Victorian Allied Health Workforce Research Program

Occupational Therapy Workforce Report

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VICTORIA State Government | Health and Human Services

Occupational Therapy Workforce Report

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Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. Where the term ‘Aboriginal’ is used, it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

Contents

Abbreviations and acronyms

ABS	Australian Bureau of Statistics
AH	Allied health
AHA	Allied health assistant
AHPRA	Australian Health Practitioner Regulation Agency
AHWQ2	Allied Health Workforce Questionnaire – 2
AIHW	Australian Institute of Health and Welfare
CPD	Continuing professional development
DET	Department of Education and Training
EBA	Enterprise bargaining agreement
EFT	Equivalent full time
NDIS	National Disability Insurance Scheme
NFP	Not for profit
OTA	Occupational Therapy Australia
PD	Professional development
SWEP	State-wide Equipment Program

Executive summary

Overview

This report provides an overview of the occupational therapy workforce in Victoria in 2016 - 2017. It is based on survey responses from 1,217 individual occupational therapists (approximately 25% of Victorian occupational therapists with registration with the Occupational Therapy Board of Australia (OTBA) in December 2016 (OBTA, 2017)), five focus groups involving 20 participants, two individual interviews, and surveys from 270 government, non-government, and private organisational respondents that provide occupational therapy services across Victoria.

When contrasted with 2015 data from the Australian Institute of Health and Welfare (AIHW) (2016), the respondent cohort included an over-representation of individuals employed in the public sector, individuals over 35 years, and people living in regional and rural areas.

Key findings

Occupational therapists	AHWQ2 survey	AIHW 2015[a]	OTBA, 2016[b]
Victorian population	1,217	4,054	4,789
Female	94%	91%	92%
Aboriginal and / or Torres Strait Islander	1%	.02%	
Australian trained	92%	92%	
Age 35 years and under 55 years and older	47% 10%	55% 9%	
Median age (years)	35		
Median income / annum	$60,000 to $69,900		
Public sector	85%		
Not for profit sector	8%		
Private sector	5%		
Principal area of practice	Rehabilitation		
Reporting advanced practice role	16%		
Work with allied health assistants	52%		
Reported use of telehealth	9%		
First qualification to practise	Bachelor degree - 75%		
Hold PhD	1%		
Intention to stay in profession for more than five years	77%		
Work for two or more employers	18%		
Of those with a supervisor, occupational therapist as supervisor	72%		
% of workforce in rural areas	7%	0%	

[a] *Source: AIHW, 2016*

[b] *Source: OTBA, 2017*

The occupational therapy workforce in Victoria is a young, female dominated and growing workforce. Participants to this research reported strong job satisfaction. Key contributors to this satisfaction included the holistic nature of their work and opportunities to work across different populations, in diverse roles, and for a range of different sectors. Within the workplace, individuals reinforced the importance of being able to make a difference to their clients, a positive team environment, supportive management, and opportunities to continue learning across their career.

Despite these positive observations, the occupational therapy respondents explained that services are under-resourced to meet current demands. Consequences were reported to include long waiting lists, an inability to meet agreed benchmarks for assessment and intervention, compromise to clinical outcomes through an inability to deliver evidence-based practice, concerns regarding service quality, concerns regarding client safety following hospital discharge or while waiting for services and equipment, risks for readmission, and an inability to deliver primary and secondary prevention services. Impacts on staff were also reported to be significant, including increasing unpaid over-time to meet clinical demand, reducing job satisfaction, increased sick leave, and burn out.

The challenges of meeting clinical demand were reported to be exacerbated by the fact that many organisations do not provide backfill during staff leave.

As a profession, occupational therapy provides services to a wide client cohort. Most respondents to this research provided services to adults over 21 years, with only 18% of respondents providing services to children and young adults. This is consistent with the observation of a notable gap in services for children and young people.

Occupational therapists recognised that the profession's holistic role in occupational performance is not well understood. To improve this, respondents felt the profession needs to communicate better to the community and other professionals about the profession's existing evidence-base, improve the consistency with which evidence is applied, and expand evidence across the continuum of care.

When recruiting occupational therapists, numerous organisations reported receiving up to 50 applications for junior positions. Even so, a handful of organisations still reported having unfilled junior positions. Significant concerns were expressed by many respondents about the increasing numbers of new graduates potentially resulting in challenges securing employment. However, no strong evidence was found to support this concern. Recruiting to intermediate and senior positions was reported to be more difficult. Applicant numbers were markedly lower than for junior positions and it appeared to be difficult to attract a person with appropriate skills and experience.

Career progression was raised as an important issue for the profession. Many respondents expressed frustration at the minimal opportunities to advance beyond grade 2. Where these opportunities existed, they typically required relinquishing a focus on clinical work in favour of a management or project-based role. Professionals reported that choosing to retain a clinical focus often meant sitting at the grade 2 level for the duration of your career, despite decades of experience and increasingly specialised clinical experience.

Although a clear majority of occupational therapists reported they have the skills and tools to carry out their roles, only half agreed they have access to adequate training to progress their career and mentorship to support career growth. The requirement for specialised training in specific areas of practice, to supplement the holistic foundations on which occupational therapy is built, was reported as a specific need. Occupational therapists employed in generic roles articulated the need for more discipline-specific training opportunities. Access to more affordable and accessible professional development opportunities was raised as an issue by many respondents. This was particularly problematic for part-time workers and professionals from regional and rural areas.

Over recent years, occupational therapists have played an increasing role in transdisciplinary teams through generic roles. This is particularly the case within mental health services. The research participants indicated that occupational therapy is well-suited to these roles given the holistic underpinnings of the profession. However, specific challenges were reported in relation to pay parity and entitlements where other professions are employed against the same job description but are paid at a higher rate and receive more favourable entitlements.

Conclusions

Key areas of consideration for the occupational therapy workforce going forward include:

- Improving community and professional understanding of the benefits of meaningful occupational engagement as a key contributor to maintaining and improving physical and mental health, and the role of occupational therapy in this process.
- Need to strengthen the evidence and knowledge base of the profession to improve referrals and develop business cases for optimal staffing levels to help improve patient outcomes.
- Reviewing funding models and models of care to optimise clinical outcomes and client safety by enabling delivery of services consistent with current evidence-based.
- Developing career structures that recognise and encourage expertise and experience.
- Exploring mechanisms that will facilitate improved capacity to meet workforce demand at the intermediate and senior levels.
- Review of pay, entitlements and rebates where different professions are delivering an equivalent service.
- Exploring holistic nature and skill set of profession and how this can be leveraged to support workforce demand.
- Exploring settings within which occupational therapists can create greatest impact (e.g. paediatrics) for improving patient/client outcomes.

Introduction

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

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

Please note:

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

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

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

Background

Who are occupational therapists?

Occupational therapy is a client-centred health profession focussed on promoting health and wellbeing through engagement in daily occupations. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to participate in, or by modifying the occupation or the environment to better support their occupational engagement (World Federation of Occupational Therapists, 2012).

In Australia, occupational therapists work with people to promote their participation in the activities of daily living at any stage across the lifespan. That is, babies and children, adolescents, adults and older people. Occupational therapy practice is person-centred, yet may be delivered directly to individuals and groups of individuals, or strategically to communities and society. In Victoria, occupational therapists work in a wide range of public, private and NFP settings, including, but not limited to:

- hospitals
- community health centres
- aged care facilities
- people's homes, including group homes
- community settings
- childcare centres, kindergartens, preschools, schools and other educational facilities
- mental health services
- alcohol and drug services
- correctional facilities
- corporate and industrial settings
- employment
- government departments and services

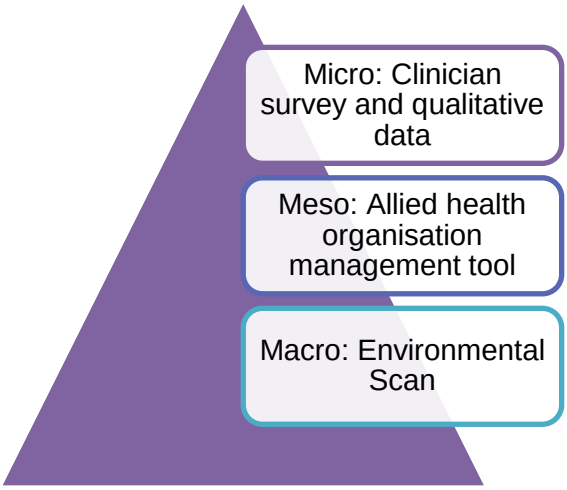
Qualification as an occupational therapist requires completion of either a four-year full-time bachelor degree or a two year full-time graduate entry master's degree.

Occupational therapy is registrable under the *National Registration and Accreditation Scheme / Australian Health Practitioner Regulation Agency* (AHPRA). To practise in Australia, occupational therapists must be registered with the *Occupational Therapy Board of Australia*.

Method

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

Figure 1: Three-tiered research approach



Macro

Environmental scan

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

Meso and micro level data

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

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

The AHWQ2 collected the following information:

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

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

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

Focus groups

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

Research governance

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

Distribution approaches

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

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

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

Analyses

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

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

Data limitations

- The challenge of distributing and marketing a survey commissioned by a single government department to distributed health services, non-government services and private providers means that the data may not be representative of the profession.
- It was difficult to engage with the NFP and private occupational therapy providers. As a result, it is not possible to determine the representativeness of the data for these groups.
- The focus group participants were invited from the AHWQ2 respondents who agreed to be followed-up. This may have resulted in selection bias as only 43% of all survey respondents agreed to further follow-up.

Results

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

Responses and respondents

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

Table 1: Respondent numbers by data collection approach

AHWQ2 (individual respondents)	AHWQ2 (organisational respondents)	Focus groups and interviews
1,217	270	Group 1 – 2 participants (early career) Group 2 – 4 participants Group 3 – 5 participants Group 4 – 5 participants Group 5 – 4 participants Individual interviews – 2

Allied Health Workforce Questionnaire 2

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

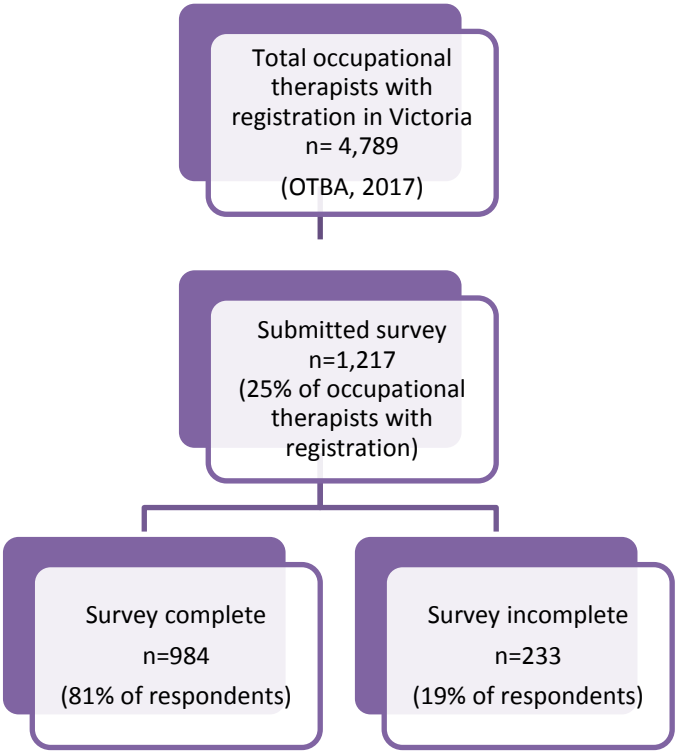
A total of 1,217 occupational therapists completed at least one question on the survey and submitted their survey. This represented 30% of the 4,084 individuals working in Victoria as occupational therapists in 2015 (AIHW, 2016) and 25% of the 4,789 occupational therapists with general, limited, provisional or non-practising registration in December 2016 (Occupational Therapy Board of Australia (OTBA), 2017). The survey was completed[1] by 984 individual occupational therapists. The range of responses to an individual question was from 937 to 3,140[2]. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not (Figure 2).

A total of 270 employers or managers of occupational therapists completed the AHWQ2. The organisations they represented employed a total of 546 full time equivalent occupational therapists.

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

[2] Some questions allowed for multiple responses

Figure 2: Survey responses



Capacity

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

Figure 3: Workforce capacity framework

Key findings

- Forty-seven per cent (47%) of respondents were 35 years and under, with the age range being from 22 to 70 years.
- Although most respondents (61%) were from metropolitan regions, there was an over-representation from regional, rural and remote areas relative to AIHW data (AIHW, 2016).
- Most participants were employed in the public sector (85%), were in permanent employment (83%), and worked Monday to Friday during the day (93%).
- Sixty-nine (69%) of respondents were employed at grade 3 or below. Grade 2 (43%) was the most prevalent employment level.
- Adults and older adults were the age group supported by the greatest proportion of respondents (62% and 53% respectively). No more than 18% of respondents worked across the age groups of infants, children, adolescents or young adults. Fifteen per cent (15%) worked across age groups.
- On average, respondent caseloads included 6% of people from Aboriginal and / or Torres Strait Islander backgrounds and 33% from culturally and linguistically diverse backgrounds.
- The most prevalent service delivery settings were hospital inpatient (31%), community (22%), the client's home (17%), and hospital outpatient (17%).
- Rehabilitation, aged care, mental health services, and general medical / hospital were the most frequently reported primary areas of practice.
- Within mental health, occupational therapists were often employed in generic roles. Although well-suited to these roles, the profession was under-represented in these transdisciplinary teams.
- Across their careers, the setting of care showed a trend from hospital inpatient towards community, hospital outpatients and the client's home. This may reflect changes in funding models.
- Most respondents (77%) intend to stay in the occupational therapy profession for six (6) years or more.
- Some organisations reported receiving over 50 applications for junior positions. However, there were still unfilled junior positions in other organisations. Notably fewer applicants were received for intermediate and senior positions and these roles took longer to fill. Organisations reported difficulties in attracting applicants to these roles with appropriate skills and experience.
- Demand for services was reported to be high and exceeds available resources. Consequences included long waiting lists, service rationing, compromise to clinical outcomes through an inability to deliver evidence-based practice, concerns regarding service quality, concerns regarding client safety following hospital discharge or while waiting for services and equipment, and risks for readmission. Reported staff impacts included reduced job satisfaction, increased sick leave and burn out.
- A wide range of specific funding programs were reported as being used to support delivery of services to individual occupational therapy clients. Home and Community Care (47%, n=273) and Transport and Accident Commission (41%, n=240) were the two most frequently cited programs. Issues were cited around allocations for time for paperwork, equipment investigation, ordering, follow up, meetings and training related to clinical work requirements.
- Even though formal recognition of advanced practice is still being developed within the occupational therapy profession, 16% of respondents reported that their work involves advanced scope of practice. The roles respondents identified most frequently as advanced practice were hand therapy (including wound care, pre- and post-surgical care, spasticity management, Botox

clinics), wheelchair and seating clinics, care coordination and key worker roles, psychological and mental health services, and driving assessment.

- 52% of the occupational therapy respondents reported that their work involves delegation to Allied Health Assistants.
- Use of telehealth was only reported by 9% of respondents. They reported used of telehealth to deliver services to people in regional, rural, remote and interstate locations and in circumstances where clients are not able to access services in person, e.g. services to prisons. Occupational therapists used telehealth for a range of clinical and non-clinical purposes including meetings, delivering and receiving professional and clinical supervision, participating in interest groups, and providing and accessing education.

Workforce distribution

Demographics

Based on the most recently available data, in December 2016 there were 4,789 occupational therapists registered in Victoria with the Occupational Therapy Board of Australia with general, provisional, limited (postgraduate training or supervised practice), and non-practising registration (OTBA, 2017). When considering employment (in contrast to registration), in 2015 there were 4,084 occupational therapists employed in Victoria (AIHW, 2016)[3].

Of the total cohort of 1,217 AHWQ2 respondents, 91% (n=1,111) were employed in the occupational therapy workforce in Victoria at the time of completing the survey. (See Appendix Table 1 for reasons why respondents were not working as an occupational therapist).

As detailed in Table 2, the occupational therapy respondents were predominantly female (94%, n=1,025). This proportion is slightly higher than Occupational Therapy Board of Australia data for the proportion of female general and non-practising registrants in December 2016 (OTBA, 2017) and AIHW in 2015 (AIHW, 2016), both of which reported that females constituted 92% of occupational therapists in Victoria.

Nearly half (47%, n=510) of the AHWQ2 respondents were age 35 years and under. This is lower than data from AIHW which reported 55% of Victorian occupational therapists were 35 years and under in 2015 (AIHW, 2016). Individuals age 55 years and over constituted 10% (n=102) of respondents; slightly higher than 9% recorded by AIHW for the 2015 workforce (AIHW, 2016). The mean age of occupational therapy respondents was 38 years (range 22 years – 70 years) and the median age was 35 years (Table 2 and Figure 4).

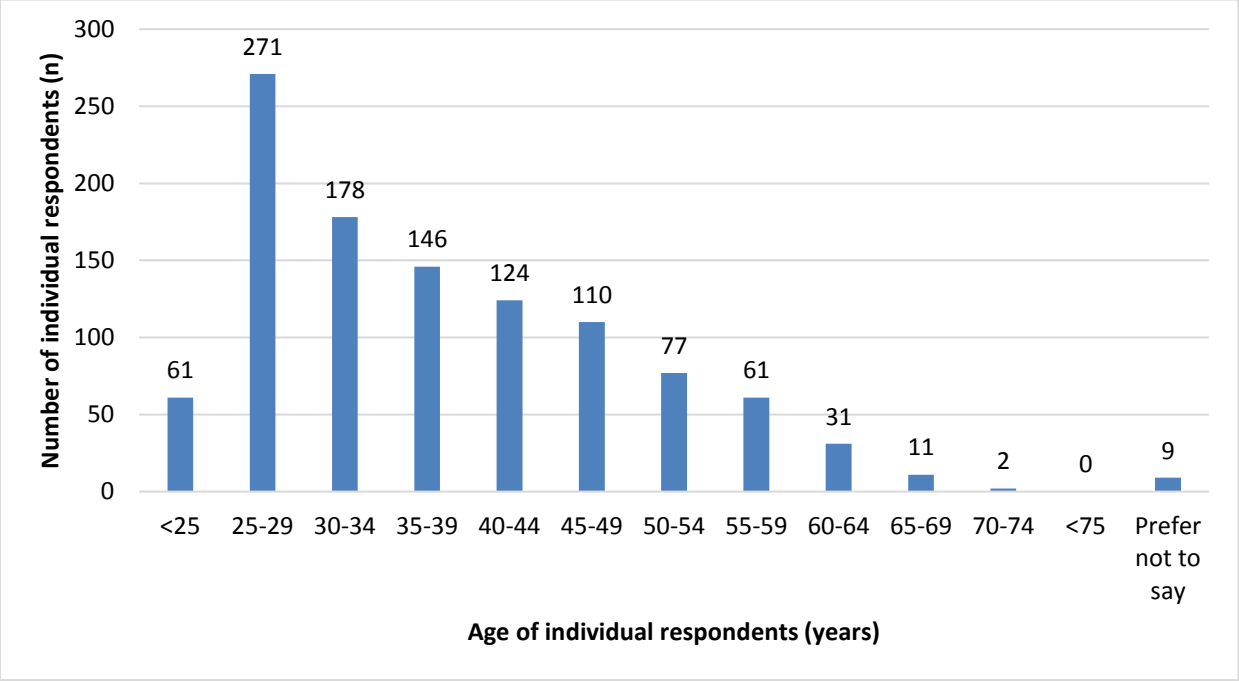
Table 2: Demographics (n=1,217) compared with AIHW 2015 data [a]

Demographics	AHWQ2		AIHW 2015	
	n	%	n	%
Female	1,025	94	4,068	92
Aboriginal and / or Torres Strait Islander	7	1	12	0.2
Australian citizen / permanent resident	1,073	98	-	-
Age 55 and over	102	10	387	9
Age 35 and under	510	47	2,424	55
Median age (years)	35	-	-	-

[a] *Source: AIHW, 2016*

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

Figure 4: Age in 2016 / 2017 (n=1,081)



Geography

Although the occupational therapy AHWQ2 respondents were predominantly from metropolitan areas (61%, n=637), including 45% (n=471) who described their main region of work as inner-metro and 16% (n=166) as outer-metro, this is notably lower than the 80% reported by AIHW for 2015 as being located in a major city (AIHW, 2016). In combination, regional, rural and remote respondents made up 39% (n=412) of the occupational therapy AHWQ2 respondents, substantially higher than the combined 20% reported by AIHW for inner-regional, outer-regional, remote and very remote (AIHW, 2016) (Table 3).

Table 3: Region of work (n=1,049)

AHWQ2			AIHW 2015		
Region	**%**	**Count**	**Region**	**%**	**Count**
Inner-metro	45	471	Major city	80	3,527
Outer-metro	16	166			
Inner-regional	24	252	Inner-regional	17	753
Outer-regional	8	82	Outer-regional	3	143
Rural	7	76	-	-	-
Remote	<1	2	Remote	0	0
			Very remote	0	0
Total	100%	1,049		100%	4,423

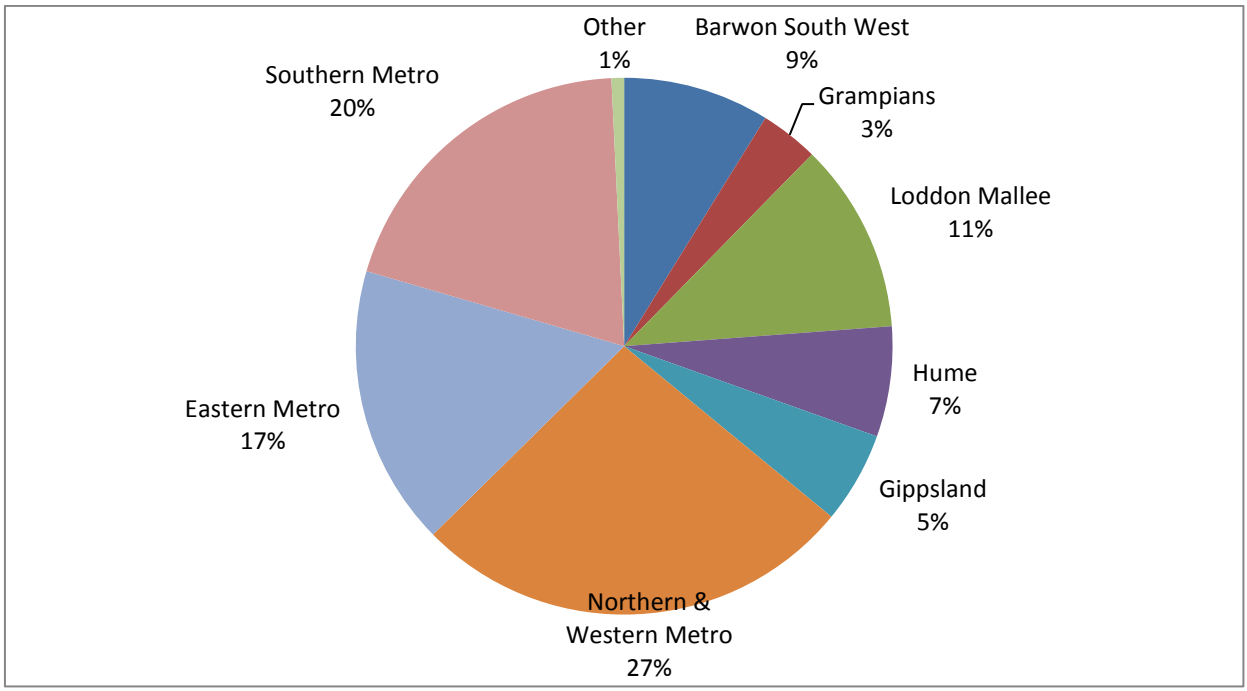
The Australian Bureau of Statistics Census of Population and Dwellings 2011 (Australian Bureau of Statistics (ABS), 2011) indicated that the highest proportion of occupational therapists were located in Barwon-South West (0.44 per 1,000), Eastern Metro (0.43 per 1,000) and North and West Metro (0.42 per 1,000), while the lowest proportion of occupational therapists were located in Gippsland (2.9 per 1,000) and Grampians (0.31 per 1,000). The AHWQ2 survey results only report the number of responses

per regional area, which cannot be directly compared to the ABS findings; however, responses were received from occupational therapists working in each Department of Health and Human Services region (Table 4 and Figure 5).

Table 4: Primary geographic location of AHWQ2 respondents (n=1,054) compared to AIHW 2015 geographic locations

	Barwon south West	Grampians	Loddon Mallee	Hume	Gippsland	Northern and Western metro	Eastern Metro	Southern Metro	Other state	Total
Primary location	91	34	114	67	55	270	174	195	54	1,054
%	9	3	11	6	5	26	17	19	5	100
AIHW location (% of respondents)	8	3	6	7	4	32	19	21	NA	100

Figure 5: Main place of work by Department of Health and Human Services' regions (n=1,054)

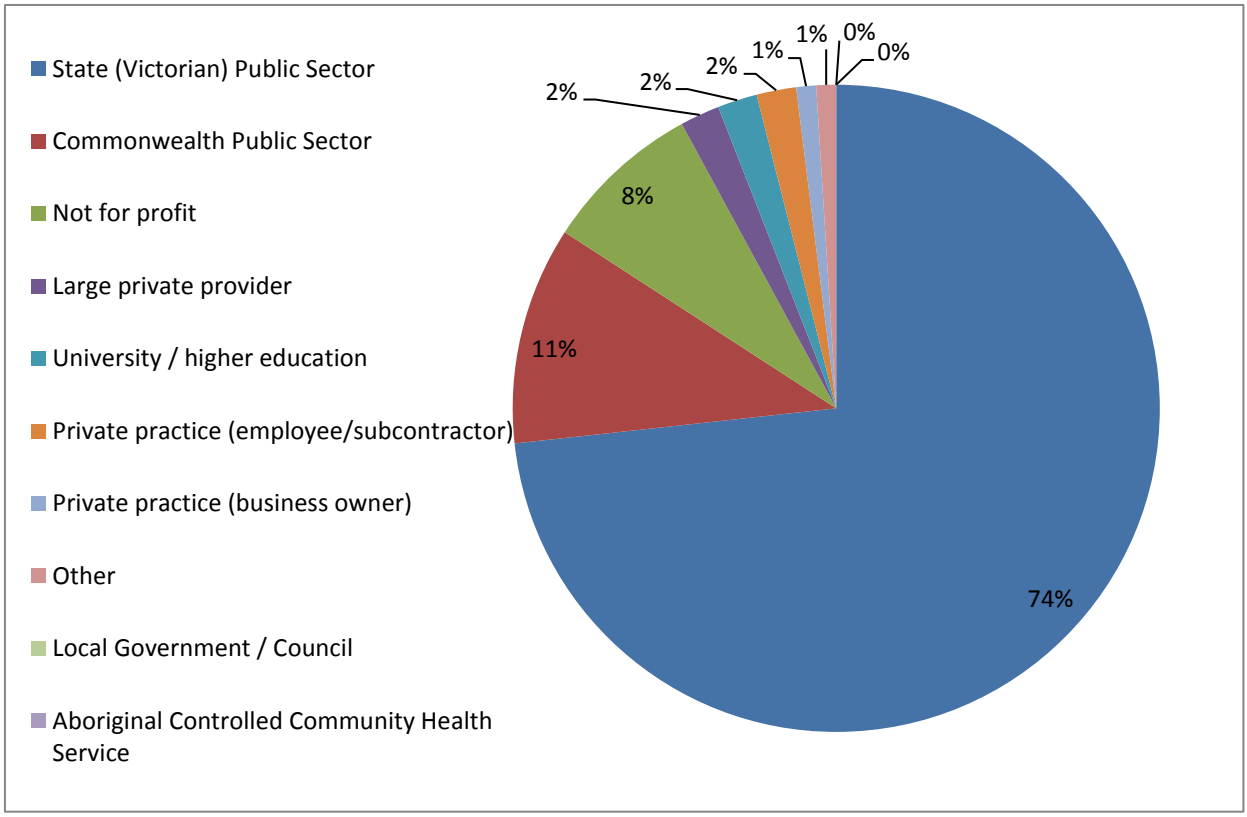


Sector

A total of 85% of AHWQ2 occupational therapy respondents reported working in the public sector, including a total of 74% (n=753) in the Victorian public sector and 11% (n=110) in the Commonwealth public sector and five individuals in local government. In contrast, the most recent data from the ABS (2011) indicated that 52% of occupational therapists were working in the public sector. It is likely that the AHWQ2 respondent cohort included an over-representation of individuals working in the state public sector due to a greater capacity to distribute the AHWQ2 survey to employees within this sector.

