supervision pathway to practice is an intensive supervised training program in psychology completed in two years (post completion of a four-year undergraduate sequence in psychology) that leads to general registration as a psychologist in Australia. The program requires the development of a supervised practice plan to be undertaken as part of paid or unpaid work roles and is approved and monitored by the Psychology Board of Australia.

tree change'. The development of rural pipelines for psychology could therefore improve recruitment and retention of rural psychologists.

As discussed in Section 6.3.4, greater support for the provision of FIFO/DIDO services, in addition to appropriate resources for local services, may be a method of increasing the number of psychologists working in rural areas. The support needs of FIFO/DIDO psychologists highlighted in Study 1, including appropriate compensation for the lifestyle impacts, induction into the rural community, office facilities, training and supervision, outline the support required to recruit and retain FIFO/DIDO psychologists.

The findings of Study 1 indicated that consistent with previous research with resident rural and remote psychologists (Sutherland, 2012; Sutherland & Chur-Hansen, 2014), rural placements were considered valuable by psychologists in introducing trainees to the benefits of rural practice as a recruitment and retention initiative. Greater support for FIFO/DIDO placements may be a way for students unwilling or unable to commit to a resident rural placement to experience rural practice and potentially experience the benefits of rural practice.

6.3.7 Primary care psychology

The findings of this thesis also provide insights relevant to primary care psychology. GPs in Study 2 held positive views on collaboration and co-location with psychologists. Previous research has identified proximity as important in establishing successful working relationships between psychologists and doctors (Bray & Rogers, 1995), which was supported by the GPs in Study 2, who indicated co-location was helpful for communication with psychologists. The findings of Study 3 indicated the majority of rural community members held positive views on collaboration between psychologists and GPs, but not co-location. This may suggest there is something less

acceptable for community members about seeing a psychologist working in the same clinic as their GP, despite evidence that collaboration between psychologists and GPs and co-location of psychologist in GP clinics in primary care results in good outcomes for clients in terms of reduction of psychological distress (Vines, 2008; Vines et al., 2004). Further research may be required to explore reasons for this (see Section 6.5).

6.4 Methodological strengths and limitations

6.4.1 Strengths

The methods employed in this thesis were appropriate to achieve the aims of each study. Given the lack of research with health professionals providing FIFO/DIDO services, Study 1 aimed for richness of data, with a qualitative exploration most appropriate for this purpose. Similarly, the lack of research with rural GPs regarding their experiences and perceptions of working with psychologists meant a qualitative approach was also most appropriate for Study 2. A quantitative survey was most appropriate for Study 3 to explore community members' perspectives of psychology and psychology services, both to allow for a direct comparison between rural and urban community members and to allow for a sensitive and ethical exploration of community members' views. In its use of different methods, this thesis achieved its aim of triangulation of methods and triangulation of perspectives. The prevalence of themes across all three studies, including the need for better communication between GPs and psychologist, and considerations related to delivering services under Better Access in rural areas, enhance confidence in the findings.

The qualitative studies (Study 1 and 2) in this thesis demonstrated methodological rigour as discussed in Section 1.7. The qualitative studies captured psychologists and GPs from a wide range of rural and remote locations, work settings,

areas of interest (or practice endorsement, in the case of psychologists) and experience. The GPs, despite being from a group notoriously difficult to engage in research (McKinn, Bonner, Jansen, & McCaffery, 2015), participated without incentive, and often spoke for much longer than the intended 10-15 minutes suggested for the interview, suggesting the research was of interest and relevance to their practice.

Another strength of this thesis is its focus on implications for practice. Study 1 outlines a clear list of challenges, advantages and support needs for FIFO/DIDO psychologists which may be used by psychologists and organisations in aiding the delivery of successful FIFO/DIDO services in rural areas. A practical attempt to address the need for greater GP education regarding psychologists is represented in Chapter 4, a paper written specifically for GP professional education resulting from the gaps in knowledge identified in Study 2. The findings of Study 3 outline a clear list of areas on which campaigns to raise awareness of psychology and psychology services in rural areas could focus.

My position as a psychologist and a person from a rural background can be considered both a strength and potential limitation of the study, having been discussed in detail in the section on reflexivity (Section 1.7.2). Both identities may have assisted in the formulation of the research and design of the studies to ensure their relevance to both rural practice and the needs of rural communities. My position as a provisional psychologist and as a person from a rural background at the time of interviewing may have enhanced rapport with the psychologist participants in Study 1, as someone with a clear interest in their work. My rural background may have assisted in developing rapport with rural GPs, although I did not tend to mention this unless the participants asked (which most did, possibly indicating their interest). Similarly, my rural background was emphasised in media attention for Study 3, the survey (see Appendix

B), which may have increased the acceptability and interest for rural community members in terms of giving their time to participate. My transition to rural ‘DIDO’ psychologist in the writing of this thesis may have provided some advantages in terms of ‘insider’ knowledge, particularly in the discussion of implications for policy and practice as a practising psychologist as well as researcher.

