Equity in health and wellbeing: Why does regional, rural and remote Australia matter?

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The demographer Bernard Salt has stated that the unfolding story of our continent indicates that there are progressively becoming "two Australias" separated by a Great Divide stretching between Port Douglas in Far North Queensland and Eucla on the Great Australian Bight. To the east lies "heartland Australia", a globally connected nation of 19 million people; to the west lies "frontier Australia", a vast resource-rich state with only three million people (Salt, 2011).

Key to this "frontier Australia" are our primary industries. Australia ranks tenth in the world as a major agricultural producer and exporter, and the mining industry contributes significantly to the economy of our country. Hence our regional, rural and remote (RRR) industries are at the core of the financial security of the nation. Given the overall reliance of Australia on the productivity of its regions, the health and wellbeing of those outside the metropolis is crucial to the overall prosperity of the nation. In stark contrast to the increasing wealth generated by these RRR-based industries, the health and wellbeing of our Indigenous population – primarily located in rural areas – has continued to deteriorate, during a time of rising prosperity for the country as a whole.

There are large inequities in health service provision across Australia and enormous difficulty in recruiting and retaining health practitioners to rural, and particularly remote, areas. This article presents an overview of current population distribution and incidence of general and mental health problems in rural communities, and demonstrates why 'RRR' matters both to our country as a whole and to us as practising psychologists. There are unique and interesting opportunities for broad experience and service delivery innovation 'in the bush', often not feasible in metropolitan centres. Yet many of us remain limited and 'metro-centric' in our view of what constitutes worthwhile work. This needs to change if psychologists as a profession are to contribute to the overall health and wellbeing of our nation.

Australia's population distribution

As an island continent of approximately eight million square kilometres, Australia is a geographically huge country with a population of approximately 22.7 million people. It is relatively sparsely populated and is densely urbanised, with one per cent of the continent containing 84 per cent of the population clustering mainly in the key capital cities, major metropolitan, outer-metropolitan and large regional areas. In contrast, the widespread regional, rural and remote areas (commonly referred to as 'the bush' or 'the outback') have a low population density.

National trends have consistently highlighted the shift of people and services from rural to metropolitan areas. In 1911, 43 per cent of Australians lived in rural areas, but in 1976 the corresponding population was only 14 per cent. The 1996 census showed that the rural population again decreased as a proportion of the total population (Salt, 2011), although the exact proportion varies from State to State.

The health of rural Australians

On the whole, Australia's rural and remote populations have poorer health than those in the city. Life expectancy declines with increasing remoteness (more so amongst men than women). The gap is widening between urban and rural people, with life expectancy increasing more than 20 per cent faster for residents of metropolitan local government areas (LGAs), compared to rural LGAs (Cresswell, 2008). These figures are affected by higher overall Indigenous mortality rates (on average, 17 years less than the rest of the population) as well as a possible drift/migration of the frail aged to some regional and rural areas (National Rural Health Alliance [NRHA], 2007).

National figures indicate that people are significantly more likely to die of heart disease if they live in rural areas, with rural patients having overall poorer health as well as being disadvantaged in relation to access to new investigation technologies and treatment techniques (Rural Doctors Association of Australia, 2008). People living in rural and remote communities also have particular risk factors and mental health needs associated with isolation and exposure to environmental hazards such as drought, flood and fire. The impact of drought alone, and the consequent enormous financial stress on farming families, has been found to lead to anxiety, depression, family breakdown, grief and anger (Australian Government, 2000). Unpredictable weather (intrinsic to rural life) forms a back-drop to other occupational hazards – such as working with dangerous machinery and farming accidents, equipment breakdowns, exposure to dangerous chemicals, changing government regulations/legislation, lack of leisure time/long hours, difficulties for couples in balancing roles with the increasing need for off-farm work – all of which combine to create higher health risk levels for rural and remote people.

There are numerous additional factors which make rural and

particularly remote life more challenging and represent risk factors for poorer health and wellbeing. These include small groups of people, enormous areas, unpredictable socioeconomic and ecological circumstances, ageing communities with the migration of young people to cities for education and work, and declining public infrastructure (e.g., health service and bank closures) (Rajkumar & Hoolahan, 2004). Risk-taking attitudes to health, illness and behaviour are also known to be more prevalent in the outback, with more rural people drinking at risky levels, and more likely to smoke, be overweight and unfit (AIHW, 2006).

In addition, on average Australian rural people are poorer and attain lower levels of education than people in urban areas: 56 per cent of rural households fall into the two lower income quintiles, compared to 36 per cent of capital city households and 45 per cent of other urban households (AIHW, 2006). In rural and remote communities the cost of basic food is also often up to at least 10 per cent higher than in metropolitan and regional centres, giving a "double deprivation" effect, resulting from lower levels of income combined with higher basic costs. Lower levels of education and higher levels of poverty are reflected in poor physical and mental health status (Wainer & Chesters, 2000).

The factors outlined above combine to create what is termed 'social exclusion' within a community, indicating what can happen when people (or areas) suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown. Such social exclusion disadvantages communities in many ways, and rural communities are considered to be the most socially disadvantaged in relation to this global index (Saunders, 2003).

Incidence of mental health issues in rural communities

The National Survey of Mental Health and Wellbeing of Adults (ABS, 1997) indicated that mental health is a significant health issue in Australia with almost 1 in 5 people suffering from a mental disorder in a 12-month period. One of the key limitations of the survey, however, was that rural, remote and Indigenous groups were not included (Whiteford, 2000) and accurate data on the distribution and determinants of mental health and wellbeing in rural and remote populations in Australia is still largely unavailable.

Current research suggests again, however, that there is a significant rural-urban health status differential and that a number of key mental health issues in rural and particularly remote areas require special attention and intervention. These include comorbid mental health and alcohol and other drug disorders, higher levels of attempted and completed suicide, unique stressors amongst farming communities, and Indigenous mental health issues. Research also indicates that rural women in remote areas are more exposed to violence in personal relationships than urban women and many are isolated without public transport. Both females and males aged 20-29 in rural/remote areas are twice as likely to consume alcohol in hazardous or harmful quantities when compared to their metropolitan counterparts (alcohol has been implicated in up to 50 per cent of all suicides in Australia). Suicide rates amongst rural communities are known to be consistently higher than in urban communities, with recent research indicating that 15-24 year old males in regional areas are 1.5-1.8 times more likely to end their life by suicide than their urban counterparts. The incidence is up to six times higher in very remote locations. Inter-regional comparisons are also poor for 25-44 year old and 45-64 year old non-metropolitan males (NRHA, 2009).

Limited access to health services

Recruitment and retention of health professionals (GPs, medical specialists, psychologists and others) in regional, rural and remote communities in Australia are major challenges, with the majority of health service providers residing and working in the large cities. Access to specialist mental health professionals is particularly limited beyond the main metropolitan centres, and rural residence has been found to be negatively correlated with frequency of use of both psychologists and psychiatric services (Parslow & Jorm, 2000).

Despite attempts to increase recruitment over the past ten years, the availability of specialist mental health professionals in rural areas is still inadequate. Analysis of Medicare statistics in 2001 indicated that only four per cent of psychiatrists practised in regional, rural and remote Australia, while the majority of the remaining 96 per cent practised in the upper-middle class suburbs of Melbourne, Sydney and Adelaide. This figure has increased over the decade since to eight per cent, still leaving a large gap in psychiatric service delivery outside major cities. Distribution of psychologists is better, with approximately 21.5 per cent of psychologists providing services in regional, rural and remote locations (for more detailed information on the psychology workforce in RRR Australia, see page 12).