Respondents from the NFP sector comprised 8% (n=80) of AHWQ2 respondents. Only 3% (n=25) of respondents were from the private sector, either as a business owner or as an employee / subcontractor (Figure 6).

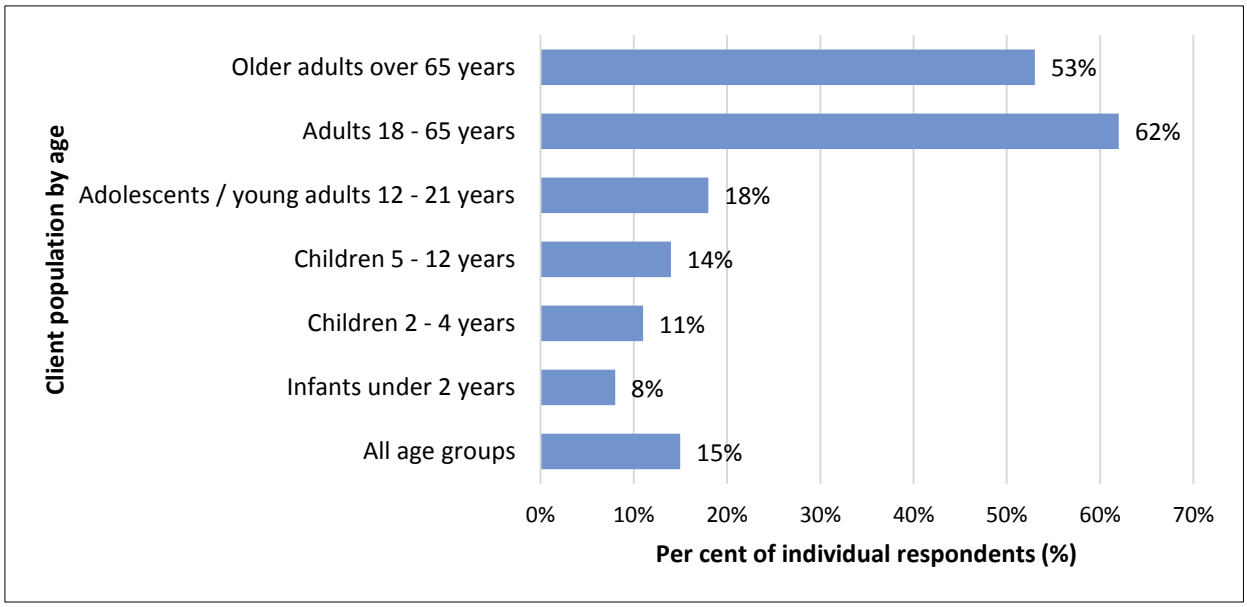
Figure 6: Employment sector of current main employer (n=1,022)



Clients

The occupational therapy AHWQ2 respondents predominantly reported working with adults (62%), or older adults (53%). Relatively few occupational therapists reported working specifically with infants, children or adolescents (Figure 7). Respondents identified a specific need to increase service provision to children and young people.

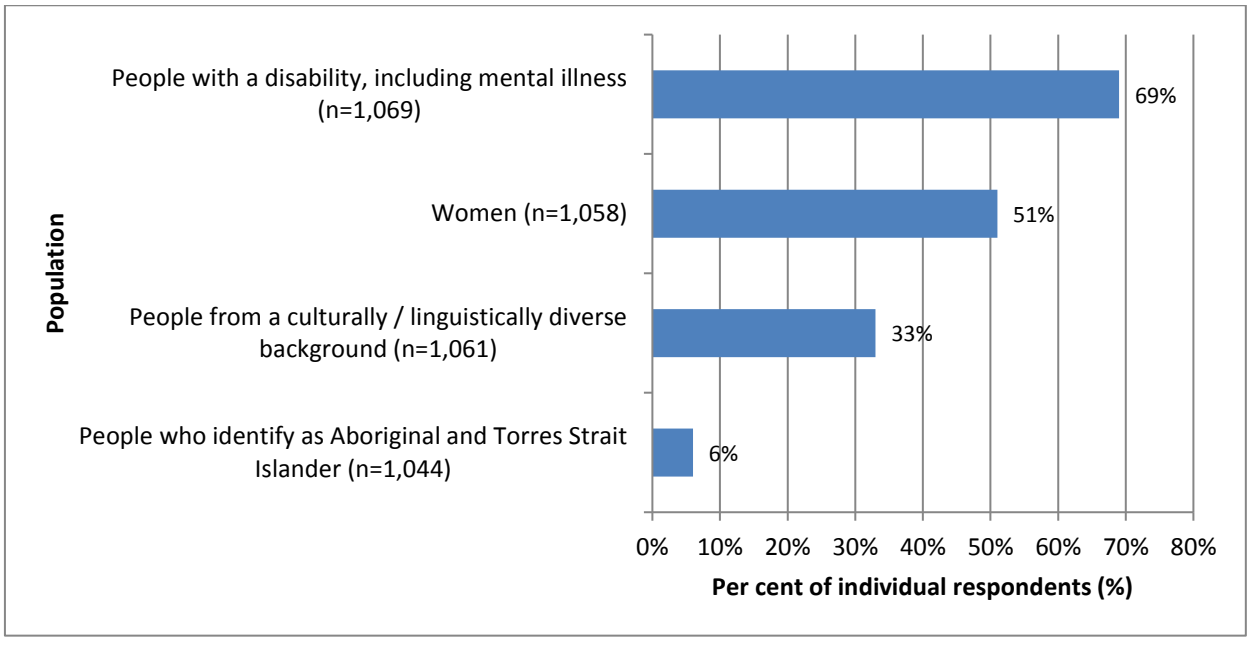
Figure 7: Clients by age (n=1,086) [a]



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

When considering specific population groups, on average, clients who identified as Aboriginal and / or Torres Strait Islander constituted 6% of the caseload of AHWQ2 respondents. On average, one third (33%) of respondents' caseloads were constituted of people from culturally and linguistically diverse backgrounds (Figure 8).

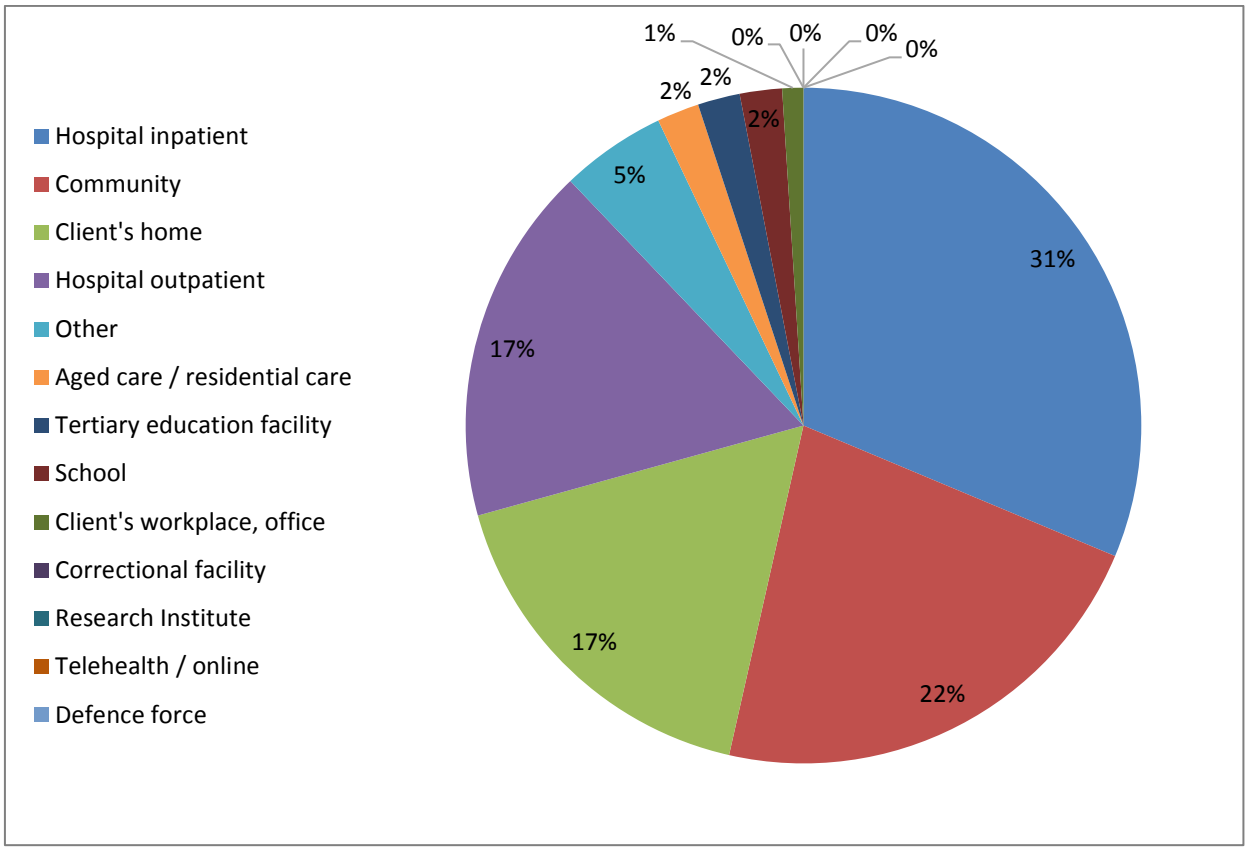
Figure 8: Average per cent of population groups represented within caseloads



Settings

Nearly one third of AHWQ2 respondents (31%, n=336) indicated hospital inpatient as the setting for service delivery of their main employer. Services within the community (e.g. private practice, community health service, etc.) (22%, n=248), clients' homes (17%, n=180), and hospital outpatient departments (17%, n=185) were the next most prevalent work settings (Figure 9).

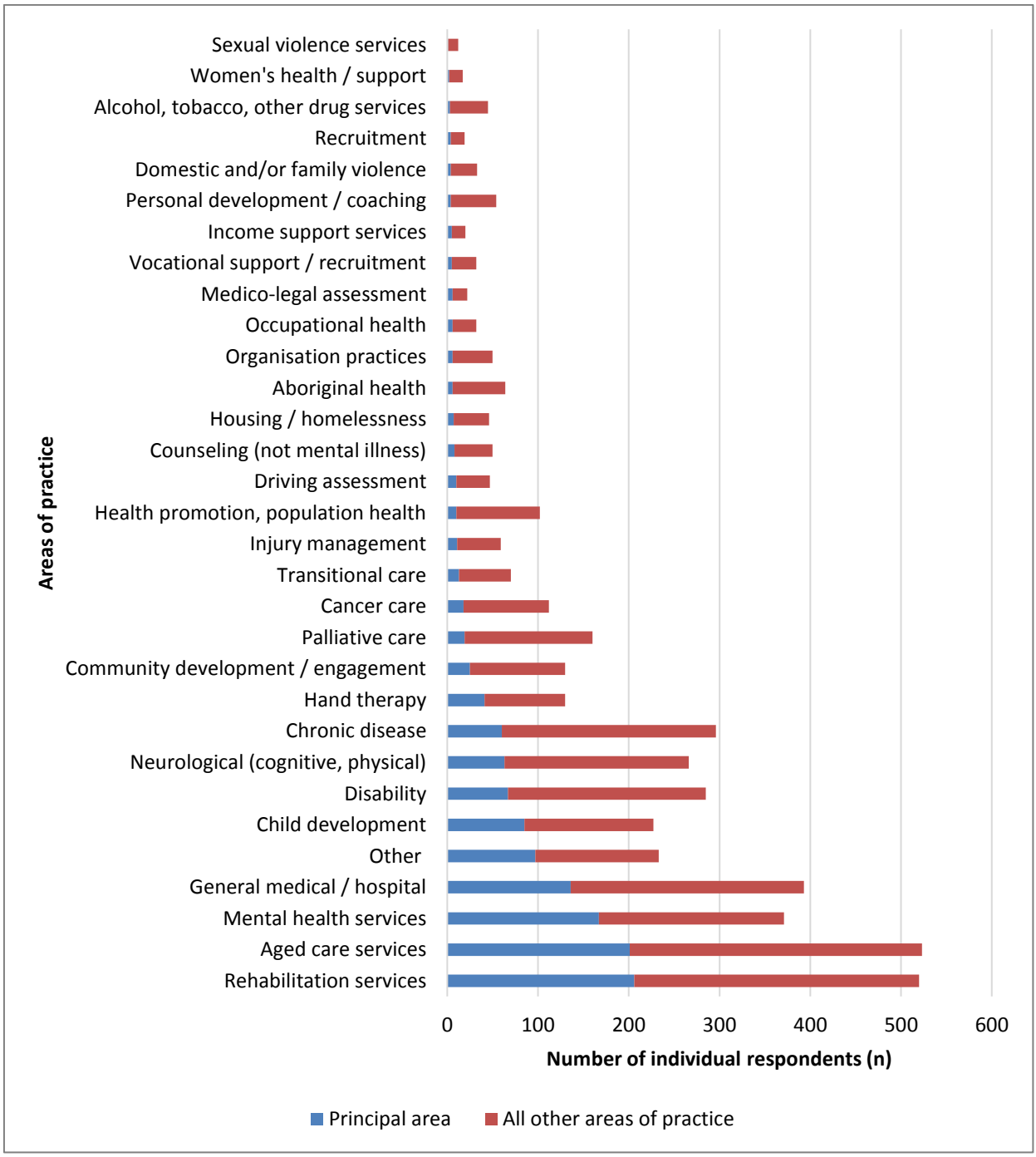
Figure 9: Setting for service delivery of current main employer (n=1,069)



Area of practice

The predominant principal areas of practice reported in the AHWQ2 by occupational therapists included rehabilitation (n=206), aged care (n=201), mental health services (n=167), and general medical / hospital (n=136) (Figure 10 and Appendix Table 2 for detailed numbers of respondents per area of practice). Please note per cent is not able to be provided in Figure 10 due respondents providing more than one answer to ‘primary area of practice’.

Figure 10: Areas of practice [a]



[a] *Respondents could select more than one response to signify 'all other areas of practice*

Funding sources

There were a wide range of specific funding programs reported as being used to support delivery of services to individual occupational therapy clients. Home and Community Care (47%, n=273) and Transport and Accident Commission (41%, n=240) were the two most frequently cited programs. Other significant funding sources included WorkCover (33%, n=194), National Disability Insurance Scheme (NDIS) (30%, n=176), Commonwealth Home Support Program (27%, n=158), Home Care Package (26%, n=149), and private health insurance (22%, n=127) (Figure 11).

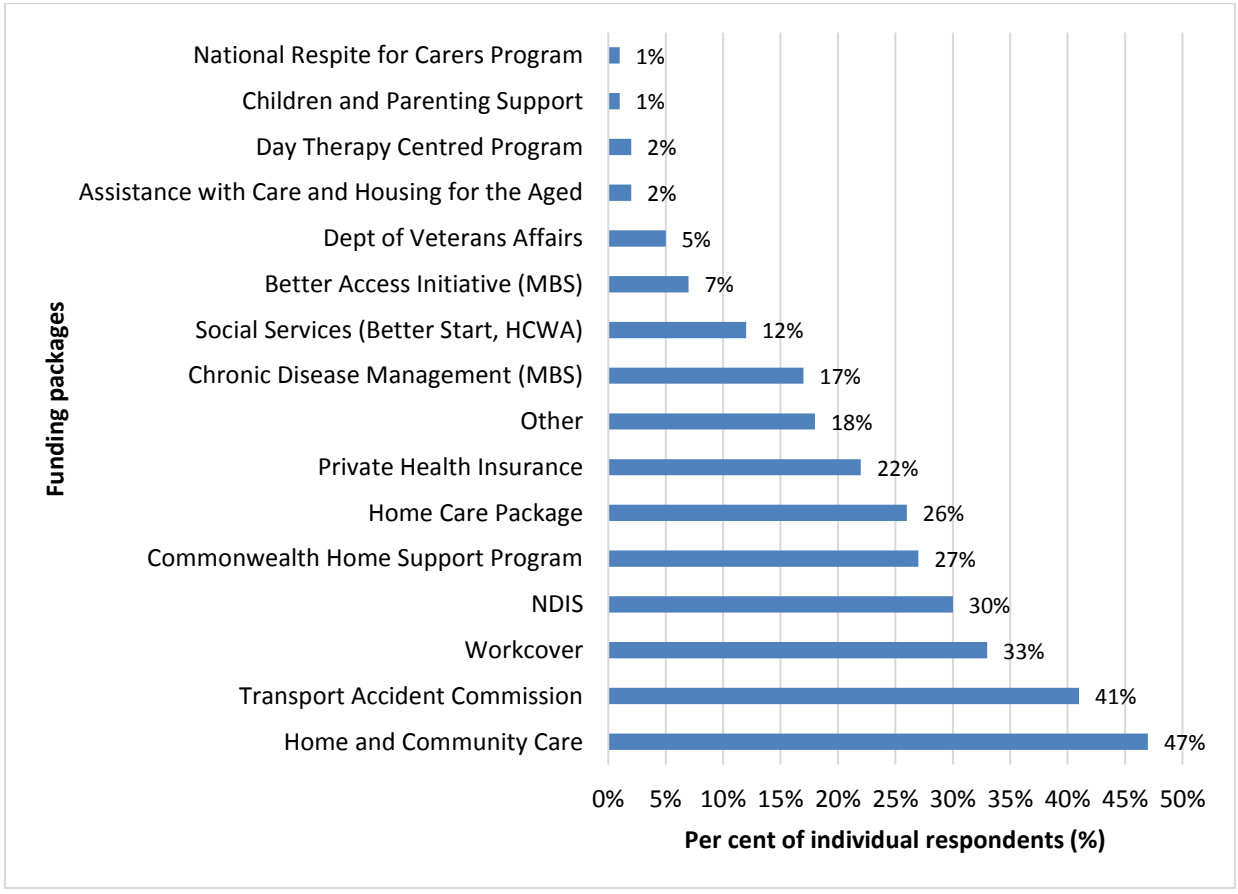
Of the respondents who answered this question, the average number of funding sources identified by an individual occupational therapist was 2.8.

Respondents also articulated the need for reimbursement to more accurately reflect the hours of work involved in client service delivery beyond direct face-to-face contact. Of specific concern was the fact that funding does not reflect the extensive time involved in tasks such as preparing detailed reports and applications for equipment.

Long waits and life-time funding limits to access equipment through the State-wide Equipment Program (SWEP), as well as lack of funding / fee rebates for driving assessments were identified as particular gaps.

"I'd like to see full funding for assistive equipment, technology and home modifications for people who cannot afford to buy their own. A huge amount of our time working in community health is spent applying to multiple government and non-government organisations to find sufficient funds for essential equipment such as electric wheelchairs, hospital beds, pressure relieving products and bathroom modifications."

Figure 11: Per cent of respondents providing services funded by specific packages (n=582) [a]



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

Demand

Organisational and individual respondents to the AHWQ2 did not provide quantifiable measures of demand for occupational therapy. However, respondents consistently described demand for occupational therapy in terms of long waiting lists, inability to meet benchmarks for waiting times, inadequate resources to meet the occupational performance needs of clients and an increasing need to contribute unpaid overtime to respond to client needs. These pressures were predominantly voiced by professionals working in public and NFP services.

The Australian Government, Department of Employment's *Job Outlook* initiative provides data on employment characteristics, trends and prospects for some occupations. Data from this initiative shows that occupational therapy is expected to experience very high employment growth in the years to 2022. (Australian Government, 2017) (Table 5).

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

- Over the seven years to May 2022, the number of job openings for occupational therapists are expected to be above average nationally (around 9,000). Job openings count both employment growth and turnover (defined as workers leaving their occupation for other employment or leaving the workforce).
- Employment for occupational therapists rose strongly (in per cent terms) in the past five years and in the long-term (ten years).
- Looking forward, employment for occupational therapists to 2022 is expected to grow very strongly compared to other occupations (Australian Government, 2017).

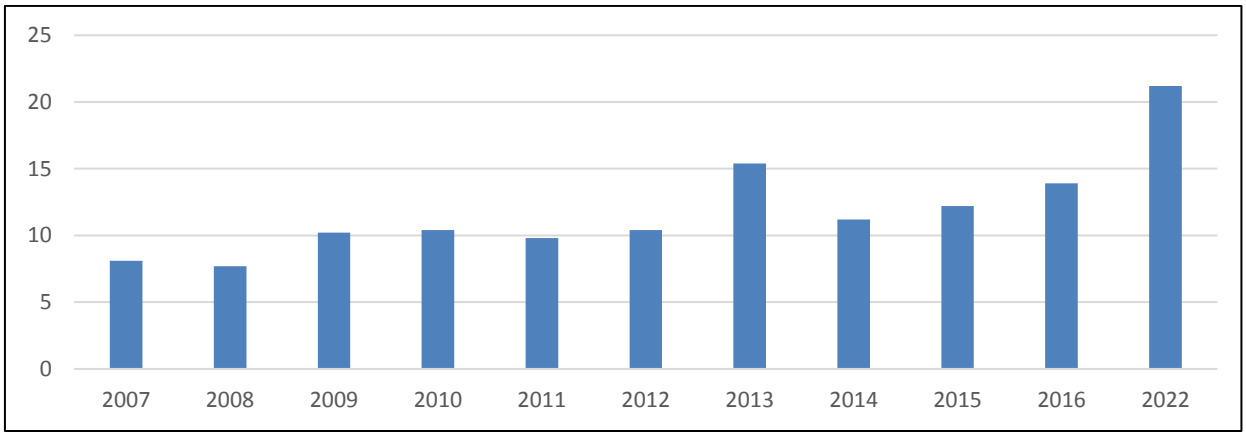
Table 5: Employment growth for occupational therapists (nationally)

Key indicators	n
Workers employed as occupational therapists	16,700
Unemployment compared to other occupations	Below average
Long term employment growth – 10 years (%)	71.6
Medium term employment growth – 5 years (%)	42
Likely future employment growth – 5 years	Very strong
Level of future job openings	Above average

Source: Australian Government, 2017, Job Outlook for occupational therapists

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

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



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

Supply

There are a number of factors that interact with and influence the supply of occupational therapists. These include the size of the occupational therapy workforce, the number of graduating occupational therapists, the age and gender profile of the workforce, employment grades, remoteness, remuneration and local approaches to recruitment.

Occupational therapy workforce

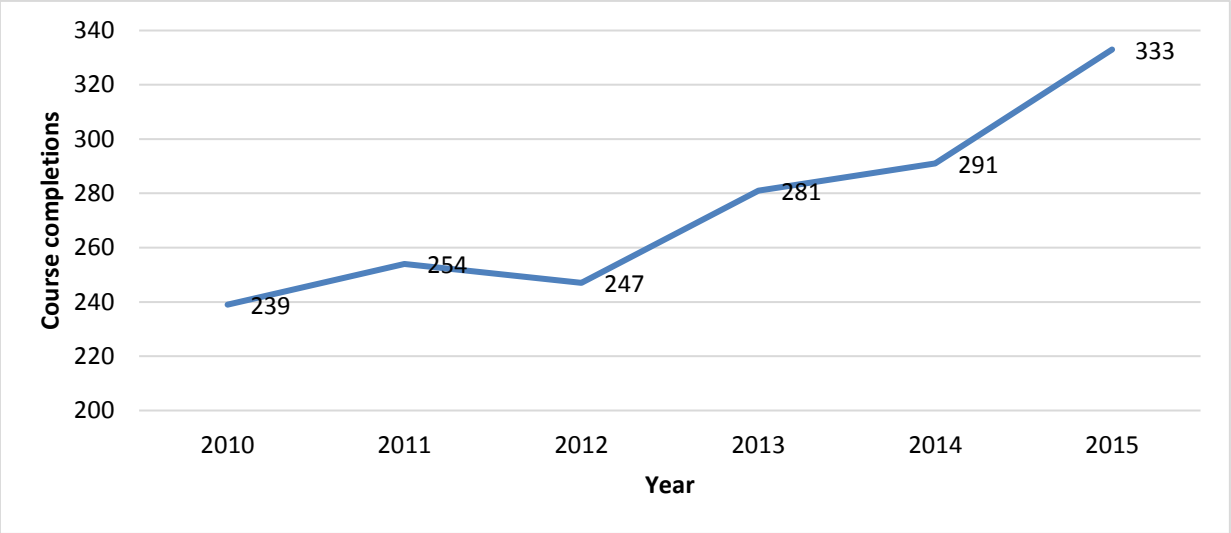
In December 2016, there were 4,627 occupational therapists with general registration in Victoria: A further 162 individuals held provisional, limited, or non-practising registration (OTBA, 2017).

