Perspectives on Clinical Psychology Training by Students at Australian Regional and Urban Universities

Edward Helmes¹ and Nancy A Pachana²

¹James Cook University, and ²University of Queensland

Training in clinical psychology in Australia has become increasingly popular after coverage for psychological services under national Medicare was introduced. All regional universities in Australia offer clinical psychology training at the master’s level, but little is known about how such training at these universities compares with training in larger, urban universities. Here, we report on results of surveys of clinical students and training directors at regional universities across Australia in order to contrast the perceived quality of training and various aspects of the nature of training. Responses from 190 students and all 35 directors of training show little difference in the perceived quality of training on several indices, with differences limited to the use of staff clinical research. Students at urban universities were less disposed to undertake a placement in a rural setting than those at regional universities.

Key words: clinical training; postgraduate training; student survey; perceived quality.

The practice of clinical psychology in regional and rural areas has common elements regardless of the country in question. Such elements include the low population densities that inherently lead to problems in service delivery. Relatively few psychologists work in rural and regional areas in proportion to the population, with specialists even less common. Few practitioners in rural and regional areas can afford to specialise, and must see a wide range of clients and be able to handle a broad range of problems. In some regions of Australia, a significant indigenous population means psychologists must also extend their services to a further highly diverse group. Maintaining confidentiality is more difficult in regional practices than in urban ones, and practitioners must frequently juggle more than one role in small communities. Such factors must be considered in efforts to improve the provision of psychological services in regional and rural areas.

While Australia has a high proportion of its population concentrated in the large metropolitan cities, several regional centres do provide tertiary education programmes, including those in clinical psychology. Many of the issues facing training programmes in rural and regional Australia are common to similar training programmes in other countries that have significant rural populations. Naturally, regional training programmes have fewer students than larger urban universities due in part to smaller numbers of academic staff in the programmes. Nevertheless, regional training programmes have operated over many years and have graduated significant numbers of students, many of whom now practice in rural and regional Australia. The current article reviews some of the relevant issues and compares perceptions of urban and regional training in clinical psychology.

The development of mental health services in rural areas was advanced in the 1970s in the USA through various initiatives of the National Institute of Mental Health across that nation (Hutner & Windle, 1991). These initiatives strove to be multidisciplinary in nature, take account of issues intrinsic in rural areas of the USA (e.g., Native American needs, lack of access to specialist healthcare professionals such as psychiatrists and psychologists). Barbopoulos and Clark (2003) and Keller, Murray, Hargrove, and Dengerink (1983) summarise the issues that psychologists in particular who practice in rural areas must deal with, including the broad range of clients, high proportion of indigenous clients, and concerns about privacy and confidentiality. Jameson and Blank (2007) cover some of the same issues and propose some solutions including especially better training for rural practice, use of new technology, use of evidence-based practice, and grassroots advocacy.

Elder (2007) notes the important role of the US Veterans Affairs (VA) programme in developing mental health services in
rural areas. Indeed, in both urban and rural areas in the USA, the VA healthcare system operates as at least a partial “safety net” for those currently and formerly in the military and their families. The VA also serves as the largest single provider of mental healthcare training to a wide range of disciplines including psychology (Hutner & Windle, 1991).

Initiatives to improve psychological services in rural settings span didactic coursework in the USA (Harowski, Turner, LeVine, Leichter, & Schank, 2006), workshops in Australia (Hodgins, Murray, Donoghue, Judd, & Petts, 2004), and placements in rural areas of Australia and Canada (Bhar, Hodgins, & Eaton, 2006; McIlwrath, Dyck, Holms, Carlson, & Prober, 2005; Murray, Hodgins, Judd, Jackson, & Davis, 2002). Many issues described in the articles can be successfully imported as ideas worth pursuing in Australia’s clinical psychology training programmes.