Mental health help-seeking in rural communities

Despite recent changes in modes of practice and accessibility of services (such as the Better Access to Mental Health Care initiative), the incidence of psychological and mental health problems managed by GPs still decreases significantly outside the major capital cities (Caldwell, Jorm & Dear, 2004), suggesting either a lack of presentation or unwillingness to deal with these complex issues, for which little help is available. Both help-seeking and service use rates (i.e., actual presentation for treatment and use of services) for mental health issues are lower in rural areas, with those suffering from mental difficulties facing more barriers to help-seeking than in the city. These include poor availability and accessibility of services (primary, secondary and tertiary), as well as a number of characteristics specific to rural communities such as lack of choice of health providers, high workloads of available GPs, geographic distance, and lack of knowledge about, and negative view of, mental health problems (and/or practitioners) by those living in rural areas and amongst their social networks (Jackson et al., 2007).

The self-sufficiency, self-reliance and stoicism known to be characteristic of rural people and communities, strict boundaries on self-disclosure (e.g., "what is considered family is private business" – Roufeil & Lipzker, 2007) and the limited anonymity present in smaller towns, all act as disincentives to help-seeking (Boyd et al., 2008). The small size of country communities (i.e., the 'small town' phenomenon) impacts both on client privacy and on boundary issues for practitioners, with concerns about confidentiality acting as a further disincentive to seeking help.

Cover feature
Psychology in the bush

The issue of stigma in relation to mental health issues remains a key factor in people's postponement or avoidance of getting help, particularly in smaller rural communities where it is thought that "everyone knows everyone else's business". Sensitivity to such common beliefs and knowledge of rural culture is crucial in successfully providing help, whilst remaining aware of dangers inherent in false stereotyping of this population.

Most people, both in rural and metropolitan areas, have been found to be more likely to seek help from a GP than a mental health professional, particularly people with lower educational levels (Tijhuis, Peters & Foets, 1990), with consultation rates amongst women being considerably higher than those of men. Rural males are 30 per cent less likely to consult a GP than their urban counterparts, and rural females are 16 per cent less likely, due to a greater perceived stigma associated with help-seeking amongst men than amongst women (Gunnel & Martin, 2004). Despite improvements in mental health literacy in many of our communities, this trend still exists.

Enhancing psychology's contribution to RRR Australia

Given that Australia is dependent on the productivity of our rural regions, the inequities in incidence of general and mental health problems in RRR Australia, and the service delivery options available to treat them, remain of considerable national concern. For "frontier Australia" to thrive, these inequities need to be addressed and we, as psychologists are a unique part of the solution. As mental health specialists with diverse areas of expertise beyond that of straightforward clinical intervention (e.g., community resilience building, health and wellbeing, etc) we have a key part to play in the revitalisation of our regional, rural and remote areas. There are unique opportunities for service delivery innovation and funding not found in city locations, and many of those practising outside the metropolis find that their capacity to 'make a difference' as part of their local community is enhanced by working in these areas. Lifestyle factors also make the choice to work outside big cities attractive to many.

Some insights as to how to enhance psychology's contribution to RRR Australia through addressing service inequities can be gleaned from those psychologists who have chosen to reside in rural and remote Australia. The APS Regional, Rural and Remote Interest Group and the APS Regional, Rural and Remote Advisory Group have implemented a pilot study of non-metropolitan members of the APS, with preliminary data suggesting that those who have chosen to work outside metropolitan areas do so largely because of pre-existing connections to rural locations and a strong appreciation of the rural lifestyle. This includes being brought up in a regional, rural or remote location, or having

APS SUPPORT FOR REGIONAL, RURAL AND REMOTE AUSTRALIA

The APS supports the health and wellbeing of Australians living in regional, rural and remote areas through two important groups.

APS Regional, Rural and Remote Advisory Group

The work of the APS Regional, Rural and Remote Advisory Group, established as an Advisory Group to the APS Board of Directors in 2010, has contributed significantly to focus attention on the profession and practice of psychology in regional, rural and remote Australia.

The primary objective of the RRR Advisory Group is to ensure that issues arising from rural communities are considered and seen as a priority in the ongoing work of the APS. The aims of the Group are to:

- Advise the Board on policy relevant to the needs and special circumstances of regional, rural and remote Australia
- Coordinate APS expertise about mental health/social and emotional wellbeing issues of people in rural and remote Australia, including those of Indigenous people through working closely with the Australian Indigenous Psychologists Association (AIPA)
- Facilitate development of a community wellbeing focus within the practice of psychology in rural and remote areas
- Increase appropriate representation on rural and remote peak bodies and at conferences relevant to rural and remote issues.

The Advisory Group works to: enhance communication between members of the APS around rural and remote issues; to coordinate resources relevant to rural and remote issues and practice for members; to support research aimed at identifying and resolving issues relevant to mental health service delivery in regional, rural and remote Australia (e.g., recruitment and retention); and to guide the APS in making timely interventions in these communities through our members.

APS Rural and Remote Interest Group

The work of the RRR Advisory Group is complemented by the APS Rural and Remote Interest Group, which has over 150 members across Australia and aims to create professional linkages on matters of mutual interest and concern to RRR psychologists. The Interest Group's Committee now has representation from every Australian State.

The Group has conducted surveys over a number of years to ascertain members' needs, and findings attest to the professional satisfaction of rural and remote practice but also identify challenges that do not exist for urban psychologists. Progress towards more accessible professional development opportunities has been a major goal of the Interest Group and some use of video-conferencing and recordings from conferences has been successful. A significant feature of the Interest Group is the auspicing of members' research and professional practice experiences at the Annual Conference of the APS. News bulletins, student support, mentoring and networking are also important and valued aspects of the group's contributions to one another.

family connections in such areas. These findings are similar to those for medical practitioners (Henry, Edwards, & Crotty, 2009), pharmacists and social workers (Allan, et al., 2007) in that for all these professions, rural background appears to be a critical factor in the choice to work outside capital cities. The preliminary data also suggest the potential utility of adopting a 'grow your own' approach to the rural psychology workforce. This approach to training has been adopted with some success by the medical profession (Henry et al., 2009). Further work is underway to better understand the factors associated with recruitment and retention of psychologists to rural Australia in order to inform strategies to build the rural psychology workforce.

The pilot study also sought to understand some of the core competencies required to work effectively as a psychologist in rural Australia. Interestingly, many respondents identified personality traits such as independence and flexibility as well as professional competencies as facilitators of successful practice. Again, this finding is commensurate with research on rural medical professionals that suggests certain personalities may be drawn to rural practice (Eley, Young, & Przybeck, 2009). Other facilitators for effective rural psychology practice that were identified included breadth of professional knowledge and experience, as well as an ability to maintain boundaries and effectively manage dual relationships. These findings are currently being explored in more depth, with the study extended to a comparison between the urban and non-urban workforce in order to better identify any key differences. What these preliminary findings suggest, however, is that practice in rural areas may require the development of unique competencies – as illustrated in the types of ethical challenges outlined in the *APS Ethical Guidelines for Psychological Practice in Rural and Remote Settings* (see www.psychology.org.au/Assets/Files/EG-Rural-remote.pdf).