Student completions

In 2015, 333 occupational therapy students completed occupational therapy training at a Victorian tertiary education facility (unpublished data, Department of Education and Training[4]). This is a 39% increase since 2010 when 239 students completed occupational therapy training (Figure 13).

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

Figure 13: Victorian university domestic course completions 2010 - 2015



Source: Department of Education and Training

Workforce supply / job shortages

As noted above, feedback from occupational therapists and service managers consistently reported a range of indicators of demand for services exceeding the capacity of the current workforce size. These included:

- long waiting lists
- inability to meet service benchmarks for timing of assessment and intervention
- service rationing
- inability to deliver evidence-based practice
- inability to contribute to primary and secondary prevention
- inability to adequately address the occupational performance needs of clients

Consequences arising from this situation were identified to include:

- reduced quality of clinical services
- compromised outcomes for clients
- increased length of hospital stays due to delayed assessment
- risks to client safety due to inadequate assessment and intervention before leaving hospital
- increased staff sick leave and burnout, and associated reduced job satisfaction

The common practice of not backfilling positions when occupational therapists were on leave was reported to compound the existing challenges meeting community need. It was also noted to have the secondary consequence of limiting opportunities for staff to develop their skills through acting in different and more senior roles on a temporary basis. These challenges were reported to be a particular issue with maternity leave where backfill is typically not available until after the period of 10 weeks paid parental leave has passed. This presents a significant challenge for a young workforce that is predominantly female.

Not all services reported challenges meeting demand. Private practitioners reported little to no wait for services they provide and some community health services reported a similar scenario.

"We are always under-staffed, never get leave cover and always find a way to increase our capacity to meet clinical demands despite a lack of paid over-time or increased pay or increased (paid) hours. Staff are at high risk of burn out and turn over."

"We have a number of families with unmet needs such as basic access to equipment and housing modifications. Our waiting list is six months long and growing. Working as contractors to a school setting, we are encouraged not to provide services to families in the community but to restrict practices to the school environment."

"We are in private practice and currently we don't have a wait list."

"Although it's not considered that there are any workforce shortages in my workplace, the EFT [equivalent full time] is not reflective of the demand for the OT [occupational therapy] service."

"We don't have a waitlist in our community health organisation. We have a steady demand for our services."

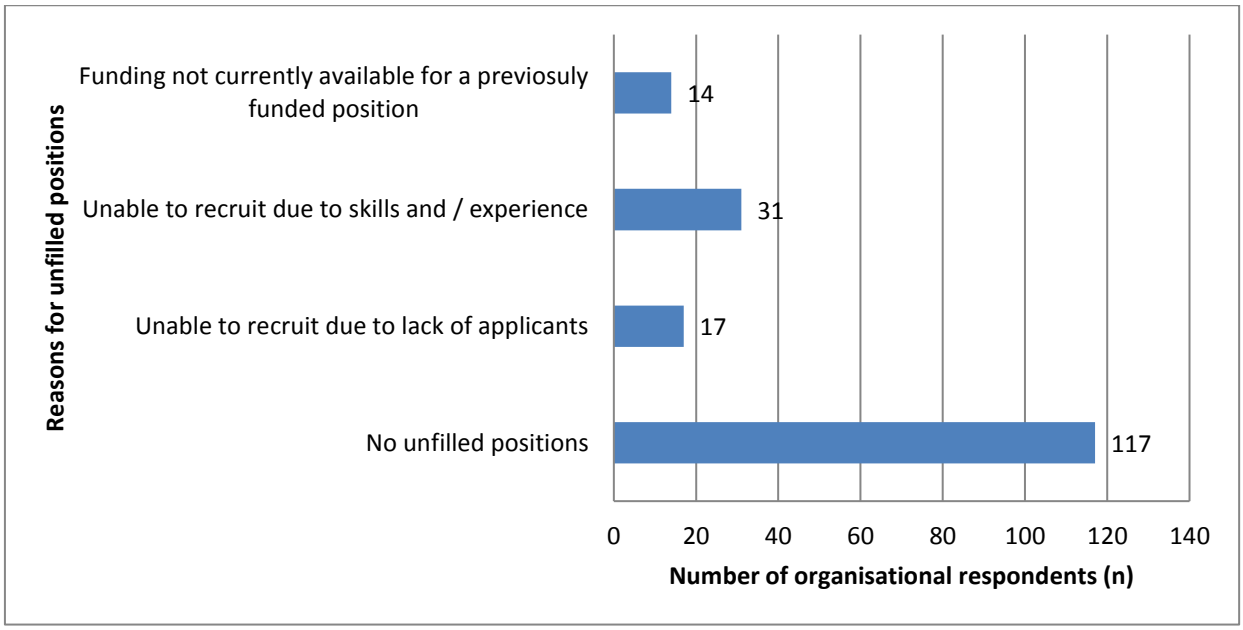
"Wait lists exist because of a lack of funding for staff."

"There is no 'shortage' at present. Workloads have increased though and in some areas our EFT is below the state benchmark e.g. in sub-acute."

Unfilled positions

Of the organisational respondents to the AHWQ2 that employed occupational therapists, 117 indicated they currently have no unfilled positions. Of those that did report having unfilled positions, an inability to recruit due to lack of applicants with appropriate skills or experience was the predominant reason (n=31), followed by a lack of applicants (n=17) and funding not currently being available for a previously funded position (n=14) (Figure 14).

Figure 14: Reasons for unfilled positions (n=179) [a]



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

Recruitment

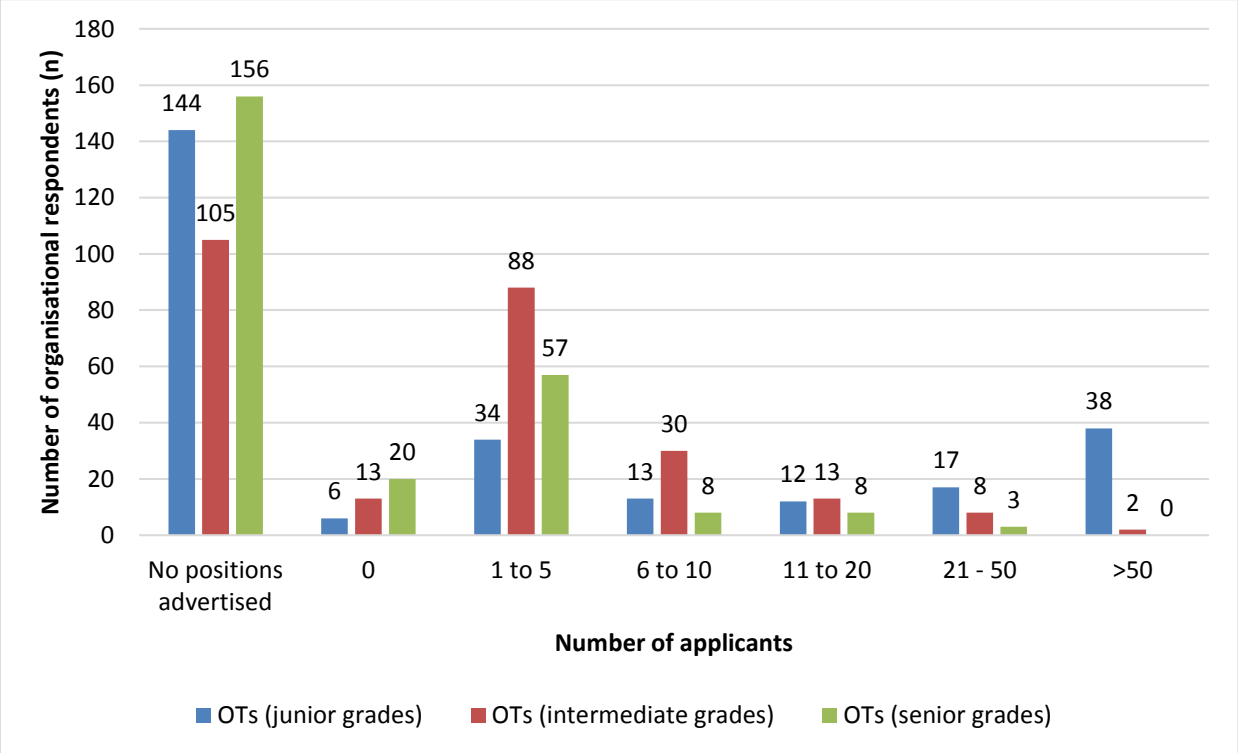
Number of applicants

Organisational respondents to the AHWQ2 were asked about the size of the applicant pool for positions advertised at different grades in the preceding year. A high proportion of responding organisations had not advertised any positions.

Of the 120 organisational respondents that reported having advertised junior positions, 32% (n=38) received more than 50 applications. Despite this apparent high level of competition for junior roles, six organisations reported receiving no applications for the junior positions they advertised. Of interest regarding this issue was that 43% (n=431) of individual respondents indicated agreement with the statement that 'there are too many new graduates in my profession'. Qualitative findings demonstrated a concern regarding the capacity for the numbers of new graduates to secure employment. Despite these findings, the two new graduates who participated in a focus group indicated that most of their peers have found work. They explained that those still looking for work were quite particular about the area of practice in which they were willing to work. They did note, however, that many new graduates were working in temporary roles.

In contrast to junior positions, greater difficulties were experienced filling intermediate and senior positions. Of the 154 organisational respondents that advertised intermediate grade positions, 57% (n=88) received between one and five applications and 8% (n=13) organisations received none. Of the 20 organisational respondents that advertised senior positions in the past year, 21% reported having received no applications in the past year (Figure 15). These findings are consistent with qualitative feedback from the survey and the focus groups.

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



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

Time to recruit

Of the organisations that responded to the AHWQ2 and advertised occupational therapy positions in the preceding twelve months, 94% (n=101) filled junior grade positions within 10 weeks and 89% (n=126) filled intermediate grade positions within 10 weeks. Although this suggests that these positions are being filled with relative ease, qualitative responses revealed that with the usual practice of positions not being backfilled while they are vacant for leave or during recruitment processes, this period of reduced staffing places a significant burden on the professional team in the context of an already very demanding workload (Figure 16).

The time to fill senior positions is consistent with findings on the number of applicants received for these grade levels. Although 72% (n=61) of organisations reported filling positions within 10 weeks, seven organisations (8%) indicated a recruitment period of between 21 and 52 weeks.

No organisations reported that positions of any grade took more than 52 weeks to fill.

A particular issue was raised regarding recruitment of occupational therapists to generic roles. The occupational therapy workforce is relatively young and therefore less experienced than the professions of nursing and social work that it works alongside in these transdisciplinary roles. As a result, occupational therapists found it hard to compete for these roles and were less likely to be recruited. The secondary effect of this outcome was that the occupational therapy profession was then under-represented in these transdisciplinary teams and clients were less likely to have the opportunity of an occupational performance perspective being brought to the service they received.

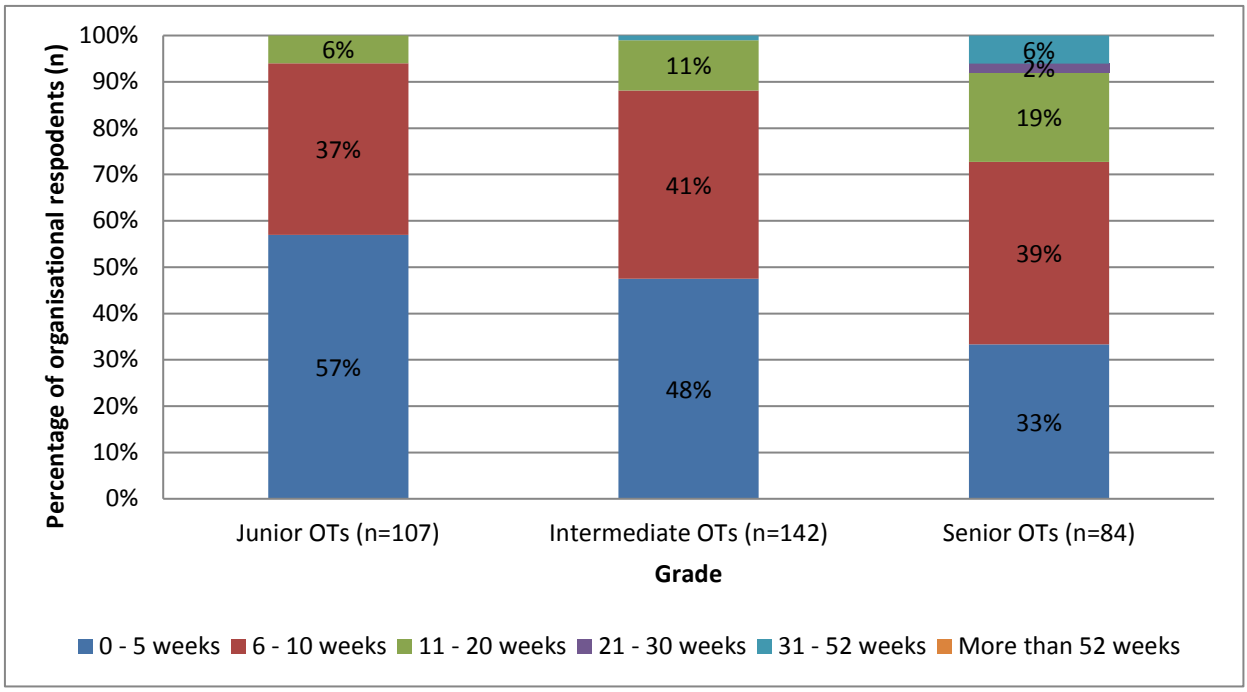
With a young, female-dominated workforce, maternity leave locums often need to be filled. However, services noted that short term roles were much harder to fill than permanent roles.

In regional areas, service growth typically occurs in small increments, such as 0.1 or 0.2 EFT. Unless a local occupational therapist is available, such a role can be difficult to fill.

"I struggle to recruit to grade 2 positions. I have needed positions to target occupational therapists as occupational therapists generally can't compete against nurses and social workers with more experience for generic positions. Operational imperative often trumps the need for greater multidisciplinary mix, e.g. if there is a social worker with five years of experience and an occupational therapist with two years of experience, although we have many social workers already the manager will argue that they need a more experienced worker. So, the social worker will get the job over the occupational therapist."

"It's difficult to recruit to a rural hospital like this one. There's high turnover of staff as a result of travelling 50 mins one way from the nearest big town and no ability to increase pay to compensate / reward staff for working in a rural area."

Figure 16: Time to fill vacancies (n=250) [a]



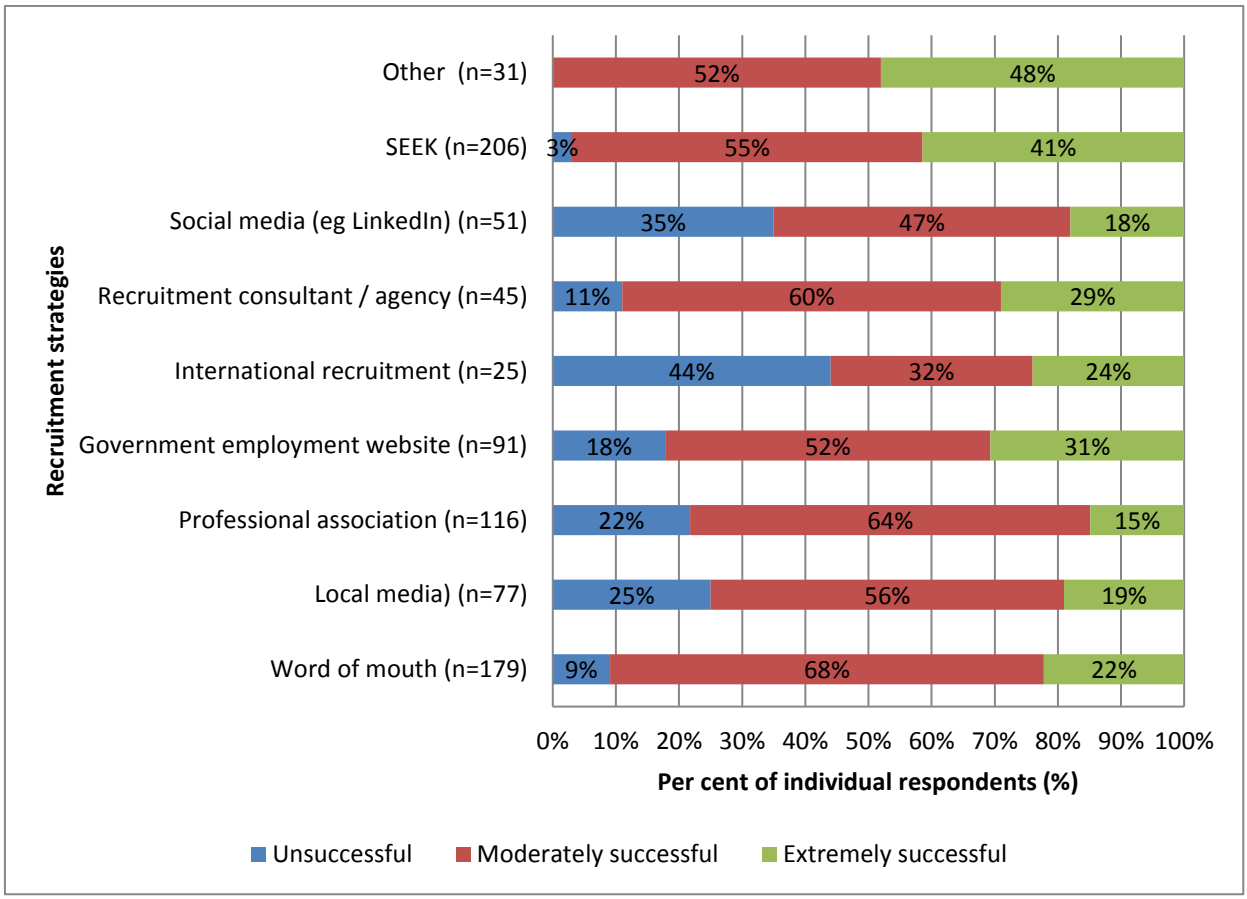
[a] *Although 250 organisational representatives responded to this question, data is only included for organisations that indicated they had vacancies in the prior 12 months.*

Recruitment strategies

Organisational respondents to the AHWQ2 reported using of a range of different recruitment strategies. SEEK (n=206) and word of mouth (n=179) were the strategies used by the greatest number of organisational respondents. Advertising through professional associations was also commonly used (n=116). Only a small proportion of organisations reported use of international recruitment (n=25). Of the 31 'other' responses, 17 indicated use of recruitment processes internal to the organisation.

Strategies most likely to be identified as extremely successful were SEEK (41%, n=85) and government employment websites (31%, n=28). Strategies reported to be unsuccessful by the greatest proportion of respondents that used the specific strategy were social media (35%, n=18) and international recruitment (44%, n=11) (Figure 17).

Figure 17: Relative success of strategies used to recruit occupational therapists (n=252)[a]



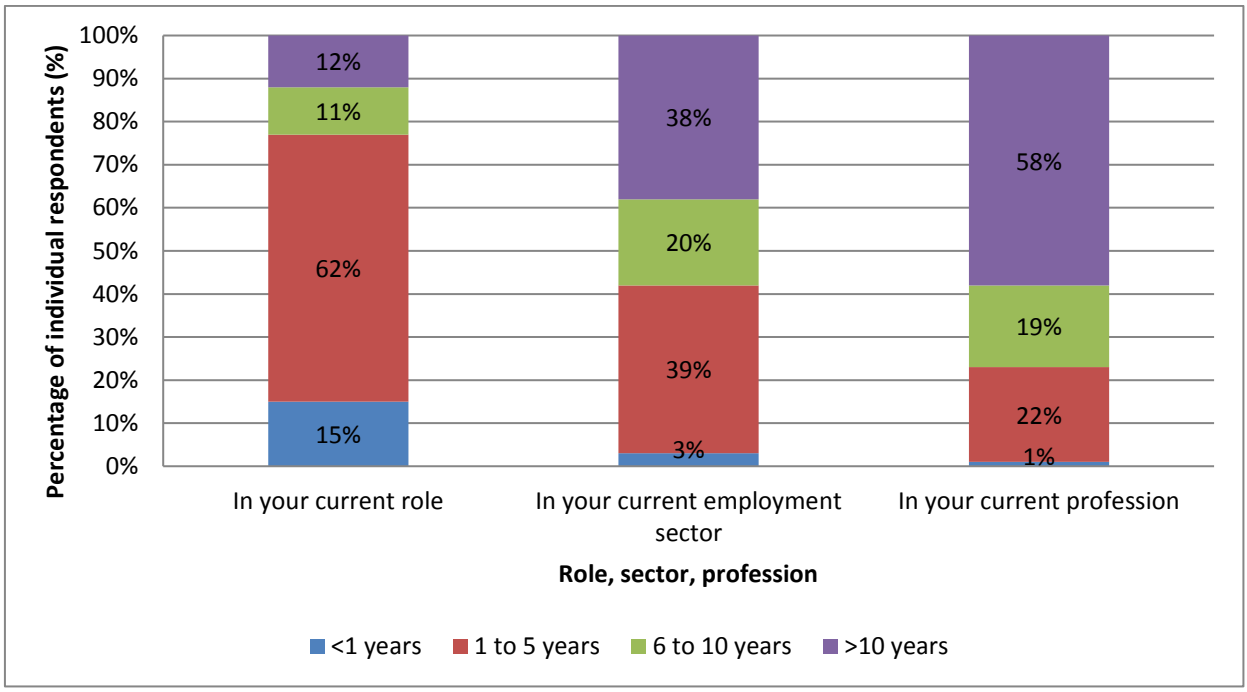
[a] *Although 252 organisational respondents responded to this question, for each recruitment strategy data is presented based on the number of organisations that reported that they used the strategy. For some strategies, such as international recruitment, a high proportion of respondents indicated they 'do not use' the strategy.*

Retention

Occupational therapist respondents to the AHWQ2 were asked about their intention to remain in their current work situation, 15% (n=153) indicated an intention to remain in their current role for less than one year; 3% (n=28) indicated an intention to remain in their current sector for less than one year; and 1% (n=6) indicated an intention to remain in their current profession for less than one year. Although these results suggested a degree of intended mobility in the roles respondents were employed in, the proportion that indicated an intention to leave the profession in the short term was very low (Figure 18).

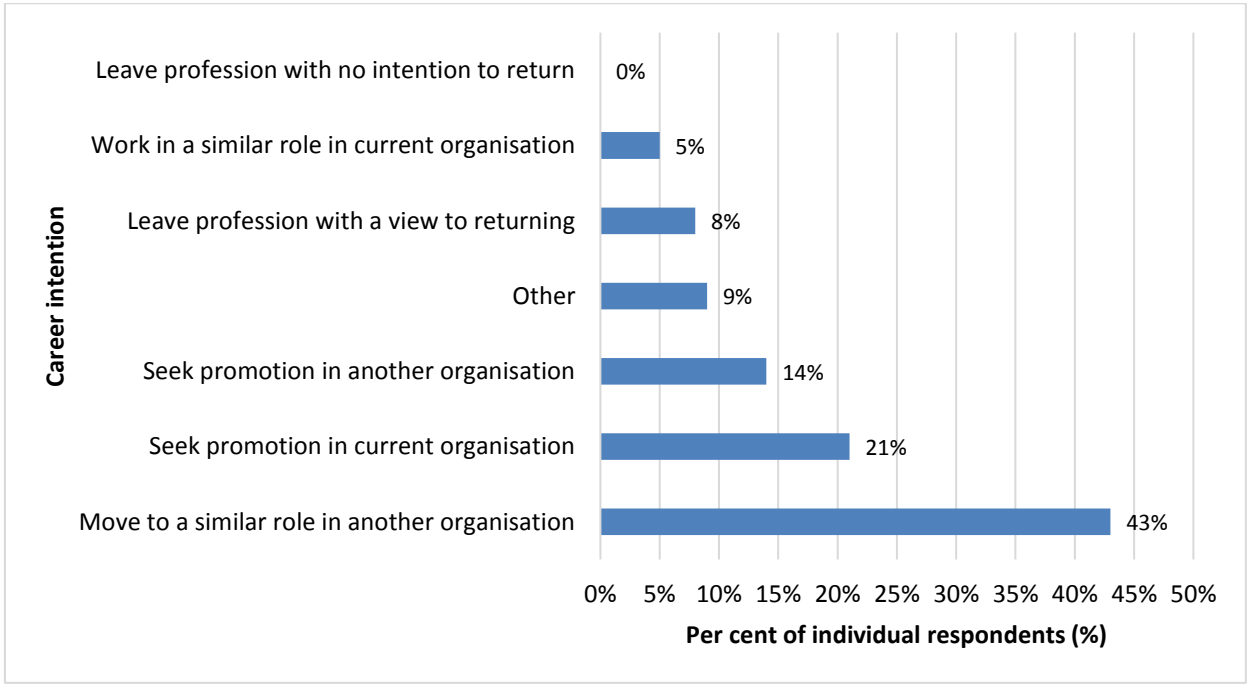
When considering the longer term, most occupational therapy respondents indicated an intention to remain in the profession for more than 10 years (58%, n=610), although within this time frame most expected to have changed employment role (88%, n=903) and sector (62%, n=636).

Figure 18: Intention to stay in current role, sector and profession (n=1,026)



Of those who intended to change their role in the next 12 months (15%, n=153), the majority reported an intention to seek a promotion (n=53, 35%) either in their current organisation (21%, n=32) or another organisation (14%, n=21) (Figure 19).