The USA, Canada, and Australia are all countries with substantial rural populations and well-established clinical training systems. However, clinical training in Australia is in transition. One major factor was the introduction of government-subsidised psychological treatment into the national Medicare scheme (Gleeson & Brewer, 2008). This development made psychological treatment more widely available in rural and regional areas of Australia (Giese, Lindner, Forsyth, & Love-lock, 2008), but with the number of clinical psychologists practising in rural areas of Australia still remaining lower than might be desired, fewer benefits from psychological services are delivered in regional Australia than in larger cities.

Changes to the common training schemes in Australia are also in transition as a system of national registration for the majority of healthcare professions replaces the State-based systems. National registration also brings changes to the pathway permitting individuals with 4 years of undergraduate training to become registered (Littlefield, Giese, Stokes, & Voudouris, 2009; see http://www.psychologyboard.gov.au for the guidelines for 4 + 2 internship programme: Provisional psychologists and supervisors). These changes to the 4 + 2 programme include the prospect of a formal examination that may make the option less attractive and reduce the number of generic practitioners entering the workforce in the future. An alternative training pathway involving a year of generic professional training plus a year of supervised practice (“3 + 1” model) has also been proposed and approved by the regulatory bodies, but it is yet to be seen how many such programmes are established by universities and how many graduates they can produce.

The concentration of population in Australia in the coastal margin of the continent means that training programmes in clinical psychology are also concentrated in such areas. Although most clinical training programmes are located within or relatively close to capital cities, eight are in areas regarded as regional. Given efforts by the Australian Psychology Accreditation Council (APAC) to maintain common elements in the training programmes that it accredits and by the College of Clinical Psychologists to do the same for programmes that it approves, training programmes across Australia likely resemble one another more than they differ in emphasis and focus regardless of whether they are in regional or remote areas. For example, all would espouse the scientist-practitioner model of training and evidence-based assessment and treatment.

Despite such efforts, differences in programmes are present due to elective content and to differences in staff orientation and teaching patterns. At the same time, the universities with clinical training programmes differ substantially in size of the parent psychology departments in terms of numbers of staff, undergraduate students, and clinical students. Numbers of associated administrative support staff and adjunct teaching and clinical supervisory staff may also vary. The demands of the local environment may also be relevant. Rare psychological conditions may simply not be present and not evident in local clinical practice due to the limited local population, while the severity of other conditions may be greater due to the relative shortage of mental health practitioners in comparison with urban settings with more mental health services.

Access to placements may differ between urban and regional settings as well. Regional and rural placements may be more difficult to organise and run due to distances involved as well as lack of financial support for students who might accrue increased costs in pursuit of such positions. The availability of qualified and trained supervisors is invariably lower in areas with lower population, leading to a likely shortage of placements and increased use of distance supervision methods. Furthermore, the ability of rural psychologists to upgrade qualifications and thus be eligible for greater supervision of students remains hampered. Limitations on web and communication networks in regional and remote regions may also have a negative impact upon placement potential, despite the current development of online training packages that could be used to upgrade the skills of rural practitioners if the level of available technology permitted (Bennett-Levy & Perry, 2009).

There have been a range of efforts to improve the uptake of clinical psychology students into opportunities offered in regional and rural areas in Australia. A pilot rural clinical psychology placement scheme was funded by the Rural Health Support, Education, and Training Scheme in 1999. This pilot was evaluated (Dollard, Shafik, Court & Heffernan, 2000), and the data showed that students showed greater interest in taking up rural psychologist positions if they had had such a placement opportunity. Similarly, Services for Australian Rural and Remote Allied Health are the new administrators of the Clinical Psychology Scholarship (formerly the Mental Health Post Graduate Scholarship Scheme). This scholarship supports students applying to commence or already enrolled in a clinical psychology postgraduate course in Australia. Both of these initiatives have met with success in terms of encouraging students who are interested in pursuing clinical work in regional Australian locations but to date have been relatively limited in scope.