Conclusion

People living in regional, rural or remote locations are subject to a number of pressures and causes of stress and illness not experienced by their metropolitan counterparts. Overall, it is envisaged that the Australian population will grow by 14 million people over the next 40 years and that "ignoring the development of regional Australia is no longer an option this country can afford" (Maher, 2008). We as psychologists have a crucial role to play in ensuring that our productive regional, rural and remote areas thrive as communities and remain a resilient core at the heart of our nation. ■

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Acknowledgements

Thank you to all APS members in regional, rural and remote Australia who completed the recent survey on the needs of non-urban psychologists. The survey results will inform planning and will also be used as a pilot for a larger nation-wide survey of registered psychologists that will investigate the differing needs of rural and urban psychologists, particularly in relation to continuing professional development.

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Profile of the regional, rural and remote psychology workforce

There are approximately 5,300 fully registered psychologists working in regional, rural and remote (RRR) Australia, representing 21.5 per cent of the fully registered psychologist workforce (estimate based on 2011 data from the Psychology Board of Australia and the Australian Psychology Workforce Survey, 2008).[1] In the past, statistics on the RRR psychology workforce have been highly variable due to poor collection of data and the use of unreliable measures of remoteness. This profile of the RRR psychology workforce in Australia presents data from a number of reputable sources using the revised ARIA+ measure of remoteness.[2]

Distribution of psychologists in RRR Australia

Fully registered psychologists

The best data available on the distribution of psychologists in RRR Australia was gleaned from the 2008 Australian Psychology Workforce Survey, which was a comprehensive and representative survey of 11,046 psychologists initiated by the Council of Psychologists Registration Boards and conducted in collaboration with the APS in 2008 (Mathews, Stokes, Crea, & Grenyer 2010). The distribution of the 21.5 per cent of psychologists who provide services in RRR Australia is presented in Table 1. While this is a better spread of psychological services in regional and rural Australia than has been previously reported, there continues to be a need to attract more psychologists to these locations.

Table 1. Distribution of psychologists in RRR Australia (source: Australian Psychology Workforce Survey, 2008).

Revised ARIA+ classification	% of total psychologists
Regional	14.1%
Rural	6.6%
Remote	0.8%
TOTAL	**21.5%**

Psychologists with recognised specialist skills

The only available data on the distribution of psychologists with recognised specialist skills in RRR Australia comes from APS College statistics. Table 2 indicates the RRR distribution of the 14.6 per cent of the total relevant APS College members who provide psychological services in these areas. This translates to 932 psychologists, and the distribution of these psychologists across the various specialties is presented in Table 3. The data indicate that just over 10 per cent of those psychologists with recognised specialist skills practice in regional locations, but that very few of these psychologists provide services in rural and in particular, remote locations.

Table 2. Distribution of relevant APS College members in RRR Australia (source: APS data as at May 2011)

Revised ARIA+ classification	% of total College members
Regional	10.6%
Rural	3.6%
Remote	0.4%
TOTAL	**14.6%**

Table 3. Number of relevant members of each APS College in RRR Australia (source: APS data as at May 2011)

Clinical Neuropsychologists	38
Clinical Psychologists	531
Community Psychologists	11
Counselling Psychologists	108
Educational and Developmental Psychologists	78
Forensic Psychologists	65
Health Psychologists	53
Organisational Psychologists	34
Sport and Exercise Psychologists	14
TOTAL	**932**

Years of experience of psychologists

The distribution of years of experience of psychologists who provide services in RRR Australia is presented in Figure 1. Of note is the high proportion (approximately 45%) of relatively inexperienced psychologists working in remote locations. In contrast, almost 30 per cent of psychologists in regional locations reported having over 16 years experience as a psychologist.

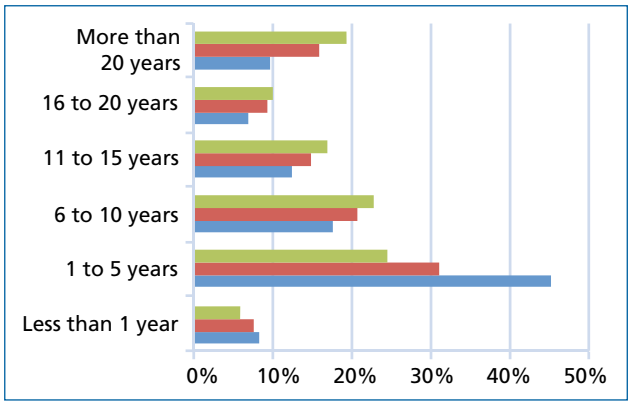

Figure 1. Distribution of years of experience of RRR psychologists (source: Australian Psychology Workforce Survey, 2008)

[1] In order to provide consistent and reliable data, this profile only presents data on fully registered psychologists, but it is recognised that a large number of provisionally registered psychologists also work in RRR Australia under supervision.

[2] The revised ARIA+ classification is a measure of remoteness based on geographic location, population size and access to service provision, which is then adjusted to take account of social indicators of access (ABS, 2001).

Workplace settings of psychologists

The distribution of the various workplace settings of psychologists who provide services in RRR Australia are presented in Figure 2. A high proportion of psychologists in regional locations reported working in independent private practice, followed by those working in the school sector. These findings are consistent with the data on the general psychology profession based on data from the Australian Psychology Workforce Survey (Mathews et al., 2010). Of particular interest is the comparative proportion of psychologists in remote locations that work in school and not-for-profit settings, and the lack of psychologists in private practice servicing these remote locations.

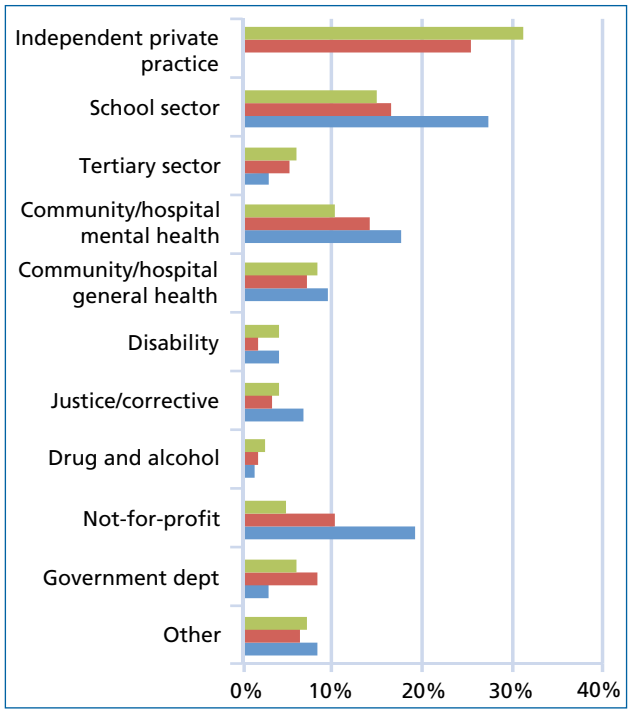

Figure 2. Distribution of workplace settings of RRR psychologists (source: Australian Psychology Workforce Survey, 2008)

Recipients of services provided by psychologists

Age of clients

The age distribution of the clients to whom psychologists provide services in RRR Australia are presented in Figure 3. Again consistent with the data for the psychology workforce in general, psychologists working in RRR areas reported spending the highest percentage of their time working with an adult population followed closely by the young adult and adolescent client groups (Mathews et al., 2010). There is little notable variability across the three RRR localities other than psychologists in rural areas reporting spending a higher percentage of time working with children and adolescents, and psychologists in remote locations spending a lower percentage of time working with young adults and older adults.