Figure 19: Career intentions of respondents indicating an intention to stay in their current role for 12 months or less (n=153)



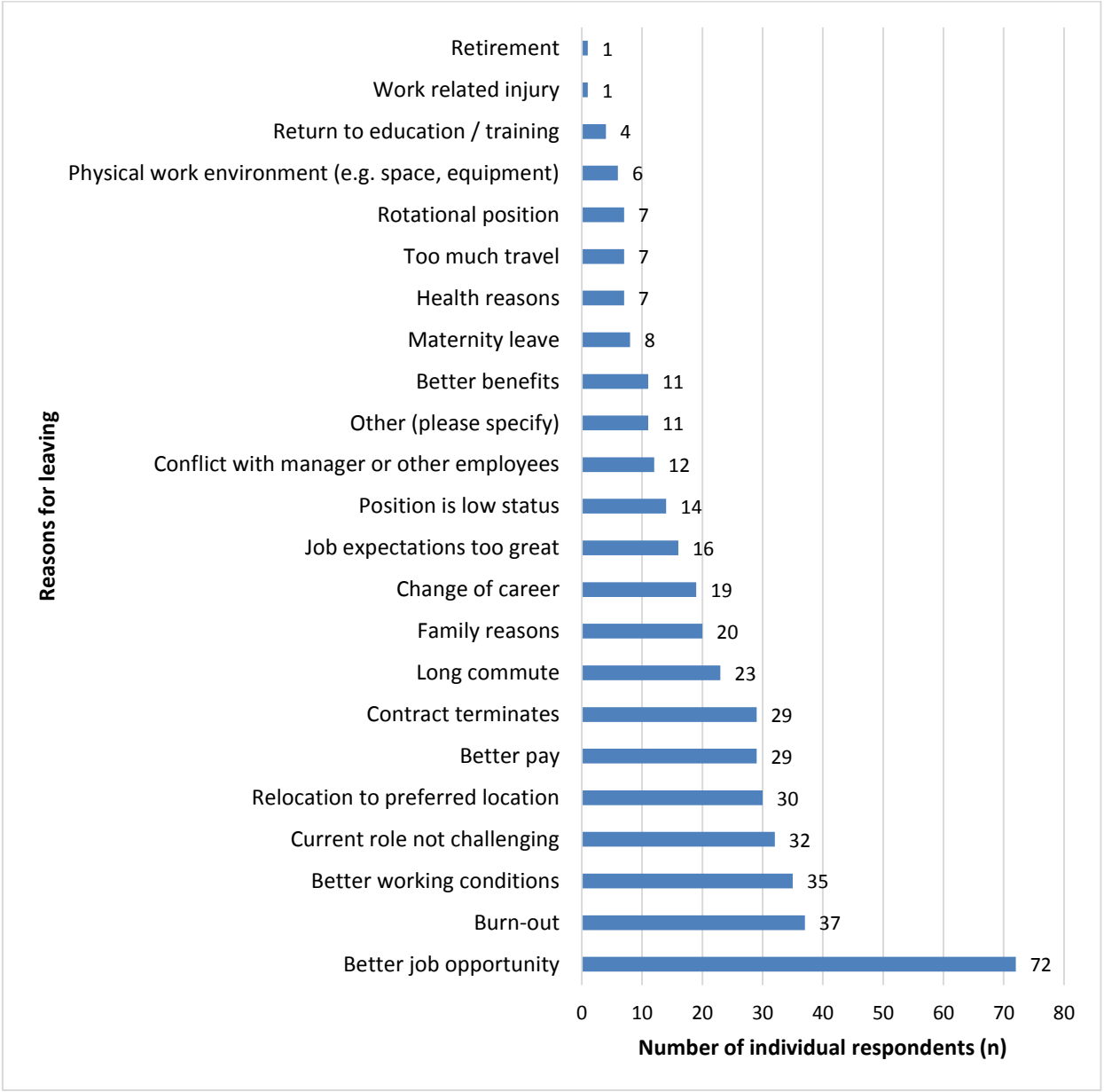
When asked about the reasons for changing roles, AHWQ2 respondents were offered the opportunity to select more than one possible reason. The most prevalent reason was for a better job opportunity (47%, n=72). Other key reasons included burn-out (n=37, 24%), better working conditions (24%, n=37), their current role was not challenging (21%, n=32), and the intention to relocate to a preferred location (20%, n=30) (Figure 20).

At an organisational level, survey respondents spoke about staff retention being affected by lack of career progression opportunities and recruitment to short term contracts which would result in staff actively seeking alternative permanent roles.

"Unpaid overtime in the public sector is huge. Staff are overworked and underpaid. No matter how hard you work, you are paid the same as someone who just works 9-5pm. I believe this is unfair. I also feel I am constantly covering for staff on sick leave (including unpaid) and maternity leave."

"I work four days per week and my current target is 10 new clients per month, plus follow up visits. However, I have been informed this is going to change to five clients per day! How will community occupational therapists be able to complete all the required paperwork, do all the required equipment investigation, attend required meetings and training in that environment? Occupational therapists will be at high risk of burn out."

Figure 20: Reasons for leaving (for respondents intending to change roles within 12 months) (n=153) [a]



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

Organisation of the workforce

Pay level

The median annual earnings for occupational therapists responding to the AHWQ2 were between $60,000 and $69,000. Nearly half (49%, n=525) of all respondents earned between $60,000 and $89,000 in the prior year and 34% (n=363) earned less than $60,000 (Figure 21).

Numerous occupational therapists expressed the need for greater pay equity. Respondents spoke about Victorian pay levels being lower than that of other states and the need for equity across the country. More specifically, they reported that occupational therapists in the public sector receive higher pay than those in other sectors and that other discrepancies also exist across areas of practice, with the health sector reported to be paid more highly than areas such as disability and education.

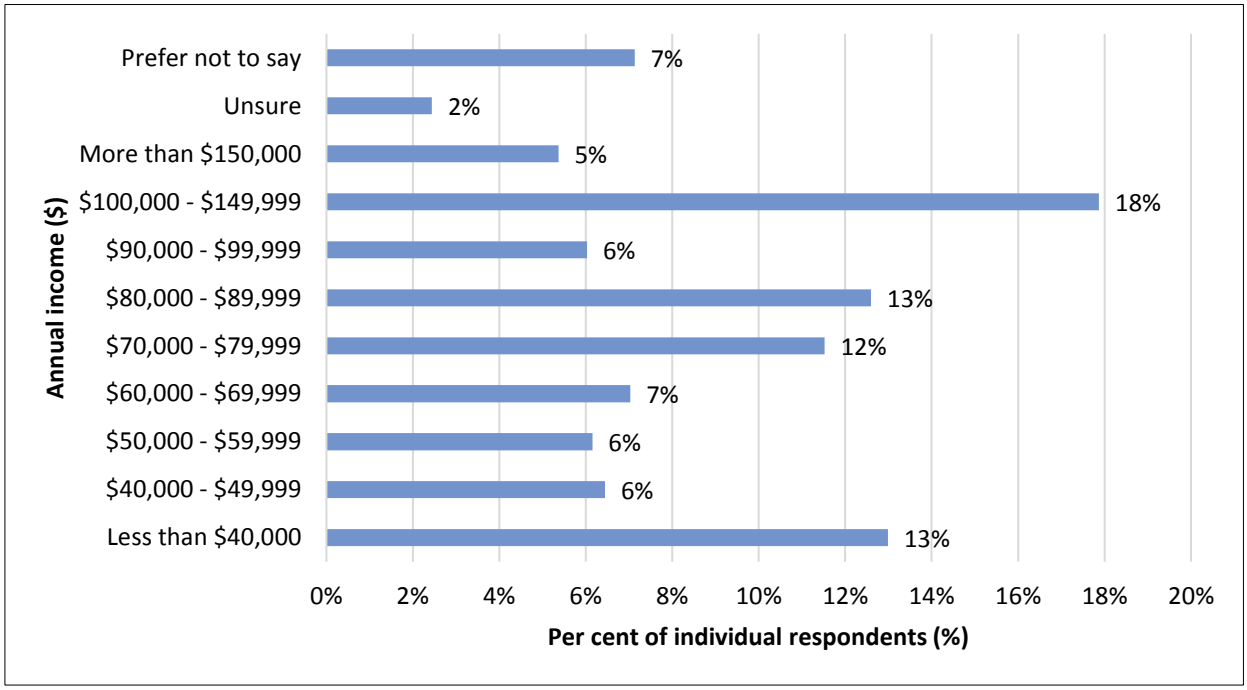
There was a strong theme of frustration from individuals working in generic roles. These individuals described working to the same position description as individuals from other professional backgrounds but that their pay and work conditions, such as leave entitlements, were not equivalent.

Finally, many individuals reported concern at their inability to advance their earning potential beyond grade 2 unless they progress to a role with a strong focus on management rather than clinical responsibilities.

"There should be parity in pay for doing the same work. For transdisciplinary OTs [occupational therapists] we get paid less than our nursing colleagues doing exactly the same role."

"I only managed 12 months in my inpatient care coordinator role. I became increasingly frustrated that the nurses who I worked with were all getting paid at a higher rate than me and getting five weeks of annual leave. I moved to a senior clinician role (grade 3) and have often looked at interesting care coordinator-type roles but they are rarely paid above a grade 2 AH clinician wage."

Figure 21: Total annual income last year, before tax (n=1,062)

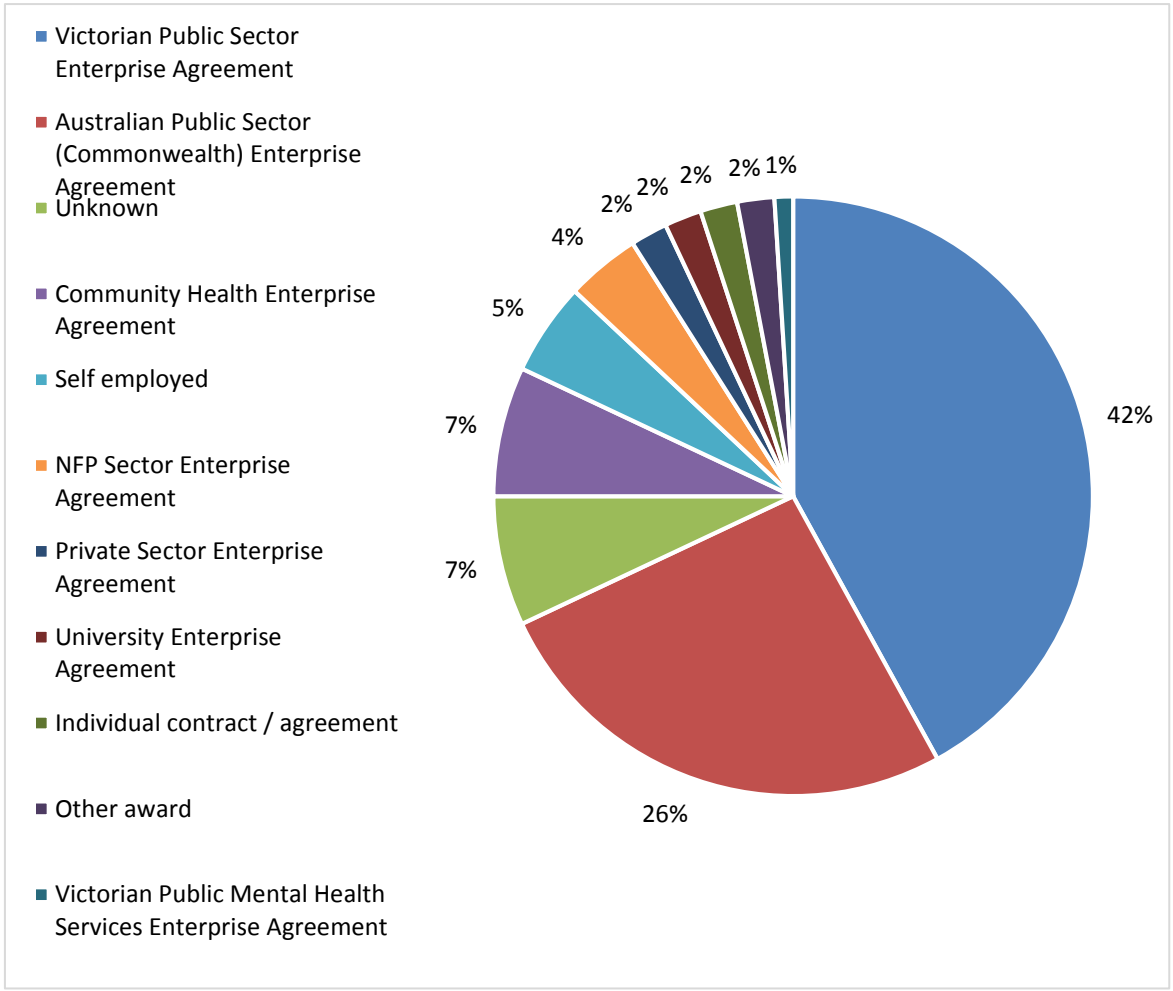


Awards

The Victorian Public Sector Enterprise Agreement was the employment award of 42% (n=445) of the AHWQ2 respondents. A further 26% (n=274) were employed under the Australian Public Sector (Commonwealth) Enterprise Agreement. The remaining respondents were employed against a range of other awards and employment arrangements. Examples include the Community Health Enterprise Agreement, the NFP Enterprise Agreement, the University Enterprise Agreement, individual contracts, and self-employment. As noted previously, public sector awards were likely to be over-represented in the respondent cohort due to the greater ease of distribution of the survey within the public sector.

Seven per cent (7%, n=78) of respondents did not know what award they were employed under (Figure 22).

Figure 22: Current award or employment agreement (n=1,051)



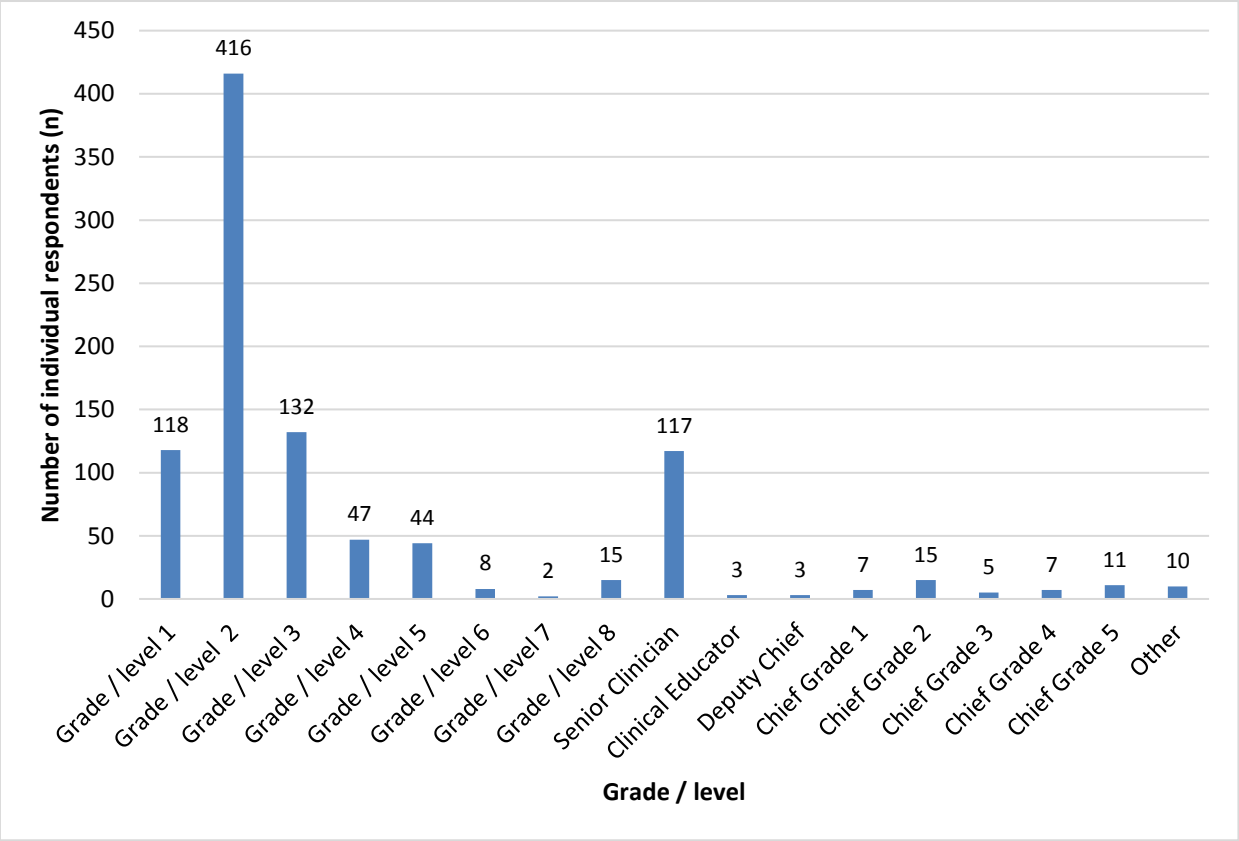
Employment grade / level

Nearly half of all AHWQ2 respondents (43%, n=416) reported being employed at grade 2 (or equivalent). Other grades were represented at notably lesser proportions, including grade 1 at 12% (n=118), grade 3 at 14% (n=132), and senior clinician at 12% (n=117). Although the number of university-employed respondents was low (n=21), a similar pattern was evident, with the majority employed at level B (67%, n=14) (Figures 23 and 24).

Members of the *Occupational Therapist Reference Group* for the project expressed interest in the low proportion of grade 1 to grade 2 respondents. From the data available, it is not possible to ascertain whether these proportions are representative of the Victorian occupational therapy workforce or whether

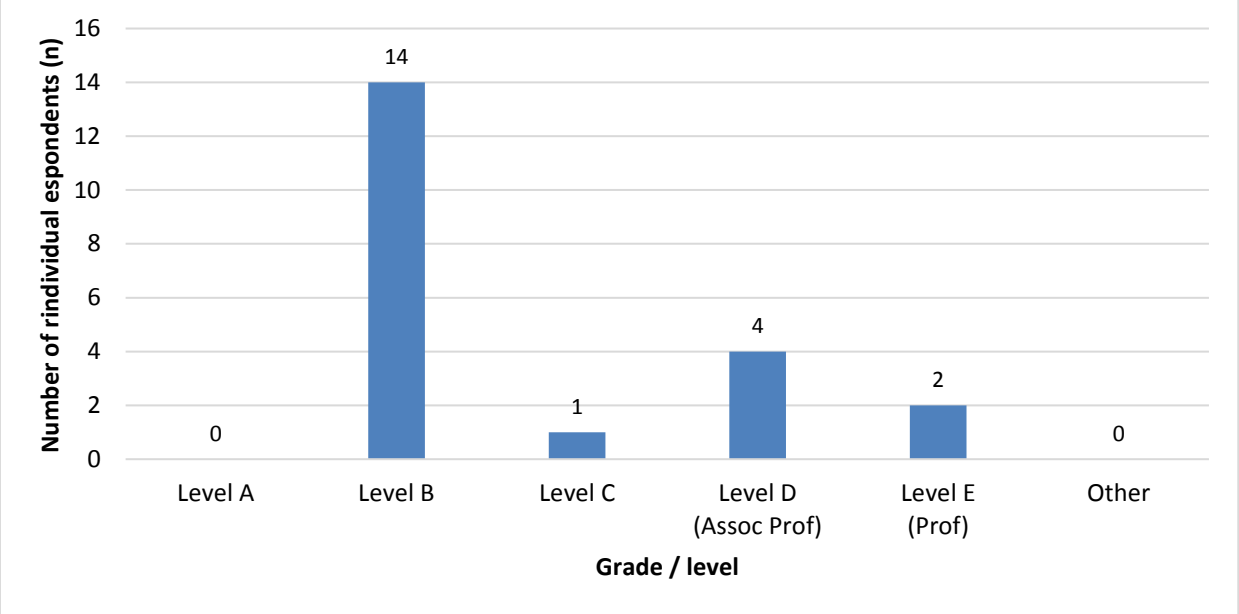
the survey received a disproportionate number of grade 2 respondents. The suggestion was made that grade 2 positions may represent a higher head count than grade 1 positions, even if the scale of this difference is not reflected in the full-time-equivalent of the respective grades. This could be associated with occupational therapy being a female dominated profession, and grade 2 professionals being more likely than grade 1 professionals to be at the stage of having young children and therefore working part-time. A further possible explanation is that grade 2 professionals may be at a stage in their career where they have a greater interest in contributing their perspectives through a project such as this.

Figure 23: Current grade (non-academic) (n=960)



[a] *Based on the grades used in the most common occupational therapy awards*

Figure 24: Current grade (academic) (n=21)



Employment status

The majority of occupational therapists responding to the AHWQ2 indicated they were currently employed in permanent roles (83%, n=851) (Table 6).

Table 6: Nature of employment with current main employer (n=1,022)

Employment status	%	Count
Permanent	83	851
Temporary	3	35
Self-employed	1	9
Contract	10	107
Voluntary	0	1
Casual	1	15
Other	<1	4
Total	**100**	**1,022**

Number of employers

The majority of occupational therapists reported having one employer (78%), with 18% reporting they had two employers or more employers (Table 7)

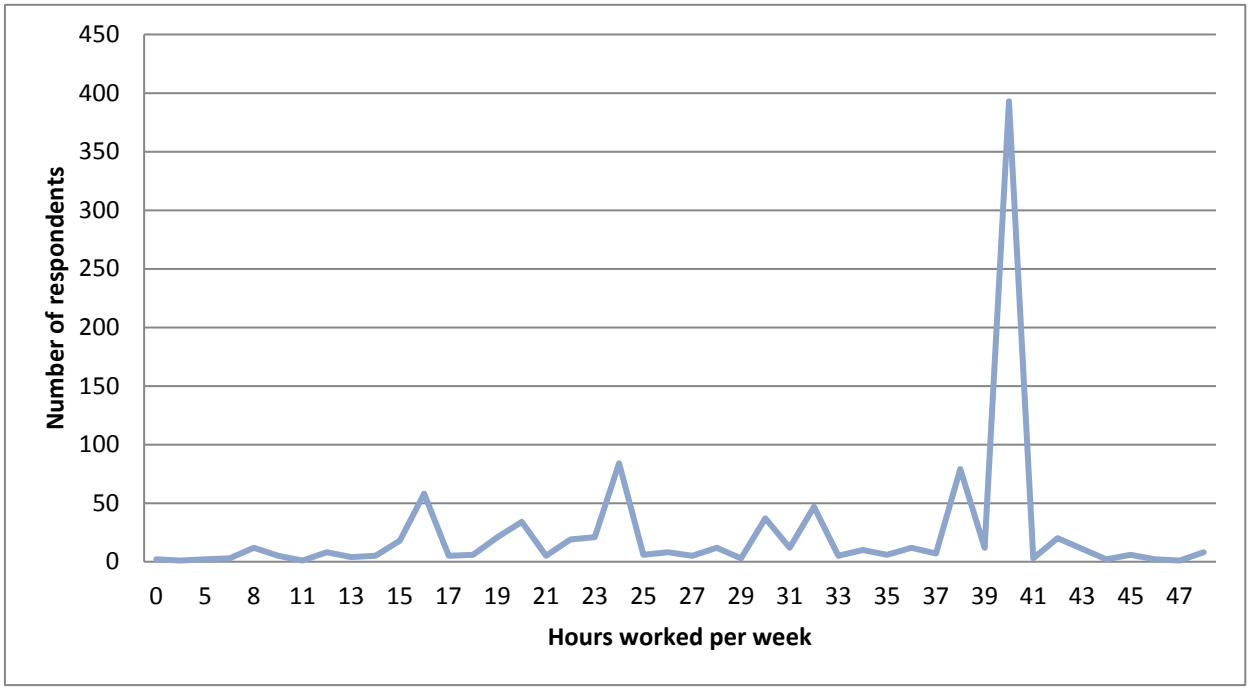
Table 7: Current number of employers (n=1,073)

Number of employers	%	Count
1	78	840
2	14	153
3	2	19
4	1	6
5 or more	1	8
I am fully self-employed	4	47
Total	**100**	**1,073**

Hours of work

On average, occupational therapy respondents to the AHWQ2 reported working 32 hours per week in their main role (n=1,012), with a range of 0 to 48 hours worked. The largest number of respondents (n=393) worked 40 hours per week, and 56% (n=577) worked more than 33 per week (Figure 25). The total average hours of paid work may be a little higher than 32 per week as 18% (n=186) of respondents reported being employed by more than one employer (Table 6).

Figure 25: Number of hours worked per week (n=1,012)



When considered by sector, the highest average weekly hours were for respondents who work for the Commonwealth public sector (mean=35 hours, n=99). Although respondent numbers were very low, the lowest average weekly hours were for local government employees (mean=20 hours, n=4) and private practice business owners (mean=25 hours, n=7) (Appendix Table 3).

Most occupational therapy AHWQ2 respondents indicated they perform their duties Monday to Friday, mostly during the day (93%, n=1,017). A small proportion indicated they worked on Saturdays (3%, n=36), Sundays (2%, n=26) and in shifts that change from day to day, or week to week (2%, n=26) (Table 8).

Many individuals spoke about increasing clinical demands resulting in high levels of unpaid overtime and subsequent negative impacts on work-life balance. In some larger services, a small number of occupational therapists reported working shift work. Individuals in these roles commented on enjoying the variable start and finish times and the flexibility this brought to other aspects of their life.

"I've recently come off a shift work role. I enjoyed the different hours, the later start time. It gave a bit of flexibility not working every day from 8-4.30. It was good for getting life admin done."

Table 8: Working pattern during a normal working week (n=1,042) [a]

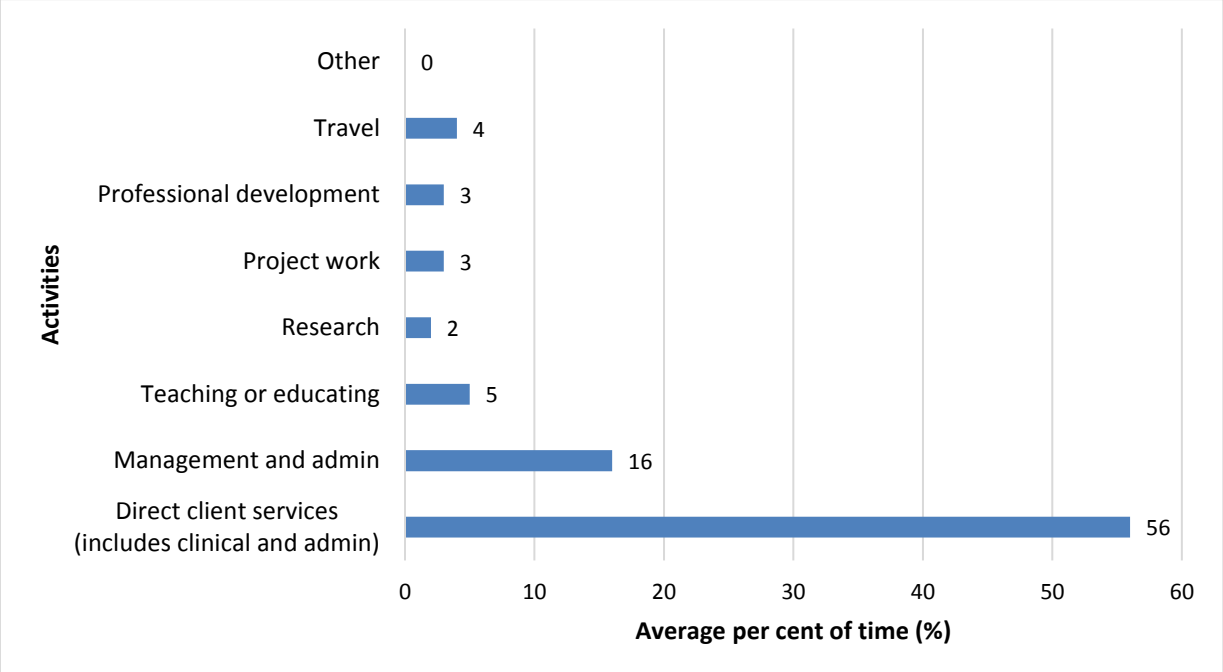
Working pattern	%	Count
Monday to Friday (mostly day time)	93	1,017
Monday to Friday (mostly night time)	<1	6
Saturday	3	36
Sunday	2	26
Shifts that change from day to day, or week to week	2	26
Other working pattern	<1	3
Total	**100**	**1,114**

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

Roles

On average, AHWQ2 respondents spent a little over half of their time (56%, n=1,041) on client related activities, including reporting and equipment requests. The average time spent on other management and administration was substantially less than this at 16% (n=1,031). When averaged across the occupational therapy workforce, teaching, research, project work, professional development and travel accounted for only a small proportion of time (Figure 26).