One question not addressed in the literature to date is the extent to which clinical psychology students at regional universities regard their training as being of good quality in comparison with their urban peers. The goal of this report is to examine differences in the reports of postgraduate students in clinical training programmes in regional versus urban Australian universities as to aspects of their training, including the perceived quality of their training.


Table 1  Comparison of Australian Urban and Regional Universities on Measures of Clinical Training

<table>
<thead>
<tr>
<th>Measure</th>
<th>Maximum Score</th>
<th>Urban universities</th>
<th>Regional universities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD (n)</td>
<td>Mean</td>
</tr>
<tr>
<td>Overall quality</td>
<td>10</td>
<td>7.8</td>
<td>1.29 (118)</td>
</tr>
<tr>
<td>Workload</td>
<td>10</td>
<td>7.9</td>
<td>1.49 (118)</td>
</tr>
<tr>
<td>Perceived stress</td>
<td>10</td>
<td>7.8</td>
<td>1.78 (119)</td>
</tr>
<tr>
<td>Use of clinical research</td>
<td>4</td>
<td>2.4</td>
<td>.88 (115)</td>
</tr>
<tr>
<td>Management of problematic students</td>
<td>5</td>
<td>3.1</td>
<td>.87 (104)</td>
</tr>
<tr>
<td>Range of clinic clients</td>
<td>4</td>
<td>3.4</td>
<td>1.10 (98)</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>4</td>
<td>2.9</td>
<td>.40 (99)</td>
</tr>
<tr>
<td>Rural placement</td>
<td>5</td>
<td>2.7</td>
<td>1.26 (119)</td>
</tr>
</tbody>
</table>

Note: *p < .01.

Method

Participants

Participants were first year students in postgraduate clinical training programmes. Students were recruited through programme directors at each of the 35 Australian universities with clinical training programmes in semester 2, 2009. Programme directors were contacted through the listserv of programme directors maintained at the University of Queensland. Of the 35 directors, 20 responded favourably and were sent questionnaire packs for the students at that university. Questionnaire packs included information sheets, informed consent form, and a four-page survey. If students consented to participate, they returned the surveys to the local programme director, who then returned them by post to the Teaching and Educational Development Institute at the University of Queensland, which collated the results, entered the data, and did the preliminary descriptive analyses (see Pachana, Scott, & Sofronoff, 2011 for further details of the survey).

Clinical directors were surveyed independently later in the year by telephone. All agreed to participate and those who identified as coming from regional universities (n = 10) answered a series of additional questions relating to placements and other issues for regional universities.

Materials

The survey was developed by the group and comprised 18 questions. Questions covered student perceptions of the best and most problematic aspects of their course and why they applied there. A 10-point rating scale was used to evaluate overall perceived quality, workload, and stress. Five-point rating scales were used for questions on teaching and assessment methods, while 4-point scales were used for questions on supervision methods and other open-ended questions evaluated other aspects, such as recommendations for improvements in the programme. For purposes of this article, only the questions most relevant to the perceived quality of training and to regional issues are examined. These were student workload and stress, use of clinical research, client caseload, supervision, and willingness to undertake a placement in a rural area.

Programme directors were asked in the telephone interview about issues relating to retaining clinical psychologists in their region, how their programme targeted those issues, approaches to clinical supervision and the use of distance supervision, placements and the use of technology for placement supervision, characteristics of field supervisors, and requirements for supervision hours, with a final question on any other matters of concern.

Results

Student Survey

The response rate at the university level was 57% with 190 surveys being returned in total. The return rate represents approximately 10 students at each responding university. It is not possible to determine the response rate in terms of the total population of first-year clinical students because of a lack of accurate information on the number of students at each participating programme. Of the returned questionnaires, 125 (71%) were from urban universities, and 51 were from the eight regional universities. Fourteen students did not indicate the location of their university.