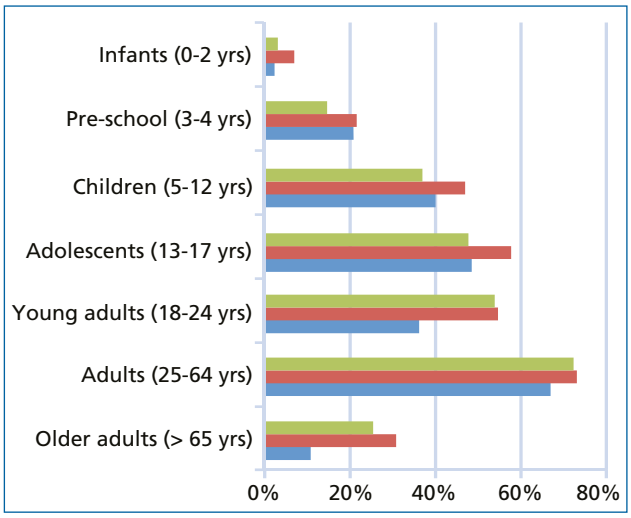

Figure 3. Distribution of the age of clients of RRR psychologists (source: Australian Psychology Workforce Survey, 2008)

Cultural group of clients

The cultural group distribution of the clients to whom psychologists provide services in RRR Australia are presented in Figure 4. As might be expected, psychologists working in remote locations reported that a high percentage of their time is directed at providing services to clients of Aboriginal and Torres Strait Islander background. ■

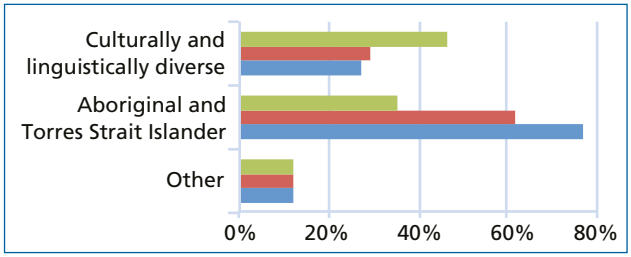

Figure 4. Distribution of the cultural group of clients of RRR psychologists (source: Australian Psychology Workforce Survey, 2008)

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KEY FOR FIGURES

Regional **Rural** **Remote**

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Getting mental health services to the bush: The innovative delivery of best practice psychological services

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Many rural and remote communities have very limited access to mental health services, especially psychology services. There are a multiplicity of reasons for this limited access including the obvious geographical isolation, plus costs associated with transport (whether the service comes to the client or the client goes to the service), the poor condition of many rural and remote roads and susceptibility to weather conditions, lack of suitable accommodation for psychologists, and the difficulty of recruiting to rural and remote areas. The isolation and nature of many rural communities mitigates against the delivery of the traditional model of psychological care, that is, regular (often weekly) face-to-face service delivery by a psychologist to a client in an office setting. This article documents some of the innovative ways in which services have adapted to the needs of their unique environment and clientele to deliver best practice psychological services to rural and remote Australia, and presents three examples of innovative and sustainable psychological services available in the bush.

Technological advances

Technological advancements have clearly assisted psychologists to get their services to the bush. This has included relying heavily on telephone counselling, but also supplementing face-to-face outreach services with 'top-ups' via telephone, videoconferencing, email and other internet-based delivery options. The evidence of the efficacy of some of these mechanisms for delivering psychological treatments is growing, although many working in rural Australia describe a number of barriers to technology becoming the ultimate solution to the tyranny of distance. One of the major barriers cited is the limited access to reliable internet access in many rural and especially remote communities. Other factors mentioned are the level of discomfort felt by both the psychologist (who has rarely been trained in the use of such service delivery mechanisms) and the client. Developing a strong therapeutic alliance can be challenging when you cannot see each others' non-verbal communication and there is a brief pause between what you and the client are saying. The level of discomfort can be significantly magnified for Aboriginal and Torres Strait Islander clients. Some services have addressed these barriers by alternating traditional face-to-face services with technology-based service delivery (e.g., Saint & Roufeil, 2004) so that there is an opportunity to develop a trusting relationship in person.

Primary health models of care

The importance of quality primary health care for all Australians was recently highlighted by the release of Australia's first National Primary Health Care Strategy (2010). Primary health care incorporates first-level care with health promotion and prevention and community development. Importantly, primary health care includes the principles of equity, access, empowerment, community self-determination and intersectoral collaboration along with an understanding of the social, economic, cultural and political determinants of health (Keleher, 2001).

Many of the organisations that deliver health services to rural and remote regions have been early adopters of the principles of primary health care. Perhaps because of the challenge posed by vast distances, staff shortages and the complex chronic health care needs of many rural populations, services in rural and remote areas have realised the value of the integrated, community and value-driven approach to care offered by comprehensive primary health care models. This integrated approach has the potential to provide lessons to metropolitan primary health care teams.

Multidisciplinary approaches

Particularly in remote regions, many psychologists work as part of genuine multidisciplinary primary health care teams that operate from a commitment to maximise community and individual self-reliance. Groups of allied health professionals travel together as functional teams according to a regular travel schedule to provide holistic care to meet local population health needs. Teams are often away for a week at a time and many not only deliver individual care, but also support local health workers. The use of the psychologist as the mental health care specialist to support the remote health care workers on the ground is a form of multidisciplinary care that has long been called for in rural and remote Australia (e.g., Dunbar, Hickie, Wakerman & Reddy, 2007).

What is noteworthy about these team-based services is the focus on holistic wellbeing as opposed to simply absence of illness, and the location of control over health in both the individual and the community. The services operate on the assumption that treating the individual is insufficient unless one also addresses the wider conditions in which these poor health outcomes were created. Thus, promoting equity and community participation and addressing the underlying causes of ill health is part of the job of the whole team, including the psychologist. Working with the community not just the individual might mean building community trust in health services and transforming attitudes to health by regularly attending play groups and youth clubs, attending or running community events and providing community barbecues. Such activities offer community members a chance to develop trust in the psychologist long before any traditional psychological treatment is delivered. Additionally, one of the unwritten rules of these teams is regular and reliable service delivery to address one of the major factors contributing to

distrust: that is, the outreach service not turning up to town when they say they are coming and frequent staff turnover.

Being part of a multidisciplinary team appears to have benefits for both the clinician and the client (Dennis et al., 2008). Working in an outreaching multidisciplinary team with a base 'hub' in a larger regional centre, for example, assists in recruitment and retention and avoids the negatives associated with being a solo practitioner in an isolated community (Wakerman et al., 2006). However, outreach multidisciplinary team work in remote communities can provide challenges for psychologists, in part because of the frequent absence of interdisciplinary education and limited exposure to primary health care, collaborative care and community capacity building principles in psychologists' basic training. It may be that clinical and community psychology training would be the optimal preparation for a psychologist wishing to work in rural and remote regions. In addition to these limitations in training, recruitment difficulties are such in many rural and remote communities that psychologist positions are frequently filled by new graduates (or provisionally registered psychologists) with limited experience. For many psychologists in such situations, understanding one's scope of practice can be a challenge.