Figure 26: Average per cent of time spent on work activities (n=1,042)



Scope of practice

Prevention and early intervention

Participating occupational therapists explained that expectations to achieve discharge in as short a time frame as possible, and focusing on those with the most acute and complex needs, results in a significant compromise to the profession contributing to early intervention and prevention across the life span.

Numerous respondents articulated their concerns about lost opportunities for secondary prevention in the adult population. In the absence of comprehensive and timely service provision across the continuum of care, they noted difficulties providing holistic care with a genuine occupational focus. This was reported to place individuals at risk of:

- preventable hospital readmissions
- preventable falls
- challenges living successfully in the community due to insufficient physical, cognitive and mental health rehabilitation

"Patients' occupational performance needs are not addressed. Some patients can be at risk of injury and occupational deprivation."

"People are being discharged from hospital earlier, sicker and with more complex needs. For us to be able to care for them at home - where people actually want to be - and save the expense of regular hospital admissions or inappropriate residential care placements…we need to be able to give them that piece of equipment - the walker that will prevent the hip fracture or the adjustable height bench top that allows the person in a wheelchair to prepare their meals independently."

"We can only do the minimum to get a person discharged. And there's less preventative intervention in the community to prevent hospital admissions from occurring."

School aged children

As noted above, a relatively small proportion of survey respondents reported working with children (<2 years 8%, 2-4 years 11%, 5-12 years 14%, 12-21 years 18%). A number of respondents made observations regarding inadequate publicly funded service access for school aged children. The need for improved research regarding occupational therapy for school aged children was also emphasised.

"Public access to services for primary school aged children is limited/not available due to government funding and focus on early intervention for young children."

"Schools understand how occupational therapists work with young children but the system doesn't employ occupational therapists – only psychologists. There's a huge scope for occupational therapists in schools. Autism is understood but there are so many other learning disabilities that impact on how children interact with education. Occupational therapy in schools works well in America but not in Victoria yet. There's a divide between the Department of Health and the Department of Education on this issue."

Generic roles

Occupational therapists were employed in a range of generic roles such as those in mental health and care co-ordinator roles. The research participants explained that occupational therapists were well-equipped for these roles given the holistic underpinnings of occupational therapy practice. They spoke about performing a generic role, but bringing an occupational therapy lens to the role which adds value to a client's care.

Despite noting the valuable contributions occupational therapists bring to generic roles, respondents expressed concern about the increasing trend towards generic roles and the loss of discipline-specific

service delivery. They felt this compromised the services clients receive and affected their identity as an occupational therapist. In contrast, a handful of respondents commented that it was important that opportunities were created to support specialisation in generic roles.

"Occupational therapy needs to be recognised and acknowledged as a valuable discipline stream in mental health. There need to be more employment opportunities in discipline-specific roles rather than performing generic functions such as case management."

"There are resources and interest groups for people working as occupational therapists but if you are an occupational therapist working in a generic role (one which can be performed by, for example, an occupational therapist or a social worker or a RN [registered nurse]) there is less support."

Advanced practice

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

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

The *Occupational Therapy Association* (OTA) does not currently recognise or endorse any specific areas of advanced practice; however, hand therapy and driver assessment are broadly recognised as being advanced practice roles underpinned by a suite of competencies / credentialing tools. The Victorian Division of OTA is leading work to specify and develop competency frameworks for a number of roles in addition to these (e.g. within specific areas of aged/complex care, oncology/palliative care, neurology, and paediatrics). This work is yet to be completed.

Even though formal recognition of advanced practice is still being developed within the occupational therapy profession, 16% (n=164) of respondents reported that their work involves advanced scope of practice. The practice roles respondents identified most frequently as advanced practice were hand therapy (including wound care, pre- and post-surgical care, spasticity management, Botox clinics) (n=27), wheelchair and seating clinics (n=14), care coordination and key worker roles (n=12), psychological and mental health services (n=10), and driving assessment (n=8).

Allied health assistants (AHA)

Just over half (52%, n=538) of the occupational therapy respondents reported that their work involves delegation to AHAs.

Telehealth

Use of telehealth was only reported by 9% (n=95) of participants. They reported use of telehealth to deliver services to people in regional, rural, remote and interstate locations and in circumstances where clients are not able to access services in person, e.g. services to prisons. The modes of telehealth described by respondents included videoconferencing, teleconferencing, and email. The clinical purposes for which telehealth was reported to be used included:

- conducting pre-surgical screening and assessment
- providing assessment services for emergency departments in other locations
- providing coaching and monitoring to clients
- providing post-surgical reviews
- delivering rehabilitation services
- seeking opinions from medical specialists and allied health professionals with specialised skills

- conducting group work and client education
- facilitating case conferencing between clients and medical specialists

A high proportion of occupational therapists that used telehealth reported using it for non-clinical purposes including meetings, delivering and receiving professional and clinical supervision, participating in interest groups, and providing and accessing education. A number of respondents qualified the nature of their use of telehealth by describing it as ‘occasional’.

See Appendix Table 4 for numbers of respondents to different scopes of practice questions.

Workforce movement

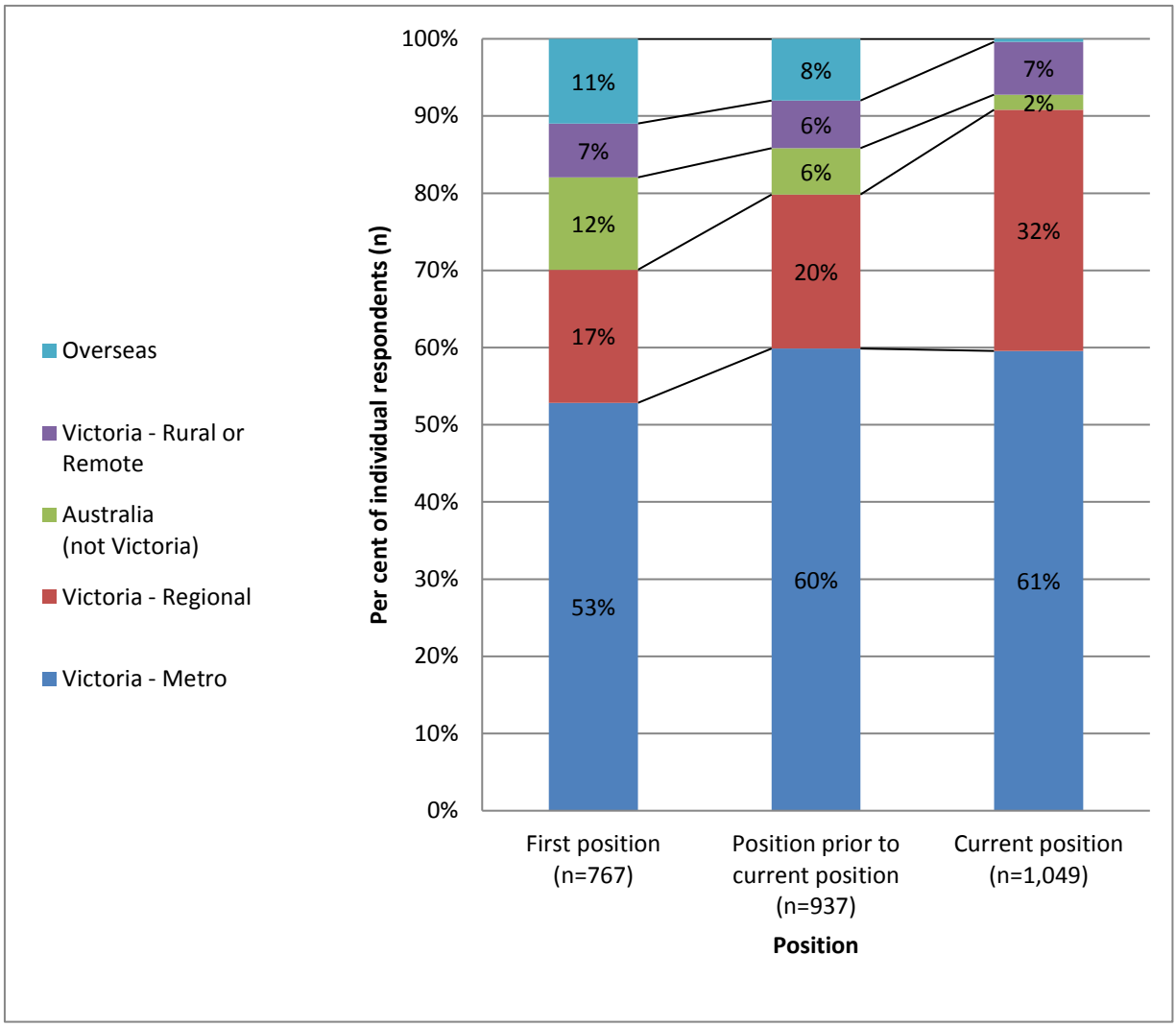
To identify patterns in the career pathway of occupational therapists, participants were asked to provide details regarding their first position, their position prior to their current position, and their current position/s. Questions focussed on position locations, roles, settings and sectors. They were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

Changes in location

The AHWQ2 data shows that the proportion of respondents working in metropolitan areas increased from 53% (409/767 respondents) to 60% (567/1,049 respondents) between an individual’s first role and the role they were in immediately prior to their current role. This proportion remained stable (61%) between their prior and current positions (637/1,049) (Figure 27).

Interestingly, respondent employment increased slightly in regional areas from 27% (205/767) to 32% (334/1,049) between respondents’ first positions and their current position at the time of the survey.

Figure 27: Changes in location across the career path (n=767 – 1,049)



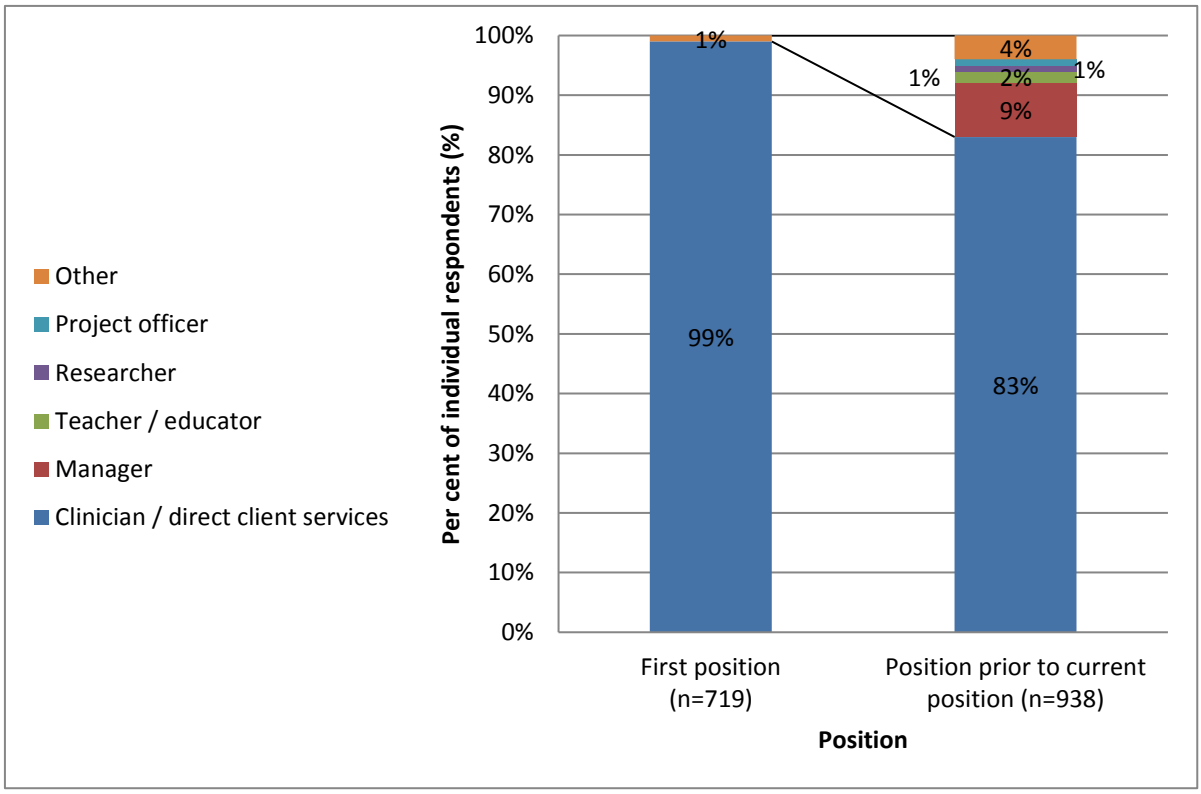
Changes in role

When employed in their first role as an occupational therapist, 99% (n=753) were employed in roles as clinicians / direct client services. This proportion shifted to 83% (n=792) for respondents' immediate prior position, with 9% (n=90) of respondents being employed in management positions and a very low number employed in a range of other role types such as researchers, project officers, and teachers / educators (Figure 28).

Occupational therapists reported that in their current role, on average 56% of their time is spent in direct clinical care; 16% of their time is spent in management or administration; 3% of their time is spent teaching or educating and only 2% of their time is spent on research. Please note due to the wording of these questions relating to current role this data was not able to be included in the same manner as the prior roles in Figure 28.

"Occupational therapists have great problem solving and project management skills which makes them suitable for other non-clinical / non-occupational therapist roles. As a result, the profession often loses occupational therapists to non-occupational therapy roles."

Figure 28: Changes in role across the career path (n=762 – 938)

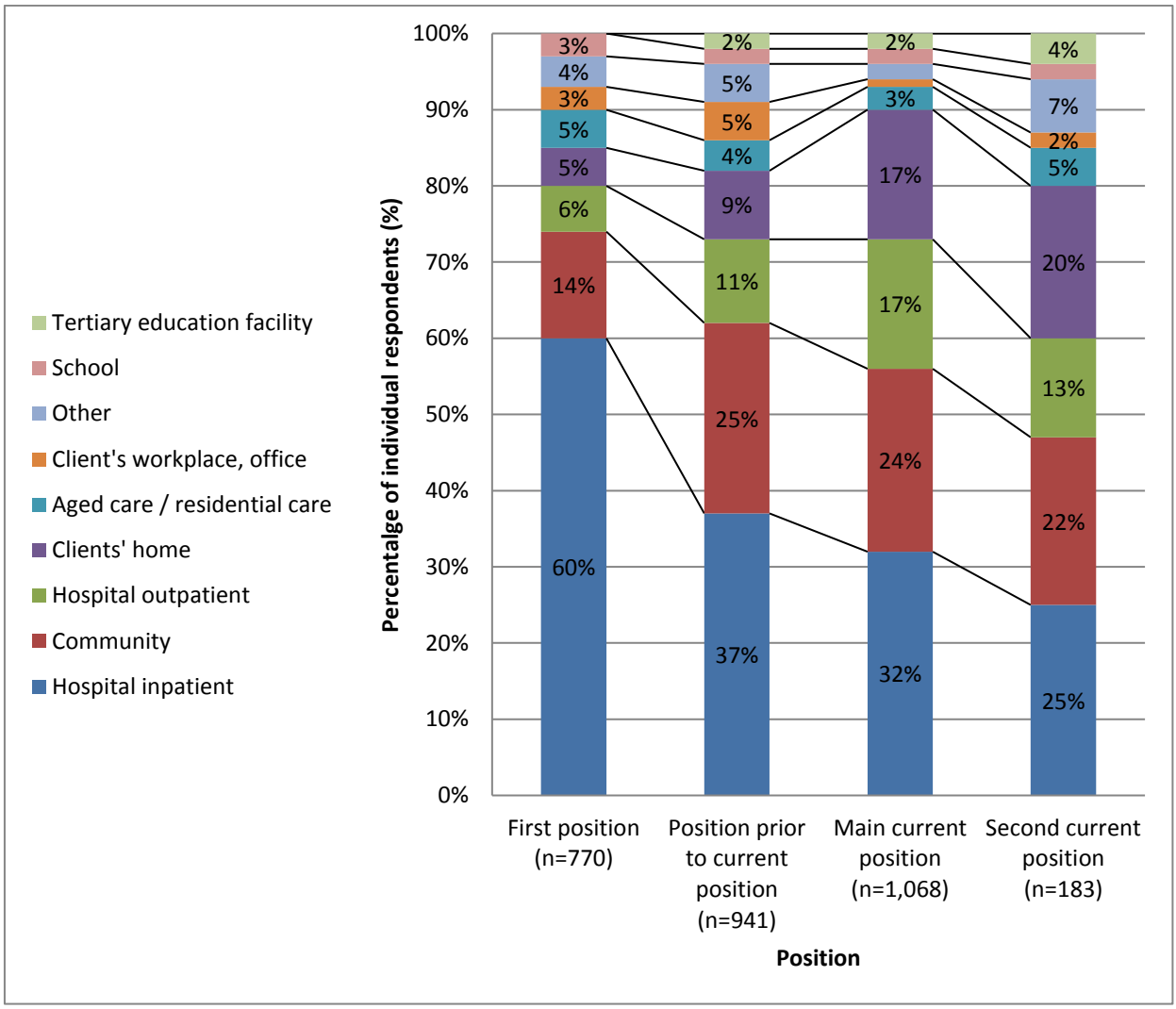


Changes in setting

Figure 29 shows noteworthy changes in the work setting of occupational therapists across their first position, their position prior to their current position, and their current positions. Respondents' first roles were predominantly in the hospital inpatient setting (60%, n=461). In contrast, about half as many (31%, n=336/1,068) work in hospital inpatient settings in their main current role. The reverse pattern is seen with the community setting and clients' homes where more individuals reported working in the community in their main current role (23%, n=248) than in their first role (14%, n=109) and in clients' homes in their main current role (17%, n=180) than their first role (5%, n=41).

It is important to recognise that these patterns are likely to reflect not only changes in setting across a career but also changing government policy and funding arrangements (Figure 29).

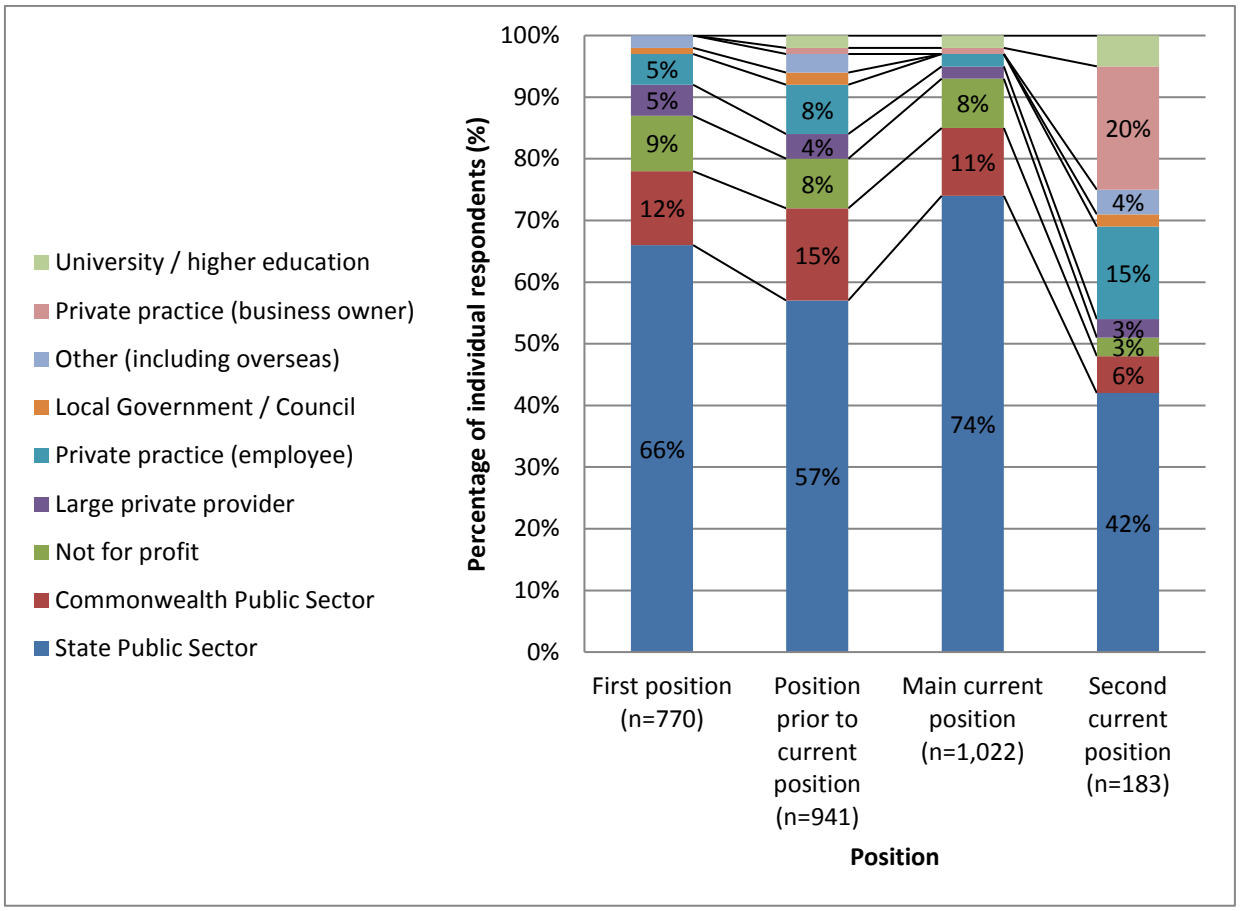
Figure 29: Changes in setting of care across career path (n=183 – 1,068)



Changes in sector

As noted previously, the cohort that responded to the AHWQ2 is likely to have included an over-representation of individuals working in the state public sector due to greater ease of distribution of the survey in this context. Given this situation, although Figure 30 suggests a trend towards employment within the state public sector across an individual's career, it is not possible to determine the accuracy of this finding. This result may simply reflect the current employment sector of the majority of the cohort.

Figure 30: Changes in sector over the career path (n=183 – 1,022)



Additional information relating to changes in employment location, sector and setting is in Appendix Tables 5, 6, 7 and 8.

Years in role

Over time, the number of years that respondents work in a role was shown to increase. The average time in first role was two years and the average time respondents had worked in their current role was six years (Table 9). When considered based on sector of employment, private practice business owners had the longest average duration of employment in their current role (10 years), followed by those employed in university / higher education (8 years) and the state public sector (6 years). The shortest average was for those employed in local government; however, there were only five respondents from this sector (Appendix Table 9).Table 9: Years in each role over the career path

	Mean	Range	Count
Years in current role	6	<1 - 40	1,058
Years in prior role	4	<1 - 40	920
Years in first role	2	<1 - 40	749

Capability

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

Figure 31: Workforce capability framework

Key findings

- The respondents identified the need for improved ways of ensuring evidence-based practice is delivered across all service settings and locations. It was suggested this requires improved capacity to translate research into practice guidelines and ultimately into service delivery.
- The need to strengthen the evidence base for occupational therapy across the continuum of care was raised and reinforced.
- Respondents reinforced that evidence-based practice cannot be delivered without appropriate funding and models of care.
- Most respondents (91%) said they have the skills needed to complete their work, but only half agreed they have access to adequate training to progress their career (54%) and access to mentorship and mentoring to support their career growth (53%).
- The need for skill development across the diverse range of areas that occupational therapists work in works in was identified, as was a need for knowledge development about major systems changes, such as the NDIS and My Aged Care. Online training was identified by respondents as a possible way to deliver this.
- Individuals in generic roles have needs for discipline-specific skill development opportunities.
- Part-time staff and professionals in rural areas indicated challenges accessing training.
- Poor opportunities for career progression were a strong and recurring theme. Respondents were frustrated at the lack of recognition of clinical skill and experience and the need to work in management roles to achieve career progression.
- Key facilitators of career progression were reported to be personal investment, supportive management providing explicit opportunities, supervision and mentoring, experiences in diverse roles, and opportunities to do research and project work.
- A formal multi-disciplinary team structure was the most common work arrangement of most participants (75%).
- Ninety-five (95%) of respondents reported having a supervisor. In most instances supervisors were occupational therapists (68%) or another AH professional (16%). Five per cent (5%) had no clinical supervisor despite working in a clinical role. The data suggests that although a professional may have an appointed clinical supervisor, this may not reflect the extent to which they receive clinical supervision.

Evidence / knowledge base

Research participants identified the need for significant development in the occupational therapy evidence base across the life span, across the continuum of care, and in new and emerging areas of practice. The need to focus on accountability for achieving outcomes for clients was emphasised by some respondents.

Specific populations identified as requiring a significantly increased research focus included paediatrics, older people, people with disability, people experiencing mental illness, and people with sensory processing disorders.

Participants reported a need for increased valuing of research and greater investment in research. They also noted the importance of more widespread participation in research by clinicians across service contexts. One specific opportunity suggested to assist this process was the establishment of clinical research academic roles between universities and service providers.

Occupational therapists emphasised the importance of improved communication about research findings and supporting translation of research into practice. Some participants noted that this includes development of practice guidelines that inform delivery of evidence-based practice across the profession, regardless of location or service setting. It was felt that this would improve clinical practice outcomes, support advocacy for service funding, and increase understanding of the occupational therapy role by other professions and the community more widely.

One respondent commented on the importance of practitioners becoming skilled in integrating the findings from systematic reviews and randomised controlled trials within the principles and processes of delivering client-centred practice.

Importantly, many occupational therapists noted that if they are to deliver evidence-based practice then funding allocations and models must be informed and guided by the available evidence.

“There need to be much higher standards of practice in publicly-funded rural health and aged care services. Practice should be evidence-based regardless of the location and funding model.”

“We need to research quality outcomes for our clients and disseminate / translate this information into practice consistently to maximise effectiveness of intervention.”

“There’s a lack of sufficient staffing to meet best practice guidelines around the amount of treatment required to see patient improvements.”

“If we have the research into the effectiveness of occupational therapy across the care continuum we can advocate for our professional role and influence funding.”