Means and standard deviations for the eight items for urban and regional programmes are reported in Table 1. The urban and regional universities did not differ on the perceived quality of training. The overall perceived quality of training was rated at a mean of 7.7 out of 10 (SD = 1.28). Workload was rated as heavy at a mean of 7.8 out of 10 (SD = 1.47), as was the overall level of perceived stress at a mean of 7.8 out of 10 (SD = 1.70). Urban and regional universities did not differ on these characteristics. One further aspect of the perceived quality of the programme from the perspective of training in the scientist-practitioner model was the extent to which clinical teaching staff used their own clinical research in their teaching. This characteristic did show a difference between urban and regional universities in that urban universities were more likely to use materials from their own clinical research in their teaching (t = 2.84, 163 d.f., p = .005, 95% CI for the difference = .12 to .69). Clinical training programmes all have means of dealing with students who fail to meet academic standards, but the challenges provided by students who show significant levels of interpersonal problems or unprofessional conduct must also be
managed. The urban and regional universities did not differ from one another in this regard but were seen by students in both settings as being neither good nor poor at handling problematic students.

Training programmes also provide students with their initial exposure to clients and to clinical supervision. A small majority of the students felt that the number of clients and their associated clinical needs were appropriate, with no differences between urban and regional universities. This was also true for the amount of clinical supervision received, with over three quarters of the students agreeing that the amount was “just about right.”

Finally, the students at regional universities were significantly more open to undertake a placement in a rural setting than were their urban colleagues \( t = 4.75, 167 \text{ d.f.}, p < .001, 95\% \text{ CI for the difference} = .60 \text{ to} 1.43 \). The students at urban universities were less than likely to undertake such a placement, whereas the students from regional universities were moderately positive at the prospect.

**Training Director Survey**

Few common themes emerged from the survey of programme directors at regional universities. Some had experienced falls in referrals to their internal clinic; others had not. All had many more applicants to their programmes than they could accept into their programmes, but external placements were an issue for many. Programme directors generally agreed that one of the impacts of Medicare funding was the departure of experienced supervisors from positions in which they provided external placements for clinical students. This was a particular problem for some of the regional programmes because of the limited number of clinical psychologists in the area who could provide supervision for students.

**Targeting recruitment and retention in rural and regional areas**

One of the respondents said that they managed these issues well because their university and programme specifically focused on the needs of rural, regional, and remote areas within Australia; they took only fully registered psychologists and provided training through distance education. The students were being provided with the necessary training to upgrade to a clinical qualification part time from the rural or remote area in which they lived and worked. The fact that these students were already employed in the area meant that they were more likely to remain there once fully qualified. Depending upon where these particular students were employed, they may have “swapped” positions with another part-time employed clinical postgraduate student to fulfil a placement requirement. One other way in which the issue of placements was managed included persuading existing supervisors to take more than one student at a time and actively encouraging their own graduates to take students on placements.

There were specific units included in a number of the programmes that were designed to encourage the students to remain in rural practice once they graduated. These courses exposed students to the demands of working as a psychologist in a rural setting. Other courses targeted issues related to the rural clinicians’ own mental health.

**Clinical supervision in rural and regional areas**

There were a number of reported ways in which rural and regional programmes managed the provision of clinical supervision for their students on placements. Some worked to build capacity through supporting beginning supervisors in their pursuit of goals, such as obtaining full Clinical College membership. University staff had been trained to supervise and often took on the full supervision load according to one of the respondents. One of the difficulties with this was that students were not exposed to a range of different supervisors. University staff may have also provided backup supervision support when there was not enough local supervision according to some of the respondents. The technology being used by regional and rural universities in providing supervision appeared similar to those used by urban universities. Respondents mentioned video and DVD cameras and digital voice recording. Two respondents said that they also used webcams.

Students from rural and regional universities completed one to two internal placements throughout their programme. Some of the students would do an extended internal placement or a further part placement in order to make up the necessary supervision hours. The number of external placements that students in regional and rural programmes completed was approximately two for the Master’s, and between two and four for the Doctorate programmes. It was common for students to be doing much more than the number of required hours, however. In some cases, students were completing up to 2,000 hr of placement in order to meet the required 400 hr of client contact according to one of the respondents. This placed considerable pressure on the student and also on the placement programme.