6.4.2 Limitations

The study employed a mostly South Australian sample, hence limitations on generalisability may apply. The population distribution of South Australia does differ from the larger Eastern states, having been described as a “city-centric” state (reference), with most of the population located in Adelaide, with few large regional centres compared to the Eastern states. In addition, the lack of psychologists in rural and remote South Australia (11.5%, compared to the national average of 25%) reflects South Australia’s population distribution. While Study 3 (the community survey) was a national survey, the demographics of the survey did not reflect the national population distribution in terms of states, with more South Australian participants than the population distribution due to the convenience sampling method employed. The findings of the study may also reflect an Australian sample, with further research required to explore international community perspectives of rural psychological service delivery, although similarities between the Australian and international context were highlighted in Section 1.3.6.

In terms of the GP study, the limitations of qualitative methods are acknowledged in that GPs with greater interest or more favourable views of psychology may have chosen to participate. The participants were however willing to share negative experiences (particularly regarding communication) and their knowledge gaps, indicating they were still comfortable discussing less favourable aspects of working

with psychologists. Similarly, while the community survey may have also captured community members with more favourable views or more interest in psychology due to the nature of the convenience sampling method, many participants were comfortable sharing negative views or experiences of psychologists, as evidenced by negative comments being the second most prevalent theme in the qualitative comments. If the sample was relatively knowledgeable about psychology and psychologists, this suggests that psychology may be even less well understood in the general community.

As mentioned, there may be some limitations of my position as a psychologist and provisional psychologist providing services in a rural area during the conduct of the research and writing of this thesis, in terms of potential sources of bias. The adherence to standards of methodological rigour, particularly in the qualitative studies as outlined in Section 1.7 minimises this concern. Particularly in terms of the GP study, my position as a psychologist asking questions about psychology is acknowledged in terms of the potential impact on GP participants' willingness to share negative views of psychology, although as mentioned many GPs did still share negative experiences of working with psychologists. As mentioned in the previous section, the strengths of my position are also acknowledged.

6.5 Suggestions for future research

As an extension of this thesis, further research is indicated in terms of developing a greater understanding of factors influencing rural psychological service delivery. While this thesis adds to previous qualitative work with resident rural psychologists in the exploration of the experiences of visiting FIFO/DIDO rural psychologists, a direct quantitative comparison between urban and rural psychologists regarding the competencies required to work in rural and remote areas versus urban areas is still required.

A quantitative comparison of rural and urban GPs knowledge and understanding of psychologists, using similar methodology to the community survey (Study 3) to assess differences between rural and urban GPs, is also warranted. The need for rural GPs to have specific training for the rural context is reflected in the development of the Australian College of Rural and Remote Medicine (ACCRM), a specific training pathway for rural GPs. In addition to other areas of practice in which rural GPs require training and support different to their urban counterparts, ACCRM have developed specific mental health training for rural doctors: 'Mental Health Disorders: Training for Rural Practitioners', a 6 hour training similar to the General Practice Mental Health Standards Collaboration (GPMHSC) training cited by GPs in this study enabling them to claim the higher rebate Medicare items for the GP Mental Health Care Plan. Future research comparing rural and urban GPs may assist in identifying broader needs for more comprehensive rural GP mental health training and also in identifying information for psychologists about the needs of rural GPs compared to urban GPs in developing education for GPs about psychology.

In terms of primary care psychology, there is a need for further exploration of the finding that while community members prefer to see GPs who work with psychologists, most community members would not prefer to see a psychologist located in the same clinic as their GP. A qualitative study of rural community members who have been referred to a psychologist by their GP may provide an appropriate framework to explore this question. Another question requiring more in-depth exploration is rural community members' reasons for preferring to see a visiting psychologist. While most rural community members indicated they would prefer to see a local psychologist, there was a subset of community members who did indicate they would prefer to see a visiting psychologist. Participants from Study 1 and 2 (FIFO/DIDO psychologists and

GPs) hypothesised this may be due to reasons of confidentiality, however further qualitative research could explore this further in providing a greater understanding of rural community members' preferences.

Given limitations of the survey sample of Study 3 (highlighted in Section 6.4.2), a community survey with a more representative sample may be useful in exploring differences between states in terms of understandings and perceptions of psychology. Finally, the finding of Study 1 that personality factors may be important in working as a FIFO/DIDO rural psychologist is consistent with previous research with rural psychologists (Sutherland, 2012; Sutherland & Chur-Hansen, 2014) and rural doctors (Eley et al., 2008). Further research is required to examine the role of personality in recruitment and retention of both FIFO/DIDO and resident rural and remote psychologists

Much of the literature on rural and remote psychology practice focuses on the disadvantages and challenges of practising rurally, with less attention provided regarding the benefits of rural psychology practice (see Section 1.3.4 and 1.3.5). Study 1 highlights the advantages of FIFO/DIDO rural practice, including the diversity of work, the sense of satisfaction from providing a valued service to an under-resourced area, and opportunities for collaborative interdisciplinary practice. There is a need for further empirical research investigating the opportunities and benefits of rural practice in developing recruitment and retention strategies.