“We need clear justification for what we do that is underpinned by more than just 'its functional' or 'its meaningful' or 'keep the patient safe'. We need to be drawing upon knowledge from cognitive, musculoskeletal AND functional elements so what we are doing is evidence-based, justifiable to the organisation, and understood by our medical colleagues.”

Training and continuing professional development

Prior work experience

The majority of respondents (68%, n = 720/1,063) had no prior profession or role before becoming qualified as an occupational therapist. The remaining respondents (32%, n=343) had worked in another profession or role full-time for more than 6 months before entering occupational therapy, with just over a third of these (34%, n=118),having worked in multiple professions. For those that had worked in another role or profession, the average number of years worked was six.

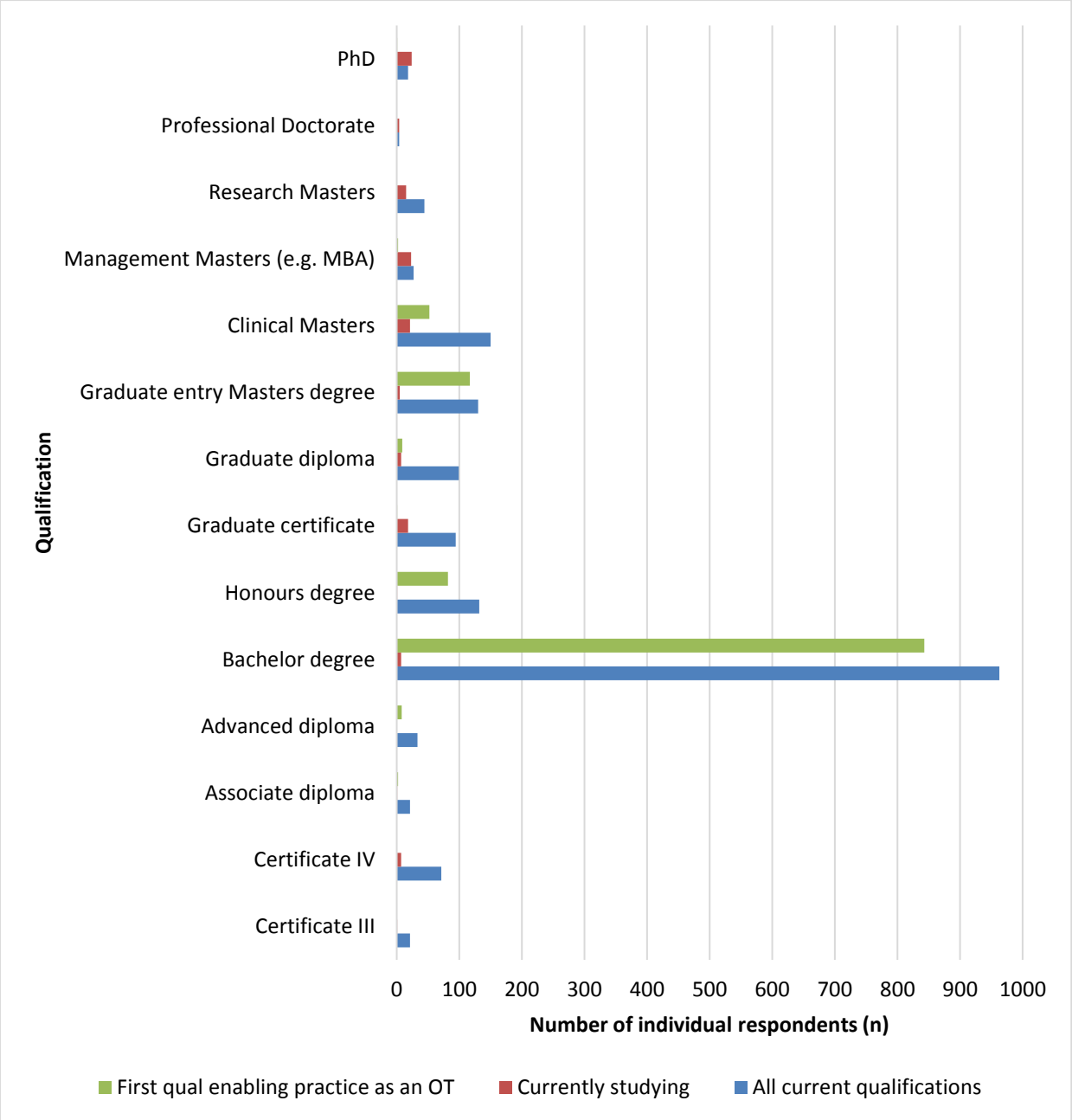
Qualifications

The predominant first qualification that enabled respondents to practise as an occupational therapist was a bachelor degree (75%, n=843). A further 10% (n=117) entered the profession with a graduate entry master's degree (Figure 32).

Respondents also reported having a range of other post-graduate qualifications including graduate certificates (n=94), graduate diplomas (n=99), clinical masters (n=150), management masters (n=27), research masters (n=44), professional doctorates (n=4), and PhD (n=18).

A further 112 respondents reported that they were currently undertaking post-graduate studies. See Figure 32 and Appendix Table 10 for detailed breakdown by respondent numbers to different qualifications.

Figure 32: Qualifications held or currently studying (n=1,123) [a]

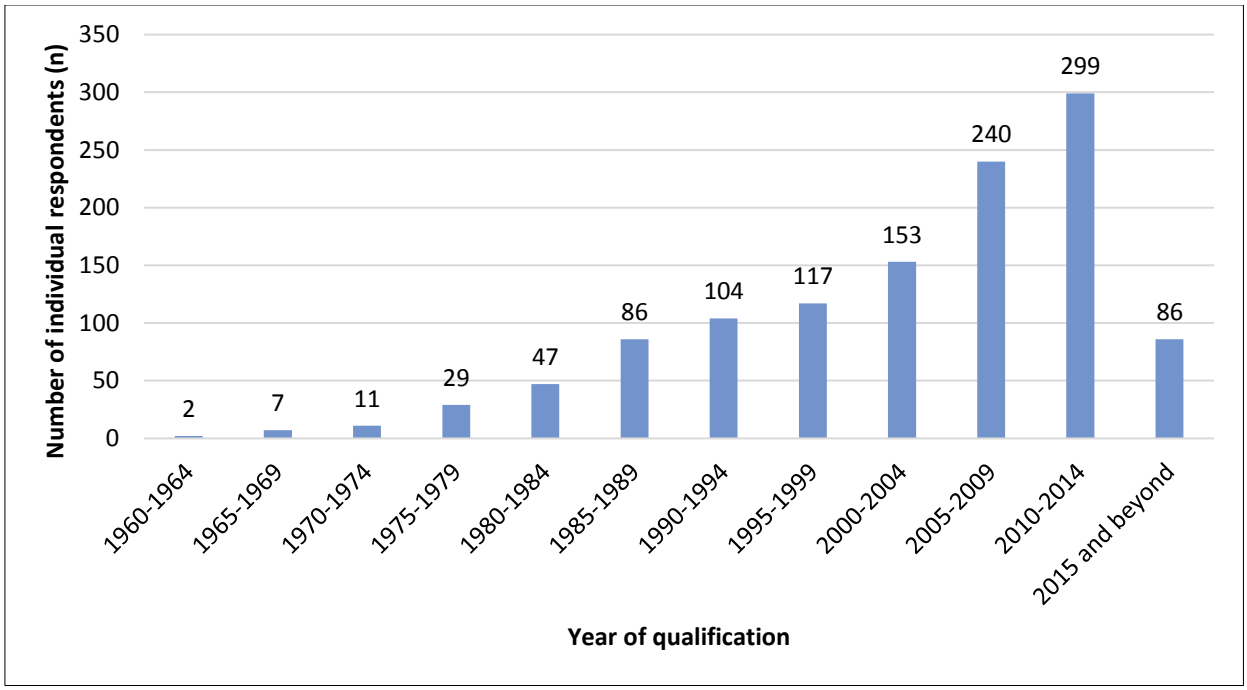


[a] *Respondents could select more than one response for 'all current qualification' and 'currently studying'*

When considering the total respondent cohort, the mean length of time since completing their first qualification was 15 years.

Nearly one third of respondents (32%, n=378) received their occupational therapy qualification in 2010 or later (Figure 33).

Figure 33: Year of qualification (n=1,181)



Most respondents qualified to practise as an occupational therapist in Victoria (75%, n=890), or another Australian state (17%, n=199), predominantly New South Wales (20%, n=39) or South Australia (20% n=39). The majority trained in a metropolitan area (80%, n=955). Overseas trained occupational therapists accounted for 8% (n=100) of respondents (Appendix Table 11 and Table12).

Continuing professional development

Just over a half of respondents agreed they had access to adequate training to progress their career (54%, n=541) and access to mentorship to support their career growth (53%, n=531). However, on both these measures it leaves close to half of all respondents indicating either a neutral answer to these statements or disagreeing.

Respondents emphasised the need for improved access to professional development in specialised clinical skills and on major service system changes such as the NDIS and My Aged Care. Occupational therapists in generic roles indicated they had excellent access to training and development in general skills but limited opportunities to access discipline-specific professional development. They reported that their managers often did not appreciate the importance of occupational therapy training and development.

Part-time staff and professionals in rural areas noted particular challenges in accessing adequate professional development. Improved access to online learning opportunities was emphasised as an important means of improving this situation.

The cost of professional development was said to be a barrier for some occupational therapists.

"There's always a need to update clinical skills in particular areas, and it can be difficult to access knowledge / training in some areas in a manner that is readily accessible and isn't too expensive."

"When occupational therapists work in such diverse areas it would be good if there was further specialty training to help equip us better."

"We have a lack of professional development in the disability sector, including a lack involvement from the professional bodies.

The variety of CPD topics needs to be increased - especially online courses so it doesn't matter where you live."

Career development opportunities

With respect to career development and progression, 55% (n=545) agreed they had local career development opportunities however only one third (33%, n=332) agreed that they had a clear career progression pathway in their profession (Figure 34). This theme was also expressed very strongly within the qualitative survey responses and focus groups.

When respondents were asked about the single most important issue they would like to see addressed by, or for, their profession, 16% (n=144) indicated career progression. The most common issue raised was the limited capacity to progress beyond grade 2. More particularly, many respondents expressed frustration that career and pay advancement required them to change into a management role, rather than achieving advancement through a clinical career. Equally frustrating was the lack of acknowledgement of high levels of clinical expertise and experience as professionals remained at the grade 2 level over many years.

Sole practitioners also commented on the lack of opportunities for career progression, despite the development of high level skills and the expectations to fulfil management duties in addition to a clinical role.

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

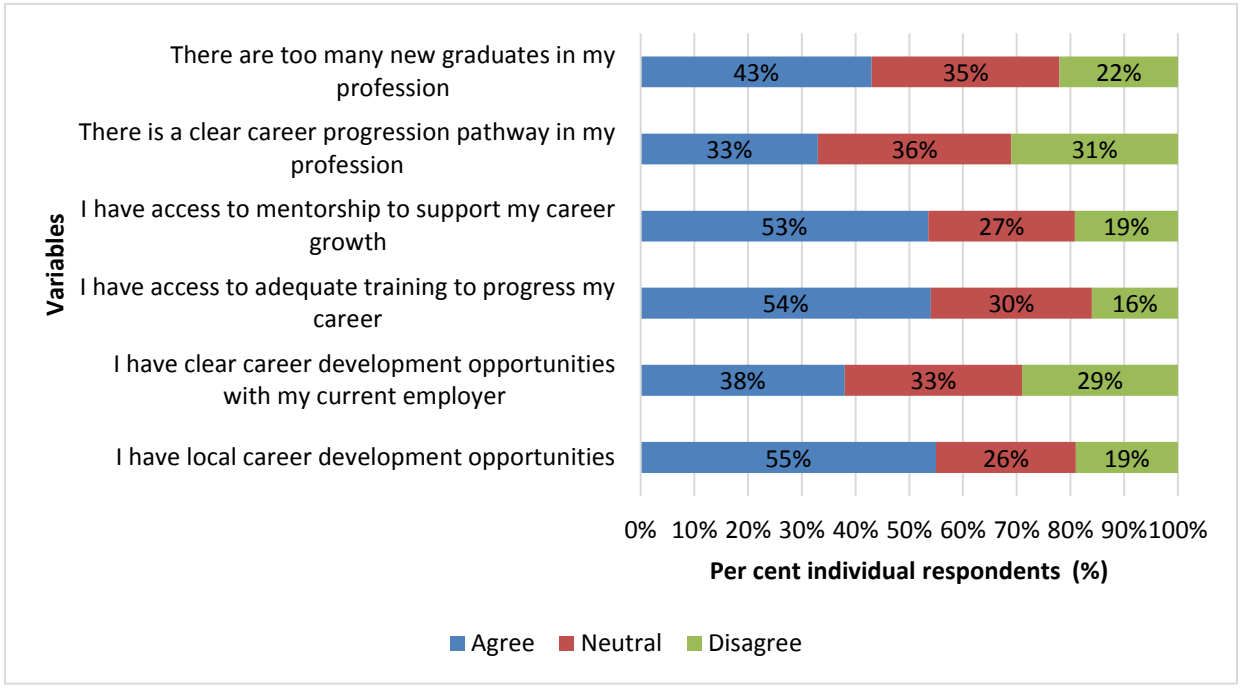
- personal commitment and investment, including participation in professional development and formal study
- supportive management that explicitly supported and created new opportunities
- good supervision and mentoring
- opportunities to experience diverse roles through rotational positions, and working in regional areas, interstate, and overseas
- acceptance within the profession of occupational therapists moving between different practice areas
- opportunities to participate in research and project work

"The fact that changing roles and employers is not seen as a negative has helped me gain skills and confidence to work in a variety of positions. It's also kept my eyes open to look into non-traditional roles as my exposure to many other disciplines has widened my understanding of the fields I can work in."

"There needs to be scope to develop clinical specialist roles. I have 30+ years of working life left and have reached the top of the pay scale (as grade 3 year 4). There are very few grade 4 positions in mental health available and a lack of prioritisation of career progression and retention of staff in public mental health."

"It's a problem that sole practitioners can't be classified as a higher grade because they don't 'supervise' other health professionals from the same discipline. There's a need to recognise their other skills in management roles and working in multidisciplinary teams or supervision of staff from other professions."

Figure 34: Career development opportunities (n=995)



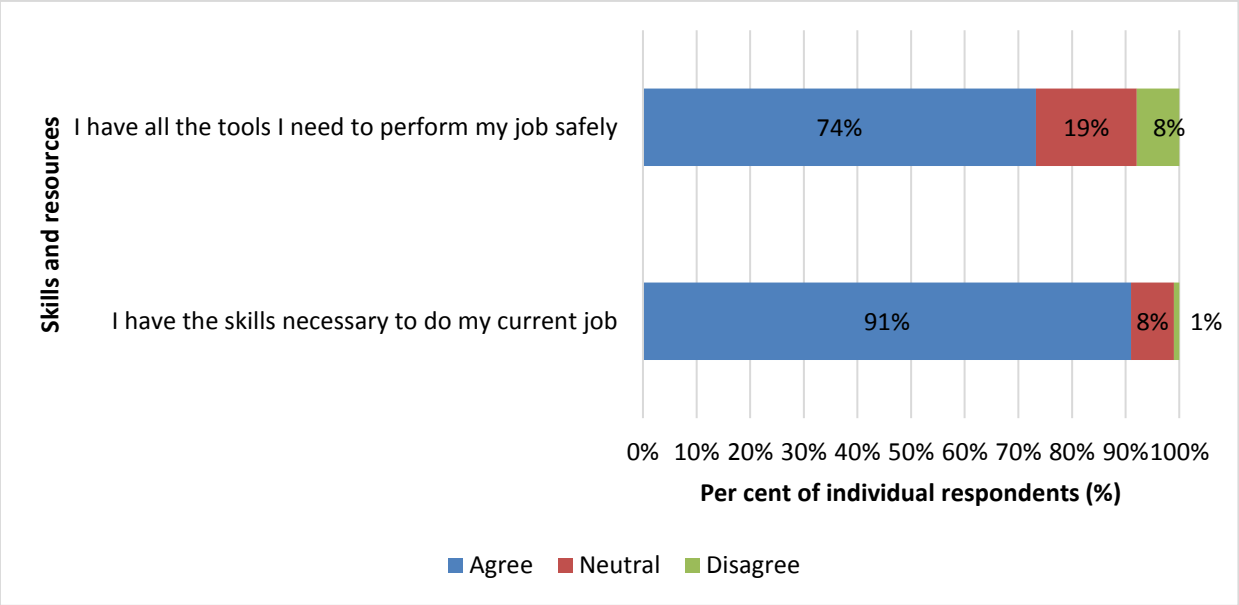
Clinician knowledge and skills

The vast majority of occupational therapy respondents (91%, n=902) indicated they have the skills necessary to perform their job. Only 1% (n=10) indicated this was not the case. Somewhat lower than this was the finding that just under three quarters (74%, n=732) of respondents indicated agreement that they have the tools needed to perform their role safely. Although a high proportion, this finding does not diminish the importance of the fact that 8% (n=75) indicated they do not have the tools to perform their job safely and 19% (n=184) gave a neutral response to this question (Figure 35).

Despite these positive findings, one survey respondent, who had practised as an occupational therapist in several countries, expressed concern regarding the limited mechanisms for ensuring clinical standards of occupational therapists across the span of an individual's career.

"AHPRA should mandate and monitor a series of learning objectives throughout the year for each occupational therapist. Look at the NZ [New Zealand] Occupational Therapy Board as an excellent example of how this can be achieved…Many clinicians have not had their practice challenged for decades or even been required to have trained professional supervision…In the absence of AHPRA mandating and monitoring standards, organisations do not provide the supervision or PD as they do not see the need or requirement."

Figure 35: Clinician skills and resources (n=995)



Skill gaps

When asked about skill gaps, 84 organisational respondents raised a range of different issues. Some respondents noted that specific arrangements are in place to ensure all their staff have the appropriate skills to perform their roles. The skill gaps identified by others could be categorised as clinical skills, professional skills and skills for other relevant roles.

One respondent observed that required skills are dependent on each individual's role, caseload, and experience and commented that it is not clear that there are specific sector-wide gaps.

Gaps in clinical skills

The identified skill gaps spanned a wide range of areas and were most likely informed by the practice area of each organisation.

Overarching areas in which gaps were identified included:

- clinical reasoning
- provision of holistic care
- knowledge of occupational performance
- interviewing skills
- activity analysis
- discharge planning
- professional documentation, including note taking, and client applications for equipment and funding

Specific areas of practice in which gaps were identified included:

- anatomy and normal movement patterns
- acute inpatients
- neurological assessment and rehabilitation
- cognitive assessment and rehabilitation
- hand therapy skills, including motor training, spasticity management, serial casting
- home visiting, home assessment and complex home modifications, including technical drawing
- complex wheelchair and seating assessment, including pressure care management
- vehicle modifications
- mental health, including risk assessment, mental state examination, and self-harm
- mental health and physical health in combination
- paediatrics and therapeutic engagement with children
- vocational rehabilitation
- driving assessment
- palliative care
- lymphodoema
- sexuality and disability
- knowledge of NDIS
- knowledge of SWEP

Several respondents noted that given occupational therapy is a profession with a broad remit, there is a need for the foundation training of the profession to be provided with then focussed development of the specialist skills required in specific areas of practice.

"The occupational therapists I work with in community health have so many skills but are just not confident because they don't see themselves as specialists of a particular area."

"Our management and seniors ensure that we as occupational therapists are adequately trained across all facets of the profession."

"Occupational therapy is a very broad profession and skills required depend on the role people go into. New grads often need a lot of supervision and support in the hospital environment. It would be useful to have a grad year funded by government to ensure they get more access to supervision and development opportunities to provide education in any gaps. Case load requirements mean they often need to build up to a full case load very quickly."

"There are many grads who finish without the main basic clinical placements of bed-based general hospital, mental health, general community."

Gaps in management, business or other professional skills

Areas where professional skill gaps were reported included:

- workplace communication
- resilience for practising in the 'real world'
- ethical obligations
- use of translational research and evidence-based practice
- outcome measurement
- quality improvement
- use of information technology and data systems

"Graduates are taught idealistic practice then have difficulty transferring those skills and knowledge to real practice. It would be useful if there was more emphasis on building resilience in AH staff."

Additional roles where respondents indicated that more formal skill development was warranted included:

- management skills and budgeting
- advanced supervision of staff and students, including management of poorly performing staff
- business skills and entrepreneurship
- research

"I'm not sure if occupational therapists have a gap in their research skills or if they simply prioritise direct clinical care to research, but this is improving."

"There are gaps in developing staff management and recruitment skills - I learnt this on the job."

Support contexts to enhance capability

Supervision and support

The occupational therapists that responded to the AHWQ2 and contributed to the focus groups emphasised the importance of good quality supervision and support. When asked an open-ended question about the contributors to their career progression opportunities, supervision, mentoring, and supportive management were identified as the most important factors.

The AHWQ2 showed that 95% (n=956) of occupational therapists have a supervisor, however 5% (n=53) indicated they worked clinically but did not have a supervisor (Figure 36).

The majority of occupational therapists were supervised by other occupational therapists 68% (n=684). A further 16% (n=171) reported receiving supervision from other AH professionals or from nurses 6% (n=56). A small proportion received supervision from medical professionals (1%, n=11) and professionals from a non-clinical background (3%, n=26).

"The excellent support I've had from managers (line managers and occupational therapy managers) has been so important."

"The concept of professional supervision is often confused and substituted with managerial supervision."

Figure 36: Professional background of clinical supervisor (n=1,009)

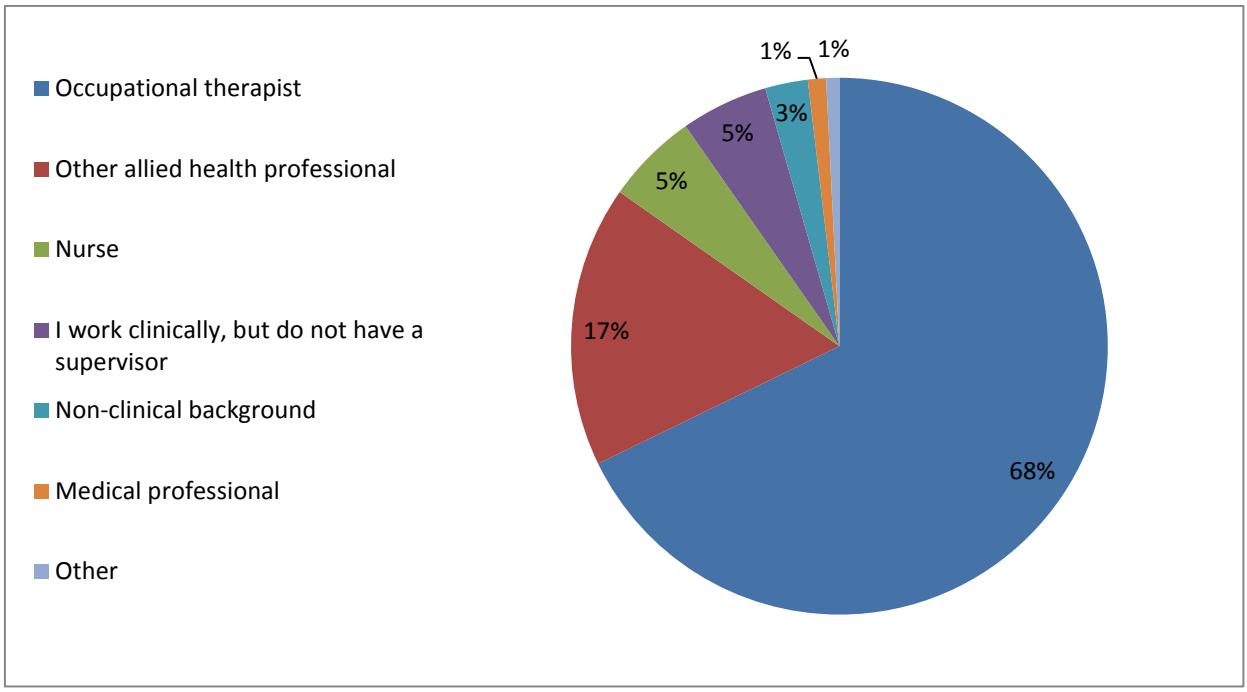


Figure 37 provides further information on the support experienced by occupational therapy respondents. Most respondents reported that they had access to peer support within their profession, they had formal management support, they were not professionally isolated, they could access assistance if they were uncertain about their work, and they had access to clinical supervision. Even so, the context of those who indicated disagreement or a neutral perspective on these issues must not be disregarded. For example, over one quarter (28%, n=267) disagreed or were neutral regarding their access to formal management support from a member of their own team.

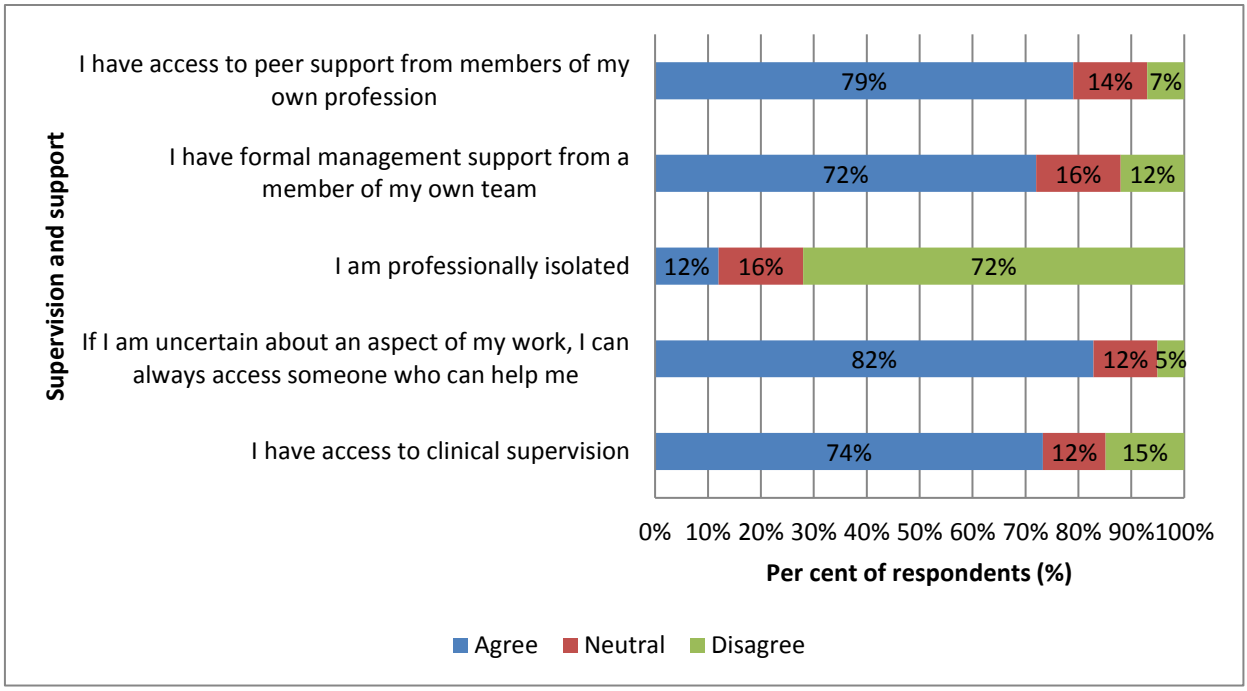
It is also of interest that although in Figure 36 (above) only 5% of respondents indicated they do not have a clinical supervisor, in Figure 37 (next page) 27% (n=252) disagreed or were neutral on the point of having access to clinical supervision. This suggests that although a professional may have an appointed clinical supervisor, this may not reflect the extent to which they receive clinical supervision.

