



Submission to the  
Senate Community Affairs References Committee  
inquiry into the  
**Accessibility and quality of mental health services in rural  
and remote Australia**



*25 May 2018*

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# ABOUT RDAA

*RDAA is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.*

RDAA's vision for rural and remote communities is simple – excellent medical care.

This means high quality health services that are:

- patient-centred
- continuous
- comprehensive
- collaborative
- coordinated
- cohesive, and
- accessible

and are provided by a GP-led team of doctors and other health professionals who have the necessary training and skills to meet the needs of their communities.

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## EXECUTIVE SUMMARY

Although important strides forward have been made in the past 30 years, mental health care in Australia is still characterised by siloed funding streams and fragmented service provision<sup>1</sup>. In rural and remote areas, a range of geographic, economic, social, cultural, demographic, and environmental factors exacerbate systemic shortcomings and impact on the accessibility and quality of mental health services.

Integration of care provided by the mental health services in these areas is often poor, failing to take into account co- and multi-morbidities particularly in relation to alcohol and other drugs. 'Bouncing' people between types of services is not uncommon and communication with GPs and with social services is inadequate.

The fragmentation and insufficiency of mental health care in rural and remote Australia continues to be of significant concern to rural and remote doctors. Although the investment in mental health announced in the 2018-2019 Federal Budget is welcome, the role of the general practitioner (GP) as the only local source of mental health treatment and support in many communities continues to be undervalued.

It is essential that a bipartisan, proactive rural and remote mental health strategic plan – grounded on an holistic approach to funding and service provision and supported by all governments – be developed to address recognised needs together with operative plans identifying key mechanisms and timeframes to achieve desired outcomes. Planning must be mindful of the impact that social, economic, cultural and environmental determinants of health have on people experiencing mental health disorders and of the complex interrelationship of mental health services with other health, social and community services.

The crucial role rural and remote doctors play as key providers and facilitators of mental health care in these areas must be recognised and supported to improve both the accessibility and the quality of mental health services in rural and remote Australia.

# RECOMMENDATIONS

RDAA believes that urgent action to improve access to and quality of mental health services in rural and remote areas is required and recommends:

1. *targeting investment to groups who are at greater risk of harm from mental health disorders, including those who live in rural and remote communities and/or who are Aboriginal and/or Torres Strait Islander people to redress inequities*
2. *supporting rural and remote GPs (and their teams) to provide prevention, early intervention, crisis and ongoing mental health support to patients by introducing MBS items that:*
  - recognise the need for patient-centred continuity of care and the longer consultation times necessary to deal with often complex mental health, co-morbid and multi-morbid conditions
  - allow telehealth consultations as part of a cycle of care which includes regular face-to-face contact
3. *investing in the up-skilling of rural and remote GPs in mental health by:*
  - establishing a strong, adequately funded National Rural Generalist Pathway to ensure rural doctors are able to undertake advanced skill training in mental health
  - providing funded Continuing Professional Development for GPs and their teams in mental health
4. *underpinning the work of rural and remote GPs in providing mental health care by providing support for an appropriately trained and resourced broader health workforce, including*
  - investing in nursing and allied health services to improve continuity of care in rural areas, including the provision of psychology locums and outreach services
  - investing in training for other mental health workforces and social and community sector workforces to improve the quality of mental health care and integration of services in rural and remote areas
5. *investing in physical, capital and technological rural health infrastructure to improve the availability of quality services and the capacity of rural doctors to provide mental health care*
6. *requiring visiting mental health services to work with local GPs and community nurses to develop integrated service models in rural and remote communities.*

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7. *investing in systemic mobilisation of the mental health workforce to cover known high-risk periods in rural and remote areas*
  8. *establishing a 24-hour child and adolescent mental health care telehealth service delivered by child and adolescent mental health care specialists to:*
    - provide support directly to patients and their families/carers
    - provide advice to GPs to manage a child or adolescent patient experiencing a mental health issue.

## BACKGROUND

Although the evidence indicates that the prevalence of mental disorders in rural and remote Australia is largely similar to that in major cities rates of suicide and self-harm are higher in remote and rural areas and increase with degree of remoteness.<sup>2,3,4</sup>

The unique circumstances that exist in rural and remote communities impact on health and wellbeing of rural and remote people and contribute to this situation. While rural living offers greater community connectedness<sup>5,6</sup>, with rural people scoring better on indicators for happiness<sup>7</sup>, there are a number of other factors which impact negatively on health and wellbeing contributing to higher disease rates and lower life expectancy, including higher rates of risky health behaviours and more risks of occupational and transport-related accidents and injury<sup>8</sup>. Rural people are less likely to seek medical help for mental and other health issues and more likely to delay visiting a doctor. Influences on help seeking behaviours include: wariness of stigma; cost; transport issues; and the perceived relative importance of other events such as harvest or shearing time<sup>9</sup>.

Rural and remote people also experience socio-economic disadvantage<sup>10</sup> that is compounded by mental illness: *Mental illness compounds existing social disadvantage and damages chances for social and community participation. Although it can affect any person at any time, at a population level mental illness disproportionately affects those who already experience some level of disadvantage and who are often those with the least access to mental health support. Those living in rural, regional and remote communities have lower access to support for health problems compared with metropolitan areas.*<sup>11</sup>

For example, environmental issues, such as flood, fire and drought, are increasingly impacting many rural people and communities. These events, and others which cause economic and social hardship – such as the closing down of a facility which employs large numbers of local people – have significant individual and community mental health implications but rural people have poorer access to ongoing support to mitigate negative effects.

Within this context, rural and remote GPs play a crucial role in providing and facilitating a range of mental health services for patients experiencing mental disorders and distress: a role that is frequently under-recognised and under-supported. GPs are the most frequently accessed part of the health system with over 85 per cent of Australians seeing a GP at least once each year<sup>12</sup>. They are best placed to identify emergent mental health issues (including during consultations about physical health), and to provide early intervention and ongoing care to patients presenting with psychological conditions while facilitating necessary specialist and community care.

# RESPONSE TO IDENTIFIED ISSUES

## *(a) the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate*

Rural and remote Australians utilise mental health services at a much lower rate than those living in more urbanised settings for a variety of well-recognised reasons, including lack of access to appropriate and affordable mental health services:

- There may be few, if any, mental health professionals and services within a local area.
- The services that do exist may not be appropriate to the patient or the mental health issue and may not be joined up with other necessary health, social and community services.
- Telehealth services may be more difficult to access, particularly where connectivity and data speeds are an issue.
- Fly-in fly-out (FIFO)/drive-in drive-out (DIDO) services, though an important mechanism to fill critical gaps, are not available to all communities. Where provided, they can only deliver limited face-to-face contact with mental health professionals and may not be available at times of crisis.
- The cost of services, both financial and other, may be an issue. People from rural and remote areas often have to travel long distances to see health professionals incurring travel and accommodation expenses as well as those associated with time away from employment. Time away from family and community may also be a burden.

Other factors that may impact on help-seeking behaviours, include

- self-sufficiency, self-reliance and stoicism traits that characteristic of rural and remote people
- fear of being stigmatised and the difficulty of maintaining privacy and confidentiality in small communities
- perceived relative importance of other events such as harvest or