6.6 Conclusion

This thesis, in its exploration of the experiences and perspectives of rural and remote psychologists, general practitioners, and community members, provides a significant contribution in understanding the perspectives of key stakeholders in Australian rural psychological service delivery. Despite different health systems,

research from international contexts (see Section 1.3.6) suggests rural and remote psychologists face similar professional challenges, and rural and remote communities face similar health and wellbeing challenges, as the Australian context investigated in this thesis. Many of the findings from this PhD thesis may therefore be relevant in an international rural and remote psychology context. The thesis highlights the importance of rural and remote perspectives in the development and implementation of mental health care policy, given the specific needs and challenge experienced by rural and remote psychologists, general practitioners and community members.

Appendices

Appendix A – Published paper resulting from previous research by the author

Sutherland, C. R., & Chur-Hansen, A. (2014). Knowledge, skills and attitudes of rural and remote psychologists. *Australian Journal of Rural Health*, 22, 273-279. doi: 10.1111/ajr.12152

Sutherland, C. R. & Chur-Hansen, A. (2014). Knowledge, skills and attitudes of rural and remote psychologists.

Australian Journal of Rural Health, 22(6), 273-279.

NOTE:

This publication is included on pages 192 - 198 in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at:

<http://dx.doi.org/10.1111/ajr.12152>

Appendix B – Media release for Study 3 (Community survey)

Media Release

www.adelaide.edu.au/news



Monday 23 March 2015

How do we improve psychology services for all Australians?

Australians are being urged to take part in a new study that aims to better understand the community's attitudes towards psychological health services, and the needs of people living in both city and country areas.

The new online survey, being run by the University of Adelaide's School of Psychology, has emerged from health workforce data that shows a greatly uneven distribution of psychologists across the nation.

With almost 30,000 practitioners, psychology is the third largest health profession in Australia after nursing and medicine. More than 81% of Australian psychologists work in major cities, with the remainder in rural and remote areas. In South Australia, more than 92% of psychologists work in the metropolitan area.

Psychology PhD student Carly Sutherland says there is a clear need to better understand the attitudes of people in city and country areas, including those who have had experiences with psychological services, and those who haven't.

"Through this study we hope to identify potential improvements in psychological health care for the entire nation, both from the point of view of the psychology providers and from the public perspective," Ms Sutherland says.

"An important aspect of this is to understand more about what's required to work as a psychologist in the country, so we can help to address this gap in services. Such knowledge may lead to improvements in recruitment and retention of psychologists in rural areas.

"Critical to the success of this study is the input of people from both urban and rural areas, so that specific issues and needs can be incorporated in our findings," she says.

As part of her research, Ms Sutherland has been interviewing psychologists who provide fly-in, fly-out (FIFO) and drive-in, drive out (DIDO) services in rural and remote areas. "FIFO and DIDO work practices have been central to the resource and mining sectors in Australia for many years, but little has been known about the experiences of psychologists who provide these services, and community attitudes towards them," Ms Sutherland says.

Ms Sutherland's interest in this field originates from her own background, having grown up in Birdwoodton, just outside Mildura in rural Victoria. "I plan to work as a rural clinical psychologist when I graduate, and I hope this research will also encourage other psychologists to consider working in the country, as well as supporting those who are already out there making a difference to rural communities," she says.

Australians aged 18 and over – from either city or rural communities – are needed to take part in a short survey about psychology services. To participate, visit the study website:

<http://bit.ly/ozpsychsurvey>

Media Contact:

Carly Sutherland
PhD and Master of Psychology (Clinical) student
School of Psychology
The University of Adelaide
Mobile: [REDACTED]
carly.sutherland@adelaide.edu.au

David Ellis
Media and Communications Officer
The University of Adelaide
Phone: +61 8 8313 5414
Mobile: +61 (0)421 612 762
david.ellis@adelaide.edu.au

CRICOS Provider Number 00123M
adelaide.edu.au

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Appendix C – Published paper resulting from Study 1

Sutherland, C. R., Chur-Hansen, A., & Winefield, H. (2016). Experiences of fly-in, fly-out and drive-in, drive-out rural and remote psychologists. *Australian Psychologist*. doi: 10.1111/ap.12194

Sutherland, C. R., Chur-Hansen, A. & Winefield, H. (2017). Experiences of fly-in, fly-out and drive-in, drive-out rural and remote psychologists. *Australian Psychologist*, 53(3), 219-229.

NOTE:

This publication is included on pages 201 - 211 in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at:

<http://dx.doi.org/10.1111/ap.12194>

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