When the findings were considered based on the employment sector of respondents, those employed in the state public sector were most likely to report having access to clinical supervision (78%, n=539), formal management support (76%, n=525) and peer support (81%, n=563). The same proportion of respondents working in the Commonwealth public sector also reported having access to peer support (81%, n=84). Those employed in university / higher education were most likely to indicate their grade and / or salary was appropriate for the work they did (65%, n=13), that they had the skills needed to do their job (100%, n=20), and the tools needed to perform their job safely (85%, n=17). Individuals employed by a large private provider, such as a private hospital, were most likely to indicate they always have access to someone who can assist when they are uncertain about their work (90%, n=19), and were least likely to indicate being professionally isolated (5%, n=1) (Appendix Table 13).

As noted previously, private practice business owners represented a small proportion of survey respondents. However, they were least likely to agree with statements that they had access to clinical supervision (38%, n=3), they had access to assistance if they were uncertain about their work (67%, n=6), they had access to formal management support from a member of their own team (0%, n=0), and their grade / salary was appropriate for their work (38%, n=3). They were also the most likely to agree that they were professionally isolated (22%, n=2) (Appendix Table 13).

Through focus group discussion, respondents indicated that lack of good quality supervision has a significant impact on work satisfaction. Some respondents commented that supervision can be seen as a secondary priority to client care, without recognition of the fact that high quality, sustainable service provision is dependent on effective supervision arrangements. Some respondents spoke about needing to access and pay for supervision from outside of their work environment.

Figure 37 Access to supervision and support (n=954)



Team structure

The vast majority of occupational therapists worked closely with other professionals from their own profession and other professions. The arrangements for this practice varied, but on the most part was reported to be in the context of multidisciplinary teams with a formal team structure (76%, n=829). A small proportion of individuals reported being sole practitioners who do not work directly with other practitioners (4%, n=43) (Figure 38).

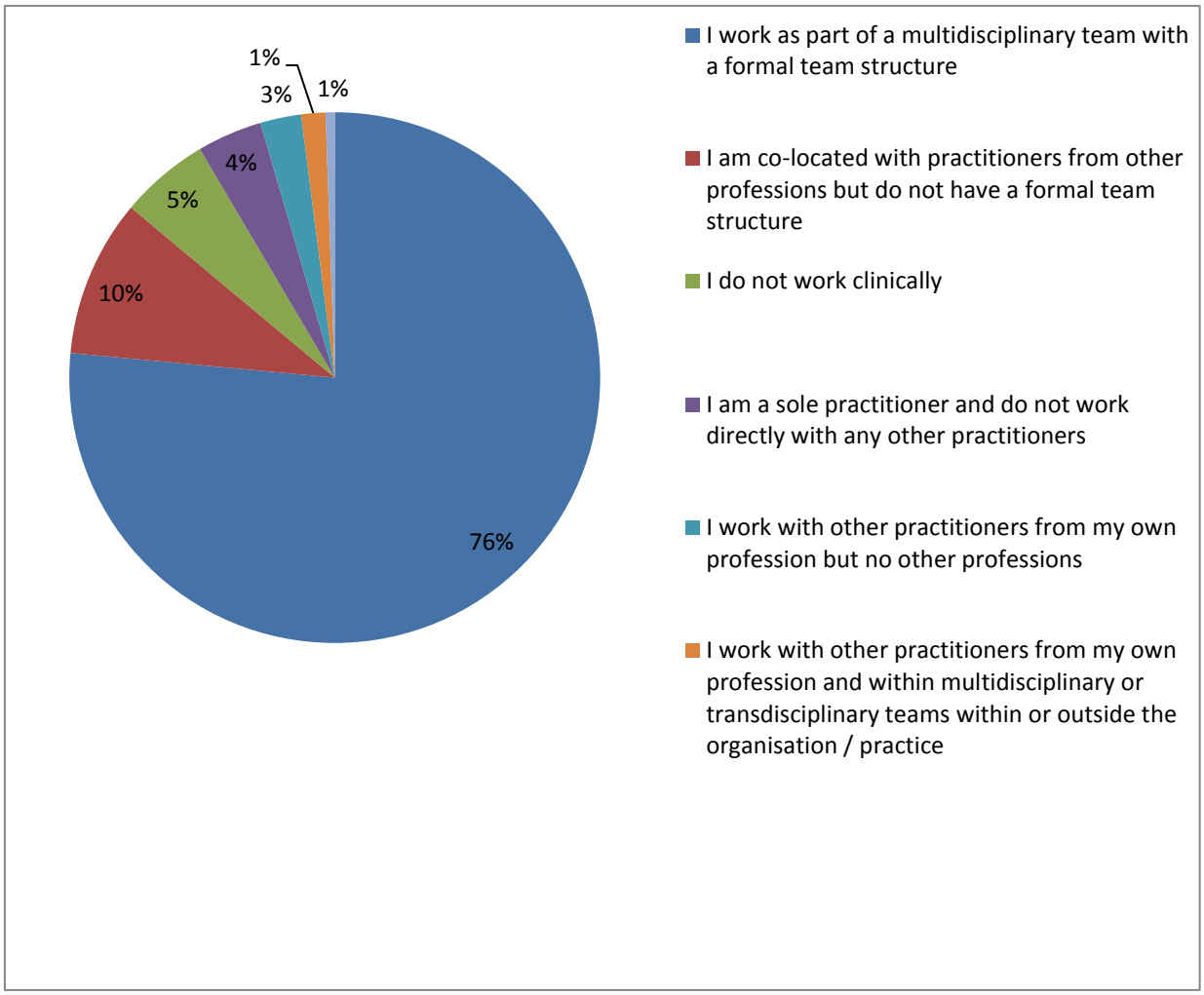
"I've always had support from a fantastic supervisor, so even when my work was complex, it was okay. There's always been help if you need it. It's good to have someone to talk to when it gets tough."

"I was satisfied for a long time with good support. I used mentors and networked with other occupational therapists. It wasn't until I was older I realised I should have had outside, discipline-specific supervision all along. I never knew if what I was doing was right or wrong. I probably needed more constructive criticism."

"I started work in a regional area. Not having informal supervision day-to-day with another colleague was difficult and supervision wasn't prioritised. I've had to unlearn those habits now I'm in a metro area."

"My current experience of supervision is varied. I rotate every six months and it can take a month or two to get used to a new supervisor. This is challenging at times."

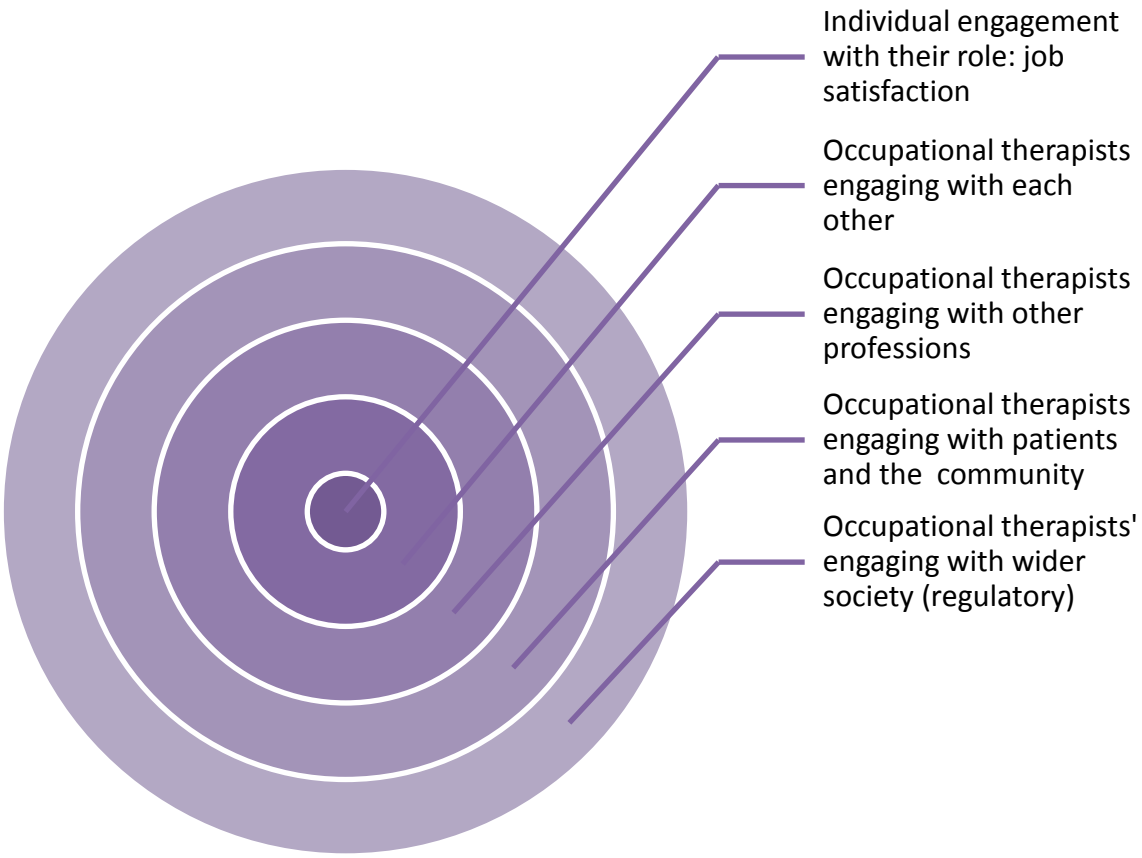
Figure 38: Practice structure (n=1,035)



Engagement

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

Figure 39: Model of engagement



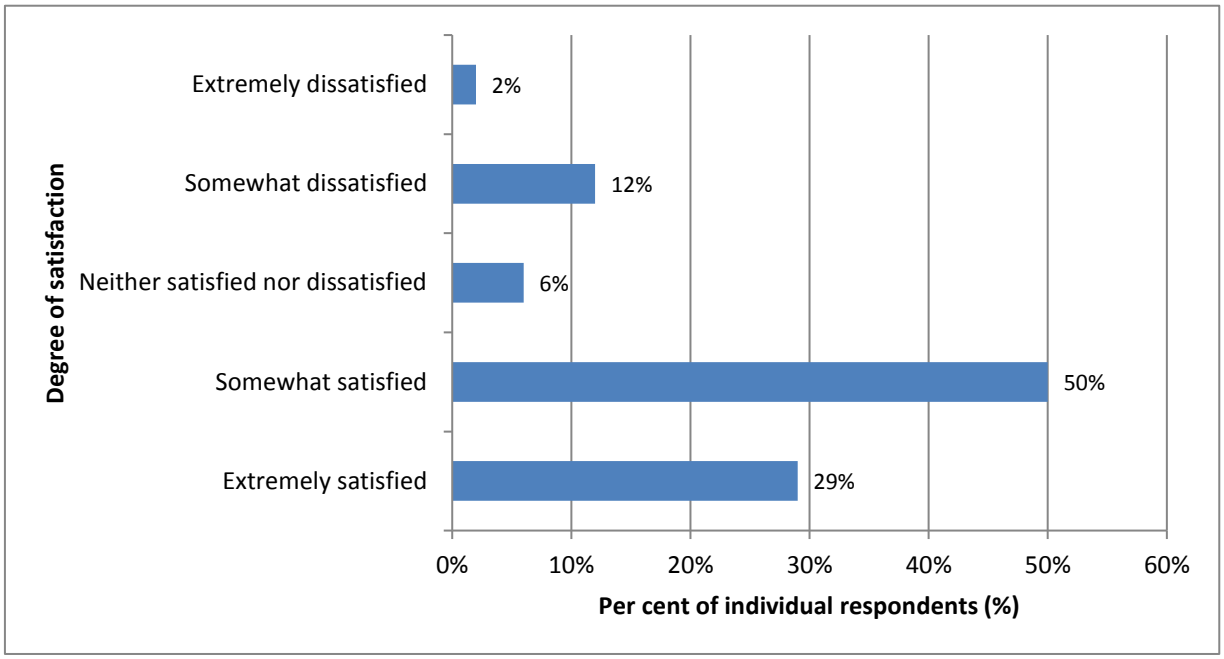
Key findings

- Most research participants expressed being extremely satisfied (29%) or somewhat satisfied (50%) with their careers.
- Respondents valued the holistic nature of the occupational therapy profession and the diversity of opportunities to work across age groups, areas of practice, sectors and roles.
- Job satisfaction was reported to be supported by making a difference to clients, working in a supportive team, experiencing the 'just right challenge' (being extended without being overwhelmed), and being encouraged and supported to continue their learning.
- Career advancement was the issue for which the highest proportion of respondents reported dissatisfaction in their current working life (31%).
- *Occupational Therapy Australia* was reflected as an important enabler of intra-professional engagement, including interest groups, professional development and conferences, mentoring, advocacy for the profession, and opportunities to contribute to the profession.
- A strong and recurring theme was the need to build community and professional understanding of the holistic role of occupational therapy in enabling occupational performance. Concerns exist that if this is not achieved the profession will lose its holistic focus and have an increasingly narrow focus on discrete tasks such as equipment prescription and home modifications.
- Occupational therapists reflected a positive perspective on their working relationships with other professions. Even so, for those working in generic and transdisciplinary roles, challenges exist in relation to pay parity and entitlements. In these roles, nurses employed against the same job description are typically paid at a higher rate and receive more favourable entitlements.
- Respondents reported that the quality, safety and outcomes of services to the community would be enhanced if funding models were informed by available evidence and used a staff to client ratio mechanism, similar to that used for employment of nursing staff.

Individual role engagement

Half (50%, n=518) of all occupational therapy respondents reported being somewhat satisfied with their current work situation. A further 29% (n=303) indicated being extremely satisfied (Figure 40). Twenty per cent (20%, n=208) of occupational therapists were ambivalent regarding their satisfaction or explicitly stated being either somewhat or extremely dissatisfied. This distribution was essentially similar for respondents across all work sectors except for those in the NFP sector. For those employed in the NFP sector, 13% (n=10) indicated they were ambivalent about their job satisfaction, 22% (n=17) were somewhat dissatisfied, and 3% (n=2) were extremely dissatisfied (Appendix Table 14).

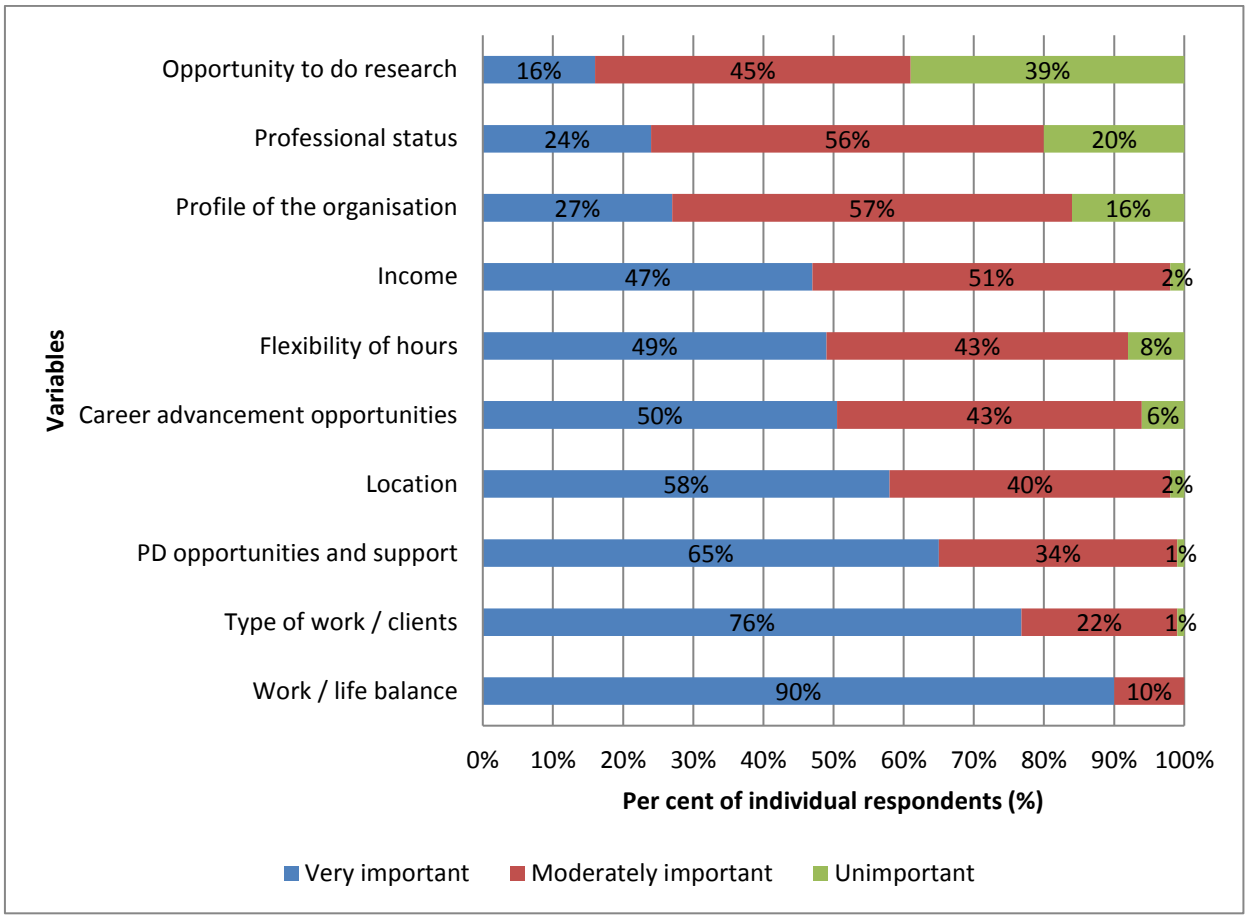
Figure 40: Overall satisfaction (n=1,029)



The research participants were asked about the relative importance of different features of their employment. The three features identified as being very important to the greatest proportion of respondents were:

- work-life balance (90%, n=888),
- type of work / clients (76%, n=752), and
- professional development opportunities and support (65%, n=635) (Figure 41).

Figure 41: Importance of factors in employment choices (n=984)



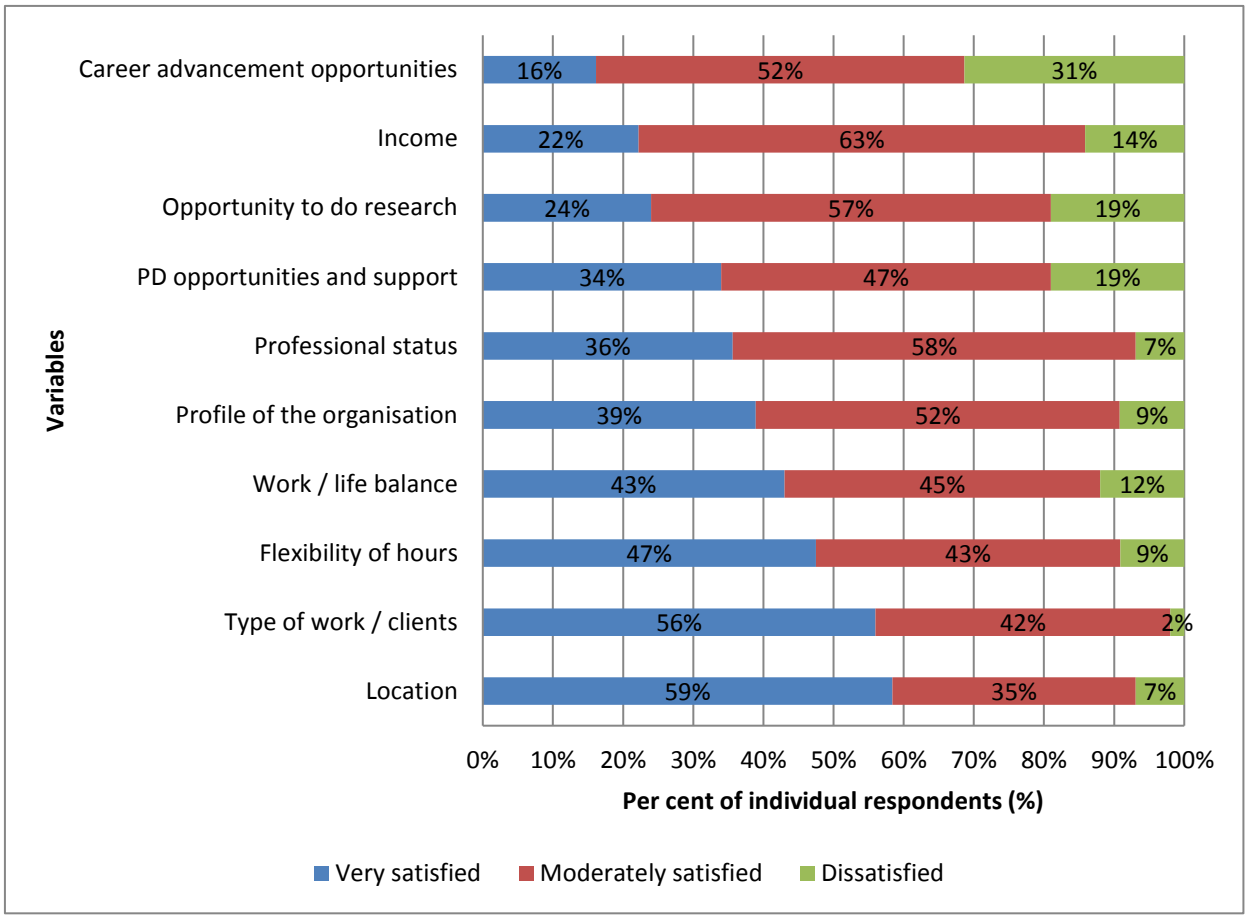
However, the proportion of those who indicated they are currently very satisfied with these top three features was markedly lower:

- work-life balance (43%, n=423)
- type of work / clients (56%, n=552)
- professional development opportunities and support (34%, n=337) (Figure 42).

The variable that the highest proportion of respondents reported they were very satisfied with was location (59%, n=577).

Career advancement opportunities was the factor where the highest proportion of respondents (31%, n=309) reported dissatisfaction in their current working life (Figure 42).

Figure 42: Current satisfaction with factors affecting employment choices (n=984)



This data was considered in more detail based on respondents' sector of employment.

Although there were only a small number of private practice business owners who responded to the survey (n=14) and only nine (9) responded to this question, a greater proportion of this subgroup identified as being very satisfied with their type of work / clients (78%, n=7), their professional status, (56%, n=5), their flexibility of hours (78%, n=7) and their location (89%, n=8).

Those working in the university sector / higher education were the most likely to indicate satisfaction with their income (60%, n=12), their professional development opportunities (50%, n=10), the profile of their organisation (60%, n=12) and their opportunities to do research (70%, n=12).

Despite the private practice business owners indicating being very satisfied more frequently than others, across a range of variables, none indicated being very satisfied with their income.

In contrast, private practice employees were the least likely to report being very satisfied on a number of variables, including work-life balance (29%, n=4), career advancement opportunities (7%, n=1), their type of work / clients (36%, n=5), their location (50%, n=7), and opportunities to do research (7%, n=1). Again, this data can only be interpreted as a guide for further exploration given the low numbers of respondents for this employee group.

Those employed in NFP organisations were the least likely to report being very satisfied with the professional status of their current role (18%, n=13) (Appendix Table 15).

"Satisfaction is about making a difference with our interventions."

"As a female with young children, it is organisation-dependent. In reality, in management, it's very difficult to be flexible. I have had that granted to me, but in another organisation they wouldn't consider

job-share. I've been lucky because I'm not in a solely clinical role. Clinicians have fairly rigid requirements. We do have a high percentage of part-time staff but management constantly question how beneficial it is for the organisation."

"As a new grad in a rural area I was satisfied learning new skills. After about three to four years, working with the same clientele, I felt stifled. I wasn't learning enough – every client was the same. I was keen to get involved with developing the service, but I wasn't encouraged to contribute in that way. I needed opportunities for leadership, regardless of the level I was at."

"Over a long career, one of the things I've loved is that you can work across different fields. I've got a grad dip in aged care and have later gone on to do paediatrics."

The issue of workplace satisfaction was explored in more detail in the focus groups; participants spoke about the importance of:

- feeling well supported
- having good relationships with colleagues
- experiencing the 'just right challenge', of being extended without being overwhelmed
- being supported and encouraged to participate in ongoing learning that is embedded in your work and also that is available through formal means
- achieving good outcomes for clients
- experiencing diversity in the tasks you are involved in across a single day or week
- having opportunities to work across different client groups and areas of practice across your career, including the chance to step into project and research roles
- being able to advance clinically and receive pay that reflects clinical skill and experience
- being paid equitably across sectors, areas or practice, and geographic locations
- having opportunities to progress in levels of responsibility and leadership, regardless of role
- being able to pair flexible work arrangements with career advancement in order to maintain work-life balance and meet family obligations, rather than having to choose one or the other
- receiving timely and comprehensive support to respond to major system changes

Occupational therapists reported that their skill set as an occupational therapist offers good opportunities for stepping into diverse project, administrative, and quality management roles. However, several participants commented that often this path is taken because of the lack of flexibility in clinical roles that would compromise their ability to meet their family obligations.

Although the absolute majority of AHWQ2 respondents indicated they were in full time work, many qualitative responses to the survey indicated that job security is an issue. The reasons for this apparent contradiction are not entirely clear. It could be speculated that this is an anticipatory response to the introduction of an increasingly market-based system through funding mechanisms such as My Aged Care and the NDIS. Additionally, it is possible that although the respondent cohort was predominantly comprised of individuals in permanent employment, their responses might reflect observations of others in the profession who may not have been reached by the AHWQ2 survey.

"I started in private occupational rehab. You were left on your own. I left that role quickly."