Cultural safety

Adopting the principles of primary health care, in particular the concepts of community self-determination and an understanding of the social, economic, cultural and political determinants of health, may also have benefits for psychologists in terms of working with Indigenous clients in a culturally competent manner. Psychologists who work in rural and remote locations are likely to encounter Indigenous clients and therefore need to intentionally develop culturally safe practice. 'Cultural safety' is safe service as defined by the Indigenous clients who receive the service (Edwards, Smith, Smith & Elston, 2008). Developing a culturally safe practice requires psychologists to undertake a process of personal reflection on their own cultural identity to be able to recognise the impact that their own culture has upon their practice. This involves understanding that their own beliefs, values and attitudes, when imposed on others, can have a negative impact. Indigenous psychologists are leading the way in assisting non-Indigenous psychologists and mental health workers to develop culturally safe practice through the delivery of Cultural Competence Workshops (see www.indigenouspsychology.com.au) by the Australian Indigenous Psychologists Association.

Conclusions

There is no 'one size fits all' way of delivering health care services to rural and remote Australia (Wakerman & Humphreys, 2011). However, psychologists are making a difference in getting mental health services to the bush. The innovative use of technology, the delivery of effective cultural competency training to the mental health workforce, and playing an essential role in outreaching multidisciplinary teams that operate according to the principles of primary health care are just some of the contributions of the profession to the social and emotional wellbeing of people living in rural and remote Australia.

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The list of references cited in this article can be accessed from the online version of the article (www.psychology.org.au/publications/inpsych/2011/october/roufeil).

PRIMARY HEALTH OUTREACH 'ON COUNTRY' AT PORT STEWART OUTSTATION

John Hannan, Team Leader – Wellbeing Centre, Royal Flying Doctor Service, Queensland

Coen is a small town of about 300 people roughly in the centre of the remote area of Far North Queensland's Cape York Peninsula. Being part of the Cape York Welfare Reform Trial, it has a Wellbeing Centre that is operated by the Royal Flying Doctor Service and is community controlled through a Local Advisory Group made up of select members of the township's Indigenous locals. I work at the Wellbeing Centre which has its origins as a centre to deal with referrals from the Reform Trial's Family Responsibility Commission for issues of drug and alcohol, domestic violence, gambling and mental health. It still performs this function but is also now an odd mix of services with the feel of a community centre combined with the capacity and actions of a mental health service.

Coen is also blessed with a number of community-supporting outstations: a mixture of private cattle stations, traditional land settlements and also now a highly effective ranger program. The Indigenous settlement of Port Stewart is one such place about an hour and a half southeast of Coen, over 95kms of roads that are rough at the best of times and often completely impassable in the wet. At the initiative of Shaun Sellwood, a counsellor with the Wellbeing Centre, an outreach was trialled to bring primary health care, including psychology services, to the inhabitants of this settlement.

And so it was that on a sunny but cool morning in early July our Wellbeing Centre team combined with a troupe of Royal Flying Doctor Service, Apunipima Cape York Health Council and Queensland Health employees to take a GP, men's

health advisor, child nurse, dietitians and counsellors out 'on country'. After an unusually smooth (but always dusty) ride out to Port Stewart we arrived at 'Top Camp' and were greeted by traditional owners. After the first order of the day (putting the billy on the open fire) we all chipped in to prepare the various work spaces for the day. For the dietitians this involved setting up a small marquee near the cooking area; for the men's health advisor a table with brochures and other paraphernalia; and for the GP a cleared space amongst the remnants of unanticipated guests in the main room of the rustic timber building. For myself, setup involved analysing which patches of grass would be most private yet also offer some shade as the sun rose over the day. As it turned out there was a progression of optimal locations throughout the day, but most involved squatting cross-legged next to one of a selection of old troop carriers.

As the morning wore on a good number of local residents convened at the site and began to flow through the various health service providers. As the men wandered around, Shaun and I opportunistically shanghaied them into consultations, whilst Marilyn Kepple (a Coen local, traditional owner for the area and Wellbeing Centre team member) and clinical counsellor, Amy Franchi, did the same with the women. Using the IRIS (Indigenous Risk Impact Screen) as a starting point, each interaction evolved into its own unique entity. As always, reflective listening, validation and a respectful client-directed therapy approach allowed the client to guide conversation to where they were comfortable. I am hesitant to preach on broad principles for engaging Indigenous clients, however, I have always found that engaging too early in a heavy psycho-education focussed style is the quickest way to repel clients. White-man burnout is a reality for many Indigenous people and the perception of you as just one more seagull is a possibility that must be respected. I find that a softly-softly approach allowing clients to 'suss you out' in their own time builds a platform for better work in the long term. For some clients at the outreach this was their first engagement with the service while others were regular clients. For new clients this was a great opportunity for them to engage with the service without feeling 'targeted' in any way. This allowed for a breakdown of barriers that has resulted in further engagement from clients that may otherwise never have utilised the service.

Other members of the outreach team had similar experiences, saying that people opened up much more about health issues on country, compared to when they visited the clinic in town, because they were much more comfortable engaging and talking in familiar surroundings. The success of the day was summed up by one of the clients, who told Shaun about her elder, who had passed away. She said: "He would be smiling down on the group because he was so thankful that people have come on to his country to provide services for us".

PRIMARY HEALTH CARE DELIVERY IN RURAL NORTHERN QUEENSLAND

Pania Brown and Dominic Sandiland, North and West Queensland Primary Health Care (NWQPHC)

NWQHPC delivers primary health care services to a population of approximately 120,000 people across 776,000 square kilometres, extending from Cardwell and Mornington Island in the north, to Birdsville in the south, east to Palm Island and westwards to the Northern Territory border. Whilst visiting services may come and go, funding providers may change priority areas, and governments may have different agendas, we know with great confidence based on many years working in these areas that the issues, needs and stresses faced by rural Australians on a daily basis remain the same. Continued demand for services is supported by our ever stable and increasing referral rates. In the past 6-12 months we have seen Mother Nature at her best with catastrophic natural disasters included repeated flooding, Category 5 cyclonic activity and the usual monsoonal wet season. For some, the trauma has come from these events, but for others it has simply made the other issues impossible to ignore. Regardless of the cause, we continue to support clients and communities through periods of immense personal hardship and are supporting a variety of post-disaster recovery efforts.

With a significant number of Indigenous clients and clients from culturally and linguistically diverse backgrounds, staff also have to develop expertise, awareness and cultural sensitivity to best support a very unique client group. Some communities only receive visits from a psychologist every 2-12 weeks, so clinicians rely on a suite of creative remote support options including tele-counselling and web-based services. We also provide advice and support to isolated GPs and other health professionals as well as organising and offering a variety of community education activities in response to identified areas of need, for example Triple P Parenting, Cancer Support Groups and Partners in Depression, to name a few.

We work from a platform of sustainability, of supporting communities to identify opportunities within locally based services, and building the capacity of individuals and service providers to allow communities to empower their members

and provide much longer lasting results. Whether services are delivered or accessed by road, air or (sometimes) water, the unique and inherent challenges faced by NWQPHC professionals keep us all smiling as we fondly recall and tell the tales of our latest adventure.