Three of the 10 programmes were using some form of distance supervision, although this was not seen by these respondents as desirable. The extent to which it was being used was quite low across the three programmes, and according to one respondent, it was not used for more than one placement. Each of these respondents said that they would avoid using distance supervision entirely if it were possible and that having a good local supervisor was far more preferable.

Issues that affected the completion of placements by students in rural and regional university programmes were reported by seven of the 10 directors. These related mainly to supervision. Some placements did not provide students with sufficient hours of supervision to meet the requirements of the college according to two respondents. One of the ways in which this issue was addressed was to run parallel groups of supervision sessions within the university programme. To a lesser extent, poor communication or personality clashes with supervisors were mentioned as issues affecting placement completion. A supervisor may say that a student is not ready for a particular placement. One other issue related to family commitments. At one university, the majority of fully registered students were at a point in their lives when they may have had to cease a placement to have a child. The remaining three respondents said that there were no concerns with the completion of placements, however,
one of these respondents stated that it was too early to judge accurately given that the programme was new, and only one of their students had completed a placement at that stage.

According to respondents of regional and rural universities, the essential characteristics of field supervisors were that they should be suitably registered, qualified, and specifically trained to supervise students, preferably a member or eligible for membership of the College of Clinical Psychologists, and have had extensive work experience in their particular specialist area. The extent to which supervisors made themselves available to the students they supervised and to university staff was seen as essential when choosing suitable supervisors. Personal characteristics were also seen as important. Possessing the ability to self-reflect, communicate well, having a thirst for knowledge, and a commitment to professional standards and professional development were also very important according to some of the respondents. One respondent also mentioned that having an appreciation of the varying abilities and skill levels of students and the ability to match the supervision to that student’s skills and abilities were vital characteristics for supervisors. Being warm and empathic with students was a desirable characteristic of supervisors for one respondent. Another respondent thought it desirable that supervisors in regional and rural areas were prepared to do more teaching with their students through role plays and feedback.

State Registration Board and APAC & APS College requirements

Respondents were asked to comment upon the need to have students meet the requirements of both the State Registration Board and those of APAC and APS College of Clinical Psychologists. One respondent noted their own affiliation with the Registration Board, as did another with the former APS accreditation committee, now APAC. A further respondent stated that because their students came to the programme already registered, they had to meet the requirements of the APAC guidelines and the particular college alone.

The vast majority of respondents saw this issue as a less than ideal situation. The respondents stated that the situation created confusion with the exception of three respondents who disagreed that there was any issue at all. Some said that this issue was particularly confusing for students and that it placed additional demands on staff who had to track whether students were meeting the different sets of requirements of one or other of the bodies. Having dual pathways to registration, that is four plus two and 6-year training, had inevitably led to the current confusion, according to respondents. One respondent felt that they should meet the requirements of the Board first and foremost.

Other issues related to training and retaining regional clinical psychologists

The other issues that were seen as important for training and retaining clinical psychologists in regional and rural Australia were many and varied. There was a comparatively greater need for regional and rural psychologists experienced a lack of peer support by virtue of their locality and also had fewer opportunities for professional development compared with urban psychologists. According to one regional respondent, persuading graduates to go from regional to more remote rural areas was also an issue. One suggestion to attract and retain psychologists in rural Australia was to have incentives in place, such as a pay differential and subsidised housing as is the case for other professions in rural areas.

Funding and access to state-of-the-art technology was seen as another important issue. The programmes were comparatively more expensive to run in rural and regional areas and expensive for students to access, despite the availability of scholarships for some rural students. Often, rural students had to leave their jobs and move somewhere else without pay to attend a placement. In that case, to support clinical psychology in rural areas it would be necessary to also support students’ accommodation requirements.