"Coping with My Aged Care changes has had an effect on morale. It's been very challenging. And there's a lot of change still ahead. There are questions about the viability of our roles long term."

"The role I have and the responsibilities I have are very satisfying. Working with people from a range of different disciplines but also working with clients from a range of backgrounds is important to me."

"I'd like to stay working in mental health. I think the work will become more satisfying the longer I stay in the area. Because confidence has a big part to play in how satisfying your work is."

Intra-professional engagement

In addition to respondents' relationships with their occupational therapy colleagues through their employment, feedback from the research participants reflected that OTA (the national association representing occupational therapy in Australia) is recognised as a key facilitator and reference point for intra-professional engagement and discipline-specific change at a systems level within and beyond the profession.

Important examples individuals referred to included:

- interest groups
- professional development events and conferences
- learning about system level changes in health and human services sectors
- MentorLink: a mentoring program facilitated by OTA for occupational therapists in the public and private sectors (OTA, 2017)
- opportunities to contribute to advocacy work for the occupational therapy profession

"Networking through involvement in my professional association helped my career progression."

"I'm currently working with OTA and the DVA [Department of Veterans' Affairs] reference group on the issue of the freezes on the occupational therapy fee schedule and the impact on service provision"

Issues respondents identified as being important for future effort at an intra-professional level included:

- building understanding of the role of occupational therapy in occupational performance and the outcomes this brings for individual quality of life as well as health service efficiency and sustainability
- advocacy for evidence-based practice that is consistent with the underpinnings of occupational therapy, to ensure achievement of client outcomes
- implementation of standards of practice across private practice
- advocacy for funding rebates that more accurately reflect the full cost of service provision
- sector-specific support roles, funded by OTA to reduce isolation, increase support, and improve practice standards in specific areas of practice

"I'd like to see OTA advocate to reinforce the importance of the occupational therapist role and the client centred, holistic way we work, rather than being pushed for throughput."

At an individual level, challenges to intra-professional engagement were reported to include:

- increasing pressures on caseload throughput resulting in restrictions on attending professional networking meetings
- the cost of professional development
- lack of support and funding from employers to attend professional development and training

Professional isolation was reported as an issue for 12% (n=117) of respondents and 16% (n=151) were neutral on this issue. The research did not shed definitive light on this issue; qualitative comments from a few respondents provided some indicators regarding this issue. A number of occupational therapists working in new areas of practice reported direct and indirect feedback from their occupational therapy colleagues about not being involved in 'real occupational therapy'. This had a significant detrimental impact on their sense of connection to the profession and their sense of how their work was perceived within the occupational therapy framework. For others, the nature of this isolation was reinforced through

less direct experiences, such as not being accepted to contribute content about new areas of practice at conferences and not having ready access to relevant professional development opportunities.

"A lot of the time, occupational therapists working in schools are the sole occupational therapist in their workplace, and can tend to be newly graduated. Whilst there are some support networks, and occupational therapists can access mentoring through MentorLink, it would be fantastic to have an occupational therapist in a role that works through a partnership of OTA and the Department of Education to support occupational therapists working in schools."

"I work at an organisation that emphasises engaging with priority groups…to ensure people who experience most disadvantage can participate in their healthcare. When I attended the Asia Pacific Occupational Therapy Congress in Rotorua in 2015 I was encouraged by the Canadian guest speakers who were suggesting that the roles I'm involved in could be the future of occupational therapy. However, career development opportunities to support occupational therapists in these roles are far and few between and don't appear to be prioritised by our associations and / or conference organisers etc."

A number of respondents commented that the current cost of membership of OTA, in combination with the requirement for professional registration through AHPRA, is not affordable. The consequence of this has been a reduction in their access to professional networking and professional development opportunities. This was reported to be a particular challenge for part-time workers.

Inter-professional engagement

Often within the health and human services sector, discussion regarding inter-professional engagement is characterised by a strong theme of 'patch protection'. Interestingly, there was little evidence of this in the findings in this research.

Some contributors explicitly raised the desire for more integrated work processes and a desire to shift from 'us and them' attitudes. They felt this could be achieved through improved representation of occupational therapy and other AH professionals in executive positions and other senior roles that are often designated as nursing or medical.

"It would be good for us to be better empowered to advocate for ourselves and be heard through better integration with nursing and medical staff. It would be great to move away from us and them in EBA [Enterprise Bargaining Agreements], education, and other aspects of our work."

"All the higher positions in the hospital require a nursing background, even the manager of AH."

When occupational therapists were asked about the single most important issue they would like to see addressed by, or for, their profession a consistent theme related to the awareness of their professional colleagues regarding the occupational therapy role and its contributions. This was an issue across the board, but specific examples were raised in a number of areas of practice including mental health, pain management, palliative care, cognition in older adults, and clients who experience high levels of marginalisation and disadvantage.

"In pain management, there's a tendency to devalue the occupational therapy role in what is a medical / physio / psychology dominated area. But the main focus of clients and policy makers is quality of life and resumption of life goals in a cost-effective way. Occupational therapists provide cost-effective interventions targeted to client's abilities and supported by their environment, but this isn't always recognised as a primary therapeutic approach and tends to be left until other avenues have been explored, or it isn't explored at all."

One respondent mentioned recent health economics evidence that occupational therapy offers excellent value for money as it is one of the most effective interventions for promoting lower hospital readmission rates (Rogers, Bai, Lavin, & Anderson, 2016). Occupational therapy respondents reported that understanding of the occupational therapy role could be enhanced if funding models and models of care

were aligned with current evidence for achieving optimal outcomes. As an example, some occupational therapists indicated that due to throughput pressures they are unable to fulfil the breadth and depth of their role with respect to occupational performance. As a result, their colleagues perceive their primary role to be one of prescribing equipment and applying for the required funding.

A further observation relevant to increasing the understanding and credibility of the profession was the need to increase the evidence base for occupational therapy interventions and then develop and consistently apply clinical guidelines.

"We need to do more research and develop more guidelines…so what we are doing is evidence-based, justifiable to the organisation, and understood by our medical colleagues."

A further issue identified as impacting on inter-professional engagement related to parity of pay for equivalent work and mechanisms used for funding of service provision. Examples included the need for:

- parity of pay and entitlements for occupational therapists, social workers and nurses employed in generic roles against equivalent role descriptions
- parity of pay and entitlements across professionals who contribute to shift work
- parity of rebates for equivalent services provided by different professions funded under Medicare and other rebated schemes
- ratio models, similar to nursing, to guide funding allocation and allied health staffing levels

"There should be parity in pay for doing the same work. For transdisciplinary occupational therapists we get paid less than our nursing colleagues doing exactly the same role."

"Recognition of the importance of adequate staffing. Nurses have designated ratios but AH staff are expected to increase the number of clients they see if someone else is on leave or a position is vacant."

"Occupational therapists, social workers, and psychologists all provide 'focussed psychological strategies' through Better Access, but psychologists receive a higher rebate for the same work. It's ridiculous when a new grad psychologist receives a higher rebate for the same work than someone like myself with 35 years clinical experience and extensive post-graduate training. Equal rebates should be paid for the same services, regardless of undergrad clinical training."

Community and society engagement

As was the case for their professional colleagues, many occupational therapists reinforced the importance of improving community understanding of the role of the profession, increasing community awareness of when occupational therapy services may be warranted, and how and where to access services. At an overarching level the need was identified to improve community understanding of the benefits of meaningful occupational engagement as a key contributor to maintaining and improving physical and mental health.

The causes of poor community awareness of occupational therapy were reported to be similar to those raised above in relation to the professional colleagues of occupational therapists. Examples included poor awareness on the part of other referring professionals, challenges delivering comprehensive and evidence-based services in the context of current funding models and models of care, and a need for greater evidence about occupational therapy interventions and outcomes that are then communicated to people across the lifespan in an accessible way.

Numerous respondents raised concerns about the quality of services their profession can deliver to the community and the associated safety consequences that arise when assessment, intervention, equipment, and home and vehicle modifications cannot be delivered in a timely or effective way.

Concern was raised that with a trend toward market driven funding models, poor awareness of occupational therapy may significantly diminish community access to services from which they may benefit.

“Up until now, we’ve offered a holistic, client centred, home visiting service. However, we’re now being told to reduce home visits and see clients on site as much as possible and basically focus on throughput, which I believe goes against the essence of occupational therapy practice.”

“Occupational therapy has a lot to offer in the community development and project management space. It would be good to see occupational therapy having a bigger focus on community centred practice - going beyond the individual focus to create/support more inclusive and responsive communities.”

“Improved community understanding and appreciation requires increased research and evidence-based practice and communication of this.”

“I would like occupational therapy to be promoted more within the community so people are aware of our role and know how to access our services”

“I believe innovation and more meaningful care outcomes can happen when we enable consumers and carers to also have lead roles informing decisions about their own care; in sharing their lived experience of using services as equal experts in skill sharing opportunities; more peer led group therapies; and services and systems being co-designed in partnership with the people who use them.”

Conclusion

Occupational therapy is a young and growing workforce. Supply of junior professionals is strong, but some organisations experience difficulties filling intermediate and senior professionals. Despite the strong growth in the workforce, the profession is experiencing significant difficulties meeting demand for services within existing resourcing. These resource challenges compromise the profession's capacity to deliver services within current evidence and defined benchmarks, as well as making it difficult to comprehensively incorporate the principles of occupational performance that underpin the field. Contributors to this research reported that the consequences of this include risks to client outcomes and safety, lost opportunities to contribute to primary and secondary prevention, and impacts on staff including burnout and reducing job satisfaction.

Within the professional community and across the broader community in general, there is a need for greater understanding of the role and contribution of occupational therapy in maintaining and improving physical and mental health through occupational performance. This could be supported through improved communication about existing evidence for occupational therapy interventions, more consistent delivery of services in line with this evidence, and a strong commitment to further developing the breadth and depth of research-based interventions.

The occupational therapists contributing to this research demonstrated a strong commitment to practising as skilled clinicians working directly with clients. They expressed aspirations to develop their skills and knowledge to deliver the best possible clinical services across their careers. Career structures to support these aspirations require considerable attention if the opportunities arising from this commitment are to be realised within the health and human service system.

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Appendix

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

Responses and respondents

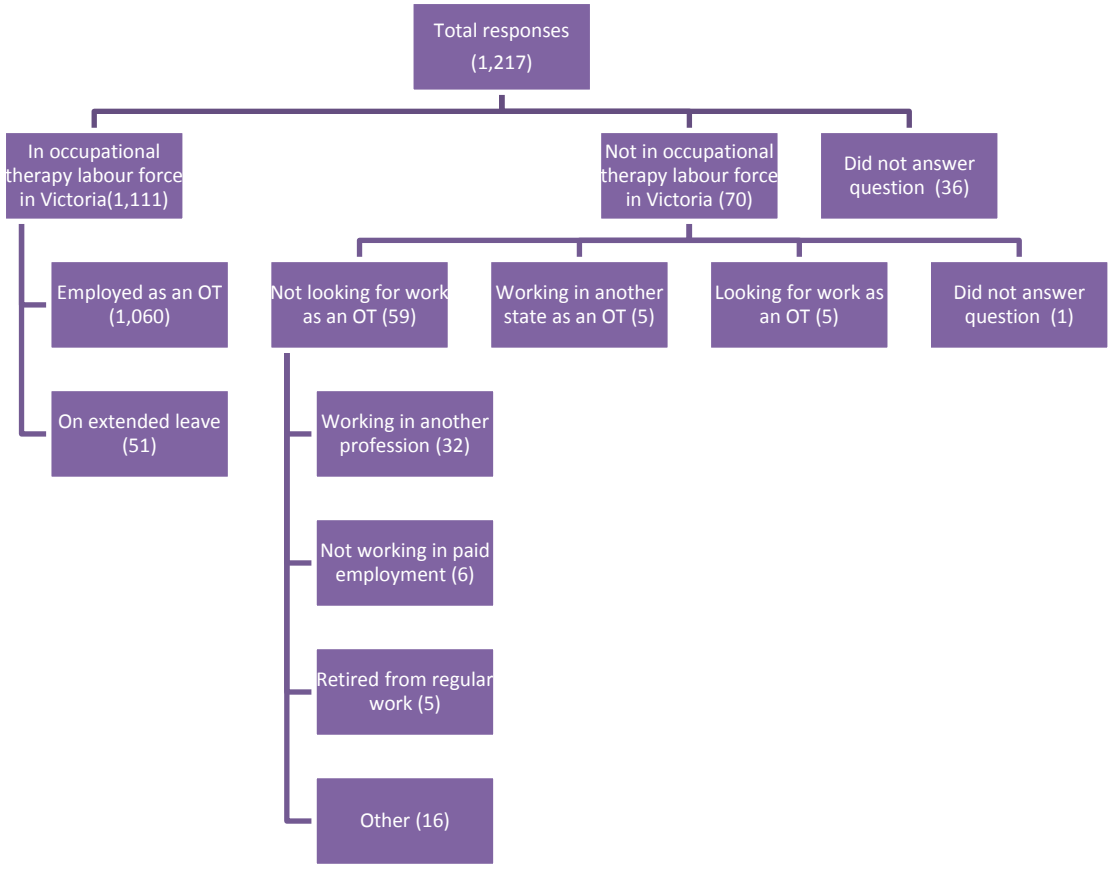
The AHWQ survey consisted of 53 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some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

A total of 1,217 occupational therapists completed at least one question on the survey and submitted their survey. The range of respondents to an individual question ranged from 937 to 3,140. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

A total of 529 respondents (43%) provided their email address and agreed to be followed up for further research.

Most respondents (91%) were employed in the occupational therapy workforce in Victoria at the time of completing the survey. Only five of the 70 respondents who indicated they were not currently employed as an occupational therapist in Victoria reported they were actively seeking occupational therapy work.

Figure 1: Current employment status[5]



[5] All data in Figure 1 and Tables 1 – 14 comes from AHWQ2 survey

Table 1: Reason for not currently working as an occupational therapist [a] (n=38)

Reason for not working	%	Count
No occupational therapy jobs available in my area	11	4
No occupational therapy jobs available that interest me	8	3
No occupational therapy jobs available that I feel qualified to do	5	2
No occupational therapy jobs available at the appropriate level/pay rate	11	4
I want to leave/have left the occupational therapy profession but still identify with my profession	50	19
I have want to leave / have left the occupational therapy profession and I no longer identify with my profession	5	2
I want to leave/have left clinical work	24	9
Illness	5	2
Family reasons	5	2
Other	8	3

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

Table 2: Principal area of practice and all other areas of practice in the week prior to completing the AHWQ2[a]

Areas of practice	Principal area of practice	All other areas of practice
	Count	Count
Rehabilitation services	206	314
Aged care services (community, residential)	201	322
Mental Health Services	167	204
General medical / hospital work	136	257
Other	97	136
Child development services	85	142
Disability services	67	218
Neurology (cognitive and / or physical)	63	203
Chronic disease management	60	236
Hand therapy	41	89
Community development / engagement	25	105
Palliative care	19	141
Cancer care	18	94
Transitional care	13	57
Injury management	11	48
Health promotion and / or population health	10	92

Areas of practice	Principal area of practice	All other areas of practice
	Count	Count
Driving assessment	10	37
Counselling (not mental illness)	8	42
Housing / homelessness	7	39
Aboriginal health	6	58
Organisation practices	6	44
Occupational health	6	26
Medico-legal assessment	6	16
Vocational support / recruitment	5	27
Income support	5	15
Personal development / coaching	4	50
Domestic and/or family violence	4	29
Recruitment services	4	15
Alcohol, tobacco and other drugs	3	42
Women's health / support	2	15
Sexual violence services	1	11

[a] *Respondents could select more than one response to signify 'all other areas of practice'.*

Table 3: Hours of paid work in each sector per week (main role)

Sector	Minimum hours	Maximum hours	Mean hours	Standard deviation	Count
State public sector	0	48	32	10	713
Commonwealth public sector	15	48	35	8	99
Local government / council	8	30	20	8	4
Private practice (employee / subcontractor)	3	40	28	12	16
Private practice (business owner)	8	43	25	10	7
Large private provider	12	40	32	8	21
Not for profit	0	43	31	9	80
University / higher education	8	48	32	12	21
Aboriginal Controlled Community Health Service	0	0	0	0	0
Other	8	40	27	11	6

Table 4: Occupational therapy scope of practice (n=1032-1037)

Practice	%	Count
Participants reporting their work includes an advanced practice role	16	164/1,032
Participants who delegate to AHAs	52	538/1,037
Participants who use telehealth (including video conferencing for supervision)	9	95/1,037

Table 5: Employment location – first position, position prior to current position, current main position (n=766 - 1,049)

Location	First position		Position prior to current position		Location	Current main position	
	%	Count	%	Count		%	Count
Victoria - Metropolitan	51	390	59	561	Metropolitan	61	637
Victoria - Regional	17	128	21	193	Regional	32	334
Victoria - Rural / remote	7	51	6	52	Rural / remote	7	78
Australia - Metropolitan	2	19	1	6			
Australia - Regional	10	77	4	42			
Australia - Rural / remote	2	19	2	15			
Overseas	10	79	7	68			
Other	<1	4	0	0			
Total	**100**	**766**	**100**	**937**		**100**	**1,049**

Table 6: Employment sector – first position, position prior to current position, current main position, current second position (n=770-1,022)

Sector	First position		Position prior to current position		Current main position		Current second position	
	%	Count	%	Count	%	Count	%	Count
State Public Sector	65	501	56	530	74	755	42	76
Commonwealth Public Sector	12	89	14	136	11	112	6	11
Local Government / Council	1	11	2	15	<1	5	2	4
Private practice (employee)	5	39	8	76	2	17	15	27
Private practice (business owner)	0	0	1	14	1	9	20	36
Large private provider	5	42	4	40	2	21	3	6
Not for profit	9	69	8	76	8	81	3	6
University / higher education	0	0	2	22	2	21	5	9
Aboriginal Controlled Community Health Service	<1	1	<1	1	0	0	0	0
Mixed	<1	1	<1	2	<1	1	0	0
Overseas	2	13	3	25	0	0	0	0
Other	1	4	<1	4	0	0	4	7
Total	**100**	**770**	**100**	**941**	**100**	**1,022**	**100**	**183**

Table 7: Employment setting – first position, position prior to current position, current main position, current second position (n=770-1,068)

Setting	First position		Position prior to current position		Current main position		Current second position	
	%	Count	%	Count	%	Count	%	Count
Aged care / residential care	5	35	4	35	3	30	5	9
Community (e.g. community centre, shopping centre, GP etc.)	14	109	25	238	23	248	22	40
Clients' own home	5	41	9	89	17	180	20	37
Correctional facility	<1	1	<1	4	<1	3	0	0
Defence force	0	0	<1	2	0	0	0	0
Tertiary education facility	<1	1	2	20	2	23	4	8
School	3	22	2	20	2	26	2	4
Client's workplace, government, corporate or not for profit offices	3	21	5	43	1	16	2	4
Research institute	0	0	<1	4	<1	2	1	1
Hospital inpatient	60	461	37	345	31	336	24	44
Hospital outpatient	6	50	11	103	17	185	13	24
Telehealth / online	<1	1	<1	3	<1	1	1	1
Residential rehabilitation	1	7	<1	2	<1	1	0	0
Mixed	1	9	1	7	1	13	1	2
Other	2	12	3	26	<1	4	5	9
Total	**100**	**770**	**100**	**941**	**100**	**1,068**	**100**	**183**

Table 8: Number of jobs held as an occupational therapist across the career path (n=1,073)

Number of jobs	%	Count
One / this is my first and only job as an occupational therapist	12	128
2	16	171
3	14	149
4	12	124
5	12	133
6	27	294
>10	7	74
Total	**100**	**1,073**

Table 9: Years worked in current main role by sector

Sector	Minimum years	Maximum years	Mean years	Standard deviation	Count
State public sector	0	40	6	6	746
Commonwealth public sector	0	24	4	5	110
Local government / council	1	4	3	1	5
Private practice (employee / subcontractor)	0	22	5	6	16
Private practice (business owner)	1	21	10	7	8
Large private provider	1	27	7	8	21
Not for profit	0	25	5	6	78
University / higher education	1	34	8	8	21
Aboriginal Controlled Community Health Service	0	0	0	0	0
Other	0	15	7	5	6

Table 10: Qualifications held or currently studying (n=1,123)

Qualification	Current qualifications	Currently studying	First qualification enabling practice as an occupational therapist (n=1,123)
Certificate III	21	1	0
Certificate IV	71	7	0
Associate diploma	21	1	2
Advanced diploma	33	0	8
Bachelor degree	963	7	843
Honours degree	132	1	82
Graduate certificate	94	18	1
Graduate diploma	99	7	9
Master’s degree - Graduate entry	130	5	117
Master’s degree - Clinical	150	21	52
Master’s degree - Management (e.g. MBA)	27	23	2
Master’s degree - Research	44	15	0
Professional doctorate	4	4	0
PhD	18	24	1

Table 11: Location where respondents gained their first qualification as an occupational therapist (n=1,118)

Country	%	Count
Victoria, Australia	75	890
Other Australian state or territory (not Victoria)	17	199
New Zealand	2	23
United Kingdom	2	29
Canada	0	3
United States of America	0	3
South Africa	1	9
Ireland	1	11
India	1	13
Other overseas country	1	9
Total	**100**	**1,188**

Table 12: Location where respondents gained their first qualification as an occupational therapist, for those who did not qualify in Victoria (n=199)

Location	%	Count
New South Wales	48%	95
Australian Capital Territory	1%	1
Tasmania	0%	0
South Australia	20%	39
Western Australia	14%	28
Northern Territory	0%	0
Queensland	18%	36
Total	**100**	**199**

Table 13: Proportion of respondents indicating they 'agree' with statements about their current experiences of professional support and development opportunities

For each of the sub-questions the number of responses varied, therefore the number of individuals who agreed with each statement is included and the per cent of the respondents this represents.

	State public sector (n=697)	Commonwealth public sector (n=105)	Private practice (employee / subcontractor) (n=13)	Private practice (business owner) (n=9)	Large private provider (n=21)	Not for profit (n=72)	University / higher education (n=20)
I have access to clinical supervision	78% (n=539/689)	76% (n=80)	62% (n=8)	n=<5 Data withheld	62% (n=13)	59% (n=41)	n=<5 Data withheld
If I am uncertain about an aspect of my work, I can always access someone who can help me	84% (n=582)	84% (n=88)	77% (n=10)	67% (n=6)	90% (n=19)	74% (n=53)	80% (n=16)
I am professionally isolated	11% (n=76)	10% (n=10)	15% (n=2)	n=<5 Data withheld	n=<5 Data withheld	11% (n=8)	n=<5 Data withheld
I have formal management support from a member of my own team	76% (n=525)	75% (n=77)	69% (n=9)	n=<5 Data withheld	67% (n=14)	64% (n=46)	75% (n=15)
I have access to peer support from members of my own profession	81% (n=563)	81% (n=84)	54% (n=7)	78% (n=7)	67% (n=14)	79% (n=57)	65% (n=13)
My grade and / or salary is appropriate for the work I do	51% (n=357)	44% (n=46)	54% (n=7)	n=<5 Data withheld	62% (n=13)	44% (n=31)	65% (n=20)
I have the skills necessary to do my current job	91% (n=637)	93% (n=98)	77% (n=10)	89% (n=8)	81% (n=17)	89% (n=64)	100% (n=20)
I have all the tools I need to perform my job safely	74% (n=513)	69% (n=72)	69% (n=9)	78% (n=7)	67% (n=14)	75% (n=54)	85% (n=17)

Table 14: Overall job satisfaction by sector

For each the sub-questions the number of responses varied, therefore the number of individuals who actually agreed with the particular statement has been included and the % they represent.

	State Public Sector (n=725)	Commonwealth public sector (n=107)	Private practice (employee / subcontractor) (n=15)	Private practice (business owner) (n=9)	Large private provider (n=21)	Not for profit (n=76)	University (n=21)
Extremely satisfied	28% (n=204)	29% (n=31)	n=<5 Data withheld	n=<5 Data withheld	33% (n=7)	25% (n=19)	43% (n=9)
Somewhat satisfied	52% (n=382)	52% (n=55)	47% (n=7)	56% (n=5)	52% (n=11)	37% (n=28)	48% (n=10)
Neither satisfied nor dissatisfied	6% (n=43)	6% (n=7)	n=<5 Data withheld	n=<5 Data withheld	n=<5 Data withheld	13% (n=10)	n=<5 Data withheld
Somewhat dissatisfied	12% (n=84)	11% (n=12)	n=<5 Data withheld	n=<5 Data withheld	n=<5 Data withheld	22% (n=17)	n=<5 Data withheld
Extremely dissatisfied	2% (n=12)	n=<5 Data withheld	n=<5 Data withheld	n=<5 Data withheld	n=<5 Data withheld	n=<5 Data withheld	n=<5 Data withheld

Table 15: Proportion of respondents 'very satisfied' with current employment features

	State public sector (n=691)	Commonwealth public sector (n=14)	Private practice (employee / subcontractor) (n=14)	Private practice (business owner) (n=9)	Large private provider (n=21)	Not for profit (n=72)	University / higher education (n=20)
Work / life balance	42% (n=293)	49% (n=51)	n=<5 Data withheld	n=<5 Data withheld	29% (n=6)	43% (n=31)	35% (n=7)
Income	21% (n=145)	24% (n=25)	n=<5 Data withheld	n=<5 Data withheld	33% (n=7)	19% (n=14)	60% n=12)
Career advancement opportunities	15% (n=107)	15% (n=16)	n=<5 Data withheld	n=<5 Data withheld	24% (n=5)	13% (n=9)	n=<5 Data withheld
Type of work / clients	57% (n=396)	49% (n=51)	36% (n=5)	78% (n=7)	62% (n=13)	47% (n=34)	55% (n=11)
Professional status	36% (n=247)	35% (n=36)	n=<5 Data withheld	56% (n=5)	43% (n=9)	18% (n=13)	40% (n=8)
Flexibility of hours	42% (n=293)	49% (n=51)	57% (n=8)	78% (n=7)	57% (n=12)	53% (n=38)	65% (n=13)
Location	59% (n=407)	51% (n=53)	50% (n=7)	89% (n=8)	67% (n=14)	50% (n=36)	55% (n=11)
PD opportunities and support	36% (n=246)	36% (n=37)	n=<5 Data withheld	n=<5 Data withheld	n=<5 Data withheld	22% (n=16)	50% (n=10)
Profile of the organisation	40% (n=274)	34% (n=35)	43% (n=6)	n=<5 Data withheld	38% (n=8)	25% (n=18)	60% (n=12)
Opportunity to do research	22% (n=154)	27% (n=28)	n=<5 Data withheld	n=<5 Data withheld	29% (n=6)	11% (n=8)	70% (n=14)