A typical day in the life of an NWQPHC psychologist

6:30am Climb aboard a small aircraft which appears to be roughly the size of the average family SUV with wings. You're a little nervous, but you are told this will save you a 7 hour drive on rough roads and 3 flat tyres changed on the side of the road with road-trains breaching the shoulder of the road as they go past.

8:45am After a somewhat turbulent and bumpy flight, you spend 30 minutes circling the airstrip before your pilot skilfully lands the aircraft.

9:00am This is the point where you hope that the local hospital groundsman will remember that he was to collect you and transport you to the local bush hospital. The penny drops, perhaps this is why you also needed to bring the satellite phone given the limited network coverage on your trendy city mobile.

9:30am Once at the hospital you settle into a vacant office space with a lone chair. You desperately scour the hallways for a second. Judging by the unique light fittings this could once have been an operating theatre. No time to swap rooms now! Your first client has arrived. The referral from the GP doesn't tell you much. It simply states that he's is a 54 year old male suffering from long-term depression and anxiety which has been exacerbated by the drought, subsequent flooding and ever increasing financial pressures from his farm. You open the door: "Welcome, come in and take a seat".

5:00pm All in all a successful day – three successful appointments and only two 'no shows'. You hear on the grapevine that there is a cattle muster in a nearby town and the rodeo is coming to town on Friday – maybe next trip.

6:00pm A quick walk from the motel to the local pub for dinner. You find yourself spoken to and greeted by name as you pass people in the street – such is life in a small community and the challenge of confidentiality when everybody knows someone. You quickly realise, there is no anonymity here and politely smile before shuffling on to order the now infamous 'Reef and Beef'.

NATIONWIDE TELEPHONE COUNSELLING SUPPORT FOR RURAL HEALTH PROVIDERS

Colleen Niedermayer, National Program Manager, and Annmaree Wilson, Senior Clinical Psychologist, Bush Support Services

Bush Support Services is the support program of CRANAplus, the professional body for all remote health professionals in Australia. It was established in 1997 through funding from the Department of Health and Ageing to provide a 24-hour telephone psychological support and debriefing service for multidisciplinary remote and rural health practitioners and their families throughout Australia. The service is available to all disciplines of health as well as paramedics, health educators, youth and aged care workers, sexual assault, and drug/alcohol workers delivering health care to the remote and isolated regions of Australia.

Bush Support Services is staffed by eight highly trained and experienced psychologists all of whom have remote experience. The Support Line can be accessed free from anywhere in Australia, 24 hours per day, 7 days per week. The Bush Support Line also offers anonymity and confidentiality, which are rare and precious resources in remote and rural health. Callers may remain anonymous if they wish, and repeat callers may speak to the same psychologist on request.

A key understanding of Bush Support Services is that rural and remote area health workers comprise a particular group of people who have specific mental health needs of their own. Stressors associated with geographic and professional isolation see people working in these sectors facing chronically high levels of occupational stress. These same workers also face increased chances of experiencing traumatic events.

The types of issues raised by callers to Bush Support Services is extremely varied. Psychologists often deal with callers who have had inadequate education and preparation for working in rural and remote areas. Callers frequently have questions about standards of practice and professional responsibility often due to the greater responsibility that is part and parcel of working in isolated areas. As with their urban and larger regional counterparts, workplace bullying and harassment are issues raised by callers.

As well, loneliness and isolation in rural and remote health workers at times amplifies the challenges presented in the day-to-day work situation. When these challenges become overwhelming, health workers can start to feel inadequate. The Bush Support Services psychologists are able to work with these callers to enhance coping skills. Support is also provided to callers who have returned from the bush and are wishing to explore their experiences. Some callers are regulars who just want to debrief or are looking for professional consultation, while others want to discuss personal issues associated with being isolated from family and friends, including depression, anxiety, and drug and alcohol issues.

The service tries to be as culturally aware and culturally safe as possible for Indigenous practitioners, which is a challenge given the diversity of Aboriginal and Torres Strait Islander cultures. An Indigenous co-counsellor assists with managing cultural issues and provides valuable input to other members of the counselling team.

Bush Support Services also provides educational packages focussing on self care and managing stress. Printed resources include self-help booklets which are available free of charge (contact: bss@crana.org.au). In addition to telephone counselling, internet counselling services, case management and professional consultation are offered (contact: scp@crana.org.au).

Bush Support Services also outreaches to remote area health workers by running fun activities such as a stress buster competition and a de-stressing knitting project. ■

Reducing the psychosocial impact of cancer for regional Queenslanders

By **Sandy Hutchison MAPS**, Executive Manager and **Samantha Clutton MAPS**, Manager, Cancer Counselling Service and **Dr Pip Youl** and **Professor Suzanne Chambers MAPS**, Viertel Centre for Research in Cancer Control, Cancer Council Queensland

Cancer is the leading cause of disease and injury burden in Australia, accounting for nearly one-fifth of the total disease burden. In 2007 over 108,000 people were diagnosed with cancer and nearly 40,000 people died from this disease (AIHW, 2010). In Queensland, the third largest Australian state by population with an estimated resident population of 4.5 million (2010), nearly 22,000 people were diagnosed with cancer and approximately 7,000 deaths were recorded in 2007 (Queensland Cancer Registry, 2010).

Improvements in early detection and treatment mean that many people are surviving and living with the consequences of cancer. While there have been significant improvements in outcomes from cancer, these improvements have not been seen in all population groups. Those diagnosed with cancer who live in rural and remote areas, and areas of disadvantage, have significantly poorer survival compared to those living in major cities. In Queensland – the most decentralised state in Australia with approximately 40 per cent of the population living outside the capital city and surrounding area – it is estimated that nine per cent of cancer deaths could be postponed beyond five years after diagnosis if the survival rates of rural and remote cancer patients were the same as the Queensland average (Cramb et al., 2011).

Significant disparities also exist in psychosocial outcomes for rural and regional cancer patients. Living in rural areas has been associated with greater unmet needs, with a recent study undertaken in a regional cancer population finding almost two-thirds of cancer patients reported at least one moderate to high unmet psychological need (McDowell, 2010). Futher evidence suggests that rural women diagnosed with breast cancer may perceive, or actually have, less control over treatment decisions, and this may be due to limited access to information about breast cancer treatment options (Davis et al., 2003).

Levels of distress associated with cancer

The diagnosis and treatment of cancer is a major life stress that is associated with a range of psychological, social, physical and spiritual difficulties, with rates of distress among cancer patients up to 47 per cent (depending on sample and assessment used), and rates of clinical anxiety and/or depression in the order of 30-40 per cent (Mitchell et al., 2011). Although over time most people diagnosed with cancer adjust effectively to their changed life circumstances, as many as one third experience heightened distress that persists or even worsens over time. In addition, many partners of cancer patients report high levels of distress, sometimes even greater than that of the patient.

Psychosocial care that includes screening for distress and referral for psychosocial interventions is endorsed as an international standard in cancer care (International Psycho-Oncology Society, 2010). Yet implementing this standard is particularly challenging in regional and rural areas where access to psychosocial services is limited. Queensland's geographically decentralised population creates inequalities of access and has a significant impact on psychosocial outcomes for people distressed by cancer. Telephone delivery of psychological services can help address these issues.