One last comment was made in relation to training indigenous psychologists. It was felt that there should be more examination of the issues surrounding how to attract and recruit indigenous students to clinical training programmes. Training indigenous psychologists is important in and of itself, and in doing so, would provide the regions in which they lived with qualified psychologists.

Discussion

For the most part, there were minimal regional-urban differences in the perspectives of the students who responded. There were encouraging reports of no differences between urban and regional universities in the perceived quality of their training. There were similar correspondences in term of client factors and clinical supervision but also in terms of heavy workloads and high levels of perceived stress. The notable difference between regional and urban programmes was in the greater use of material from staff clinical research in the urban programmes. Further differences reflecting greater resources in the urban programmes would also have been expected but such were not observed. Indeed, the similarity in reports by students from both urban and regional centres was striking. Given the sample size, the reason for the lack of differences is unlikely to lie in a lack of statistical power. We can but speculate as to other factors that might lead to a lack of differences, but it is likely that the policies embodied in APAC accreditation and college approval lead to both similar programme structures and similar attitudes and behaviours on the part of the clinical teaching staff who have graduated from Australian clinical programmes themselves. We did not ask about the background of clinical teaching staff, so we cannot confirm that this is indeed a factor.

It is not surprising that students in regional training programmes are more willing to undertake a rural placement than their urban colleagues. For many of them, such a placement would be an obvious preference. The next question is what can be done to encourage students in urban settings to undertake a rural placement. The immediate barriers include the shortage of qualified supervisors. At the same time, placements in regional settings that do have supervision available often go unfilled because no students apply. A central directory of placements,
akin to the directory of APA-accredited internships, might be one solution to make rural placements better known to students at urban universities that may be experiencing difficulty finding placements for all students. Certainly, other efforts are warranted as well. The inclusion of content related to practice in rural and regional Australia should be a requirement in accredited training programmes, and programmes should be encouraged to have admission policies that would encourage practitioners from regional and rural areas to upgrade their skills. An example of a policy that operates against selection of experienced practitioners is the requirement for all students to undertake their initial placement in a programme’s internal clinic. Subsidised accommodation, travel expenses, and a different experience in often attractive environments can be incentives for rural placements. Rural medical practitioners and Divisions of General Practice can be educated in the benefits of psychological services for their clients and in turn can become advocates for positions for psychologists in the regions. In addition, work with indigenous clients, rural issues that can incorporate conditions arising from natural disasters such as drought and flood, may be appealing to students looking for a different placement experience. Indeed, both urban and regional programmes have an interest in promoting better training for practice in the regions. Initiatives to improve rural psychological training often have arisen from metropolitan programmes (Lyon, McLean, Hyde, & Hendry, 2008; Murray et al., 2002). Others arise from regional universities, such as the problem-based learning programme of Charles Sturt University (Kiernan, Murrell, & Reff, 2008). Publications from Manitoba (Dyck, Cornock, Gibson, & Carlson, 2008; McIlwraith et al., 2005), Nebraska (Hargrove, 1991; Hargrove & Howe, 1981), Mississippi (Wood, Miller, & Hargrove, 2005), Oregon (Campbell, Campbell, O’Friel, & Kennedy, 2009), Saskatchewan (Crossley, Morgan, Lanting, Dal Bellow-Haas, & Kirk, 2008), and Hawai’i (Oliveira et al., 2006) illustrate both the common issues of factors related to geographic distance from metropolitan areas, but also unique characteristics caused by the particular rural environment can lead to notable differences across different rural geographies. The proportion of indigenous clients is often a factor in such differences, while in other cases, cultural differences among migrants to a community may become a particular issue in a different rural community.

Certainly, a placement in a regional or rural area would only be considered for a student with a degree of experience and emotional maturity, as noted by one programme director whose programme only takes as students registered psychologists. In such a case, might an argument be made for a regional or rural placement preference for the final placement for clinical doctoral students? The greater length of the doctoral placement would certainly provide time for adaptation to the setting and for seeing clients through to termination without the need to hand over treatment. If so, are there sufficient doctoral students to make a difference?