The Cancer Counselling Service

In 2004 the Cancer Council Queensland developed the Cancer Counselling Service (CCS) to address the psychosocial needs of Queenslanders distressed by cancer, particularly those in regional areas. The CCS is the first and only service in Australia staffed by psychologists to provide specialist psycho-oncology interventions via the telephone to cancer patients and their loved ones.

The CCS is embedded within a stepped care model of intervention that provides progressively higher levels of care for increasing levels of distress (Figure 1). Initial levels of care are provided by the Cancer Helpline, a toll-free cancer information and support service staffed by oncology nurses and other health professionals to deliver informational, practical and emotional support, and includes screening for distress and triage to higher levels of care (Hutchison et al., 2006).

The CCS provides in-depth psychological care (Extended and Specialist Care in the Tiered Model) that includes counselling and coping skills training, through to individual or couple therapy for mood and anxiety disorders or significant relationship/sexual problems. The service draws on current best practice guidelines for effective psychosocial interventions for people distressed by cancer. Intervention comprises up to five sessions of semi-structured therapy designed to target challenges commonly experienced across the illness trajectory, and a range of therapy materials and patient resources are utilised to augment therapy. Support is delivered by telephone to enable people to access care regardless of geographic location; and face-to-face services are also available in Brisbane, Gold Coast, Townsville, Cairns, and more recently Rockhampton and Bundaberg. Patients and family members with severe or complex support needs are appropriately referred to acute care or multidisciplinary mental health services.

Since 2004, over 2,250 people from regional areas of Queensland have received psychological intervention for cancer-related difficulties from as far north as Bamaga on the mainland and Thursday Island in Torres Strait, to Mt Isa and Boulia in the west, east to Magnetic and Stradbroke Islands, and south to Stanthorpe, Goondiwindi and into Northern NSW. Data for the 2008 calendar year indicates 230 referrals were from regional

areas, 54 per cent for people with cancer and 46 per cent for their partners or family members. A broad range of cancer diagnoses were represented with the most common being breast, bowel, gynaecological, lung and prostate. The majority were female (80%), aged 50-59, with 63 per cent older than 50 years. The most common presenting problems were adjustment to cancer, anxiety, survivorship issues and anticipatory grief.

Mindfulness and cancer

The use of mindfulness-based interventions in health care settings is rapidly growing, and involves open awareness of current experience and the intention to observe habits of reacting as they arise. Qualitative studies of mindfulness for cancer patients have identified positive changes in acceptance, self-control, personal growth, shared experience and self-regulation. A recent Australian randomised control trial of mindfulness-based cognitive therapy (MBCT) showed that cancer patients experienced significant improvement in depression and anxiety and a trend for improved quality of life compared to a waitlist control (Foley et al., 2010) and a recent meta-analysis of mindfulness-based stress reduction in cancer patients reported moderate positive effects on psychological distress (Ledesma & Kumano, 2009).

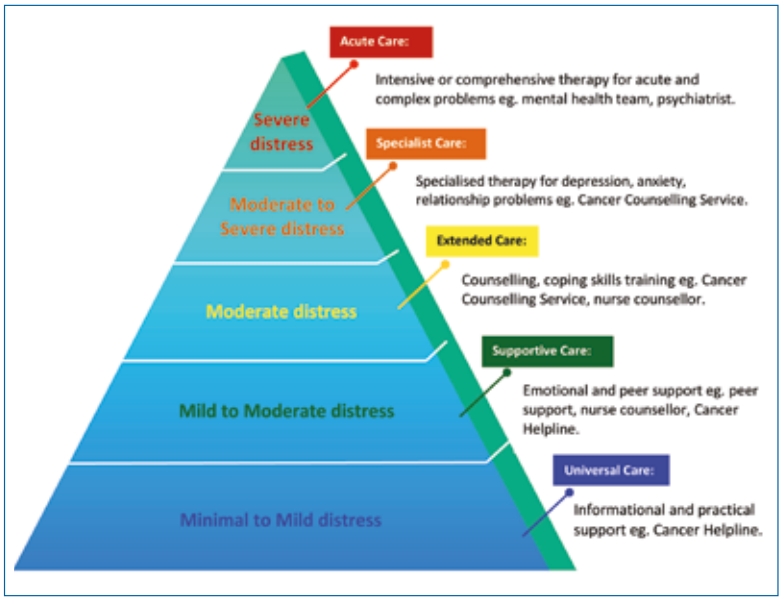

Figure 1. Tiered Model of Psychosocial Care (Hutchison et al., 2006)

Since 2009, the CCS has run 8-week MBCT programs for cancer patients and family members. A total of six groups (49 participants) have been conducted in regional offices, including a combined face-to-face and telephone group in Rockhampton. In future telephone and/or web delivered groups will be further explored.

Conclusions

The Cancer Counselling Service demonstrates that psychosocial interventions for cancer can be effectively delivered regionally, and that the needs of many people in regional and rural areas would remain unmet if not for the broad reach of a telephone-delivered service.

Although working over the telephone can present challenges, for people unable to access face-to-face services it is a worthwhile and viable alternative. Telephone has advantages over text-based web delivery including personal contact with the therapist, verbal expression of concerns, and tailoring of intervention to individual circumstances. In the future we envisage making use of technology (including voiceover internet protocols) to more closely replicate face-to-face therapy over distances, as well as having a variety of web-based services available (self-management materials, structured self-paced therapy programs, real-time web therapy). However, with cancer being more common with older age, the current generation are more universally likely to utilise telephone rather than internet delivered services, thus making telephone the most effective and economical option for remote delivery at the present time.

Some client groups are more difficult to service via telephone, such as hearing or speech impaired and culturally and linguistically diverse groups, including Indigenous Australians. Although telephone translation and relay services are available, face-to-face service delivery is likely to be more effective for these groups. Service to men remains a challenge, and although an issue for psychological services generally, a greater understanding of the types of services men would prefer to access and the methods to best promote services to men is needed. In our programs and research we have done considerable work with men with prostate cancer and continue to enhance our understanding of the needs and preferences of this group.

In summary, tele-based services to deliver psychosocial interventions for cancer have broad reach and overcome a range of barriers to access, including health status, finances, transport/inability to drive, and carer responsibilities. These services also cater to those who are less likely to access face-to-face services and prefer the anonymity of a telephone service, thus increasing access to a subgroup who might otherwise avoid seeking help. In addition, tele-based services have potential for national implementation, increasing access to high quality evidence-based psychological support and interventions for all Australians with cancer who are experiencing significant psychological distress. ■

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The list of references cited in this article can be accessed from the online version of the article (www.psychology.org.au/publications/inpsych/2011/october/hutchison).

Helping the helpers in rural Australia: An innovative mentoring and supervision program in NSW

By **Graham Parry MAPS**, Illawarra and South East Region Department of Education and Community, and **John Hambridge MAPS**, **Chris Willcox MAPS** and **Wayne Clarke**, Hunter New England Local Health District

Psychologists in rural and remote Australia frequently work in great geographical and professional isolation yet deal with complex presentations, resource issues and ethical dilemmas related to their situation. The rural workforce has many junior and inexperienced psychologists and it is difficult to attract and retain psychologists, to the detriment of the mental health needs of rural and remote communities.

Recognising the need to provide and maintain quality psychological services in rural and remote areas, the NSW Psychologists Registration Board (now the Psychology Council of NSW) awarded a grant of $250K to a team of psychologists from Hunter New England Local Health District. The original grant proposal was to develop and implement a mentoring scheme for approximately 25 rural and remote area psychologists (RRAPs) in NSW, supplemented by educational initiatives. The aims were to decrease the sense of isolation experienced by RRAPs and enhance their skill level and knowledge base. It was also hoped this might help to sustain and increase the psychology workforce in rural and remote areas. Two part-time psychologists were employed to develop and implement the program.

The project commenced in August 2010 and in just two weeks 98 RRAPs had completed an online survey outlining their experience and needs, and enrolled in the program. The cohort consisted of 22 senior and clinical, 50 general and 26 provisionally registered psychologists. The level of demand meant that the original proposal was modified and quickly evolved into a range of support options across four platforms: supervision, mentoring, online support and training. Direct supervision delivered by the two psychologists working part-time on the project provided a total of 371 hours of supervision to 45 general psychologists over a 12-month period.

Participants were introduced to the world of blogging through a wordpress site (an interactive blog site) and later through a NING (a blog specifically designed to enable individual blog pages and direct connection to upcoming workshop presenters).

Seventy-six RRAPs attended a 'country week' in Sydney and participated in a range of subsidised workshops including: Interpersonal Therapy; Grief and Loss; Image Reprocessing and Rescripting Therapy; Beginner and Advanced Level Acceptance and Commitment Therapy; Ethics in Rural Practice; and Giving and Receiving Good Supervision. Twenty-four psychologists joined a voluntary mentoring program either as mentors and/or mentees. Psychologists from as far away as Dareton, Broken Hill and Lightning Ridge connected with their rural colleagues through the project and formed many personal and professional links.

With the new Psychology Board of Australia requirements for psychologists to have a continuing professional development (CPD) learning plan, and to log training and supervision events in order to retain registration, there are additional pressures on isolated remote and rural psychologists. Those in the Rural and Remote Area Psychologists Program (RRAPP) have been able to:

- Receive inexpensive and targeted training both live and online
- Receive direct supervision counting towards CPD hours
- Participate in peer mentoring
- Access an array of focused webcast learning opportunities via in-house blogs
- Participate in a forum to discuss casework and share resources
- Overcome isolation through participation in an online community.

Evaluation of the program

Survey responses indicate that the RRAPP succeeded in reducing burnout and the sense of isolation, increased skill levels and formed networks amongst RRAPs. Individual feedback has confirmed that RRAPs need and appreciate any extra support they can get. An Illustrative comment from the survey makes this point.

> *"It is very difficult to access supervision, resources and training in a rural area, as the options and costs often prohibit participation. This program makes supervision, training, connection and resources accessible, all of which are crucial for our role. These aspects are even more pertinent with the new Registration Board requirements, and this program will facilitate continued (and improved) practice for many rural psychologists."*

The program has just received an additional grant from the Psychology Council of NSW to carry the project through until 2012 and in the future is hoping to partner with national bodies. Psychologists in NSW who would like to find out more about the current project and any rurally-based psychologists who would like to express an interest in joining any future funded national project should email the principal author of this article. ■

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Enhancing health and wellbeing in regional, rural and remote Australia through professional networking

By **Simon Canny MAPS**, clinical psychologist in private practice, **Associate Professor Timothy A. Carey MAPS**, Centre for Remote Health and Central Australian Mental Health Service, and **Professor Don Thomson FAPS**, Deakin University

This article highlights three key organisations across regional Australia that offer opportunities, skills sharing and resources for psychologists and other professionals to improve the health and wellbeing of Australians living and working in 'the bush'. Psychologists are not often the first point of call for people living in rural and remote areas, and neither is the profession the backbone of the community in the same way as a GP, the pastor or the sports club might be. However, psychologists have an advanced level of understanding of people and their 'fit' within the physical, social, ecological and political landscape, so should take the opportunity to spread psychological knowledge through regional organisations to assist in improving the lives and relationships of those in regional, rural and remote (RRR) Australia.

The National Rural Health Alliance (NRHA) has as its goal that all Australians should have equitable access to appropriate health services, regardless of where they live. Similarly, the primary objective of Services for Australian Rural and Remote Allied Health (SARRAH) is to advocate for, develop and provide services to enable allied health professionals who live and work in rural and remote areas of Australia to confidently and competently carry out their professional duties in providing a variety of health services. The National Farmers Federation (NHF) supports 135,000 farms which produce 93 per cent of Australia's domestic food supply from 61 per cent of the landmass, and this vital activity requires reciprocity from all of us. These three regional organisations already have psychologists working within them, but more are required.

National Rural Health Alliance (www.nrha.ruralhealth.org.au)

The NRHA is the peak non-government rural and remote health organisation in Australia, with 33 member bodies including the APS through the participation of the APS Rural and Remote Interest Group. This membership enables representation of what psychology has to offer to the health and wellbeing of individuals and communities in rural and remote Australia. NRHA has a bimonthly, peer reviewed journal – *Australian Journal of Rural Health* – and a large conference every two years.

The health of rural Australia will continue to be a focus of governments' initiatives across the next decade, and the application of psychological knowledge and decision making is crucial to ensure evidence-based models are developed and implemented effectively. Representatives of the NRHA member bodies meet throughout the year via teleconferencing and have one face-to-face meeting with Government Ministers in Canberra each year to discuss health priorities in the bush. A number of issues relevant to psychology have received attention from parliamentarians and policy makers over recent years. In addition to the ongoing plea for better mental health services, the under-representation of psychologists has resulted in other health professionals asking for greater psychological input and collaborative care in areas such as neuropsychological services and management of dieting behaviours.

Services for Australian Rural and Remote Allied Health (www.sarrah.org.au)

SARRAH offers its members an online training package to assist with transitioning to rural and remote practice and free online access to a cultural orientation program and the A*ustralian Journal of Rural Health*. It also provides Australia-wide access to continuing professional development through the Victorian Department of Health's Allied Health Education Program (AHEP), designed to improve rural recruitment and retention rates. As an organisation, SARRAH is critically located in a position of trust and respect with access to Federal Government Ministers and the Department of Health and Ageing, and provides the opportunity to guide initiatives funded through Australia's rural health budget.

National Farmers Federation (www.nff.org.au)

The NFF is a body representing farming organisations based in the various States, and rural commodity organisations. A key aim of the NFF is to obtain better access to services for people – farmers, businesses and communities – in regional Australia. Through individual members' initiatives like the NSW Farmers' Mental Health Network and Rural Mental Health Support Line, this goal has been brought to fruition. As a result of lobbying, the Federal Government introduced additional services and financial and personal counselling to the wide regions of Australia affected by flood, drought and natural disaster. In addition to mental health services, psychologists' participation in the NFF or its member organisations can also enable greater access to organisational, environmental and community psychology principles.

As psychologists, we don't just have to undertake research or practise as clinicians to make a difference in RRR Australia, but can join key regional organisations and share our knowledge, skills and unique ability to understand the biopsychosocial approach to the development of solutions for people in their context. The wellbeing of the nation depends on psychologists contributing their knowledge, and the future of the profession requires it. ■

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