Clinical training in Australia is moving slowly towards the 6 years that are common in most of developed world, ranging from six in Europe with the EuroPsy award (Lunt, 2008) to the eight or more common to Doctor of Philosophy degrees in clinical psychology in Canada and the USA (Helmes & Pachana, 2005; Helmes & Wilmoth, 2002). International mobility of employment for Australian psychologists remains limited in the case of the UK and North America because of the doctorate degree being taken as the minimum qualification for independent professional practice in those jurisdictions. Many state and provincial registration boards would only accept Australian professional doctorate awards, whether Doctor of Psychology or Doctor of Philosophy. Nevertheless, it is highly likely that the 6-year standard for clinical training will continue to be the common programme among university training programmes and be increasingly accepted as the basic degree for independent professional practice. That may still not be sufficient to fill the demand for clinical psychologists in rural and regional Australia.

Recent evidence suggests that clinical training at the doctoral level is fading in popularity (Voudouris & Mrowinski, 2010). Whether or not this is a function of financial pressures on universities to reduce money-losing programmes (Voudouris & Mrowinski, 2010) or such pressures on students to finish their degrees sooner in order to enter the workforce to reduce their accumulated debt from six or more years of university fees and expenses. However, individual university experiences may differ—for example, at the University of Queensland, interest in the professional doctorate programmes has been steadily growing (Pachana, personal communication, 30 August, 2010).

Rural and regional areas are not homogeneous, and the diverse features mean that different responses are needed. Given these results and the relatively modest efforts to date to encourage students in regional and remote areas to pursue clinical training in psychology, we would encourage students in general to at least have knowledge of non-urban practice issues. Based on our current surveys and experiences, we offer the following suggestions to students interested in practice in rural and regional Australia, universities, clinical teaching and supervision staff, and the relevant professional bodies:

- Provide additional support for regional, rural, and remote placement and study scholarship schemes
- Make knowledge about practice issues in regional and rural Australia required as part of clinical training in all programmes
- Increase the flexibility of accreditation guidelines to regional and rural issues
- Improve the access of regional psychologists to upgrade their clinical skills and credentials so as to increase their capacity to offer supervision for students and their peers
- Educate regional and rural general practitioners (GPs) in psychological interventions and to the various roles and services offered by psychologists that can be accessed via Medicare
- Limitations of the study include its cross-sectional nature and participation of students from just over half of the training programmes in Australia, leading to limited generalizability of the results. Such a snapshot cannot evaluate the development of student trainees through their coursework and placements to become more skilled, and presumably more confident in their practice. Presumably, stress levels also subside once the programme is completed, but only a longitudinal study that continued after graduation could confirm this. Anecdotal reports suggest that stress levels in many positions occupied by psychologists remain high, but this needs to be confirmed by empirical studies. It may well be that those who desire less stress
in their practices gravitate towards positions in rural settings and they consequently do experience less stress (Birk & Kim, 1995). This study also provides a broad sample of student perspectives on their training, and the lack of differences between urban and regional university programmes provides some evidence that the national accreditation system does operate to reduce at least some disparities across the range of universities in Australia. As the new national registration system becomes established, greater uniformity of training standards will also ensue. It is clear that the flux within Australian clinical training is not abating and that additional developments will take place. One can but hope that further changes will be subject to empirical study, and that evidence will have a role to play in the context of political priorities.

Acknowledgements

Support for this work has been provided by the Australian Learning and Teaching Council Ltd, an initiative of the Australian Government Department of Education, Employment, and Workplace Relations (Award PPR-900 to N. A. Pachana, K. Sofranoff, A. Baillie, M. Kyrios, G. Murray & E. Helmes). The views expressed in this report do not necessarily reflect the views of the Australian Learning and Teaching Council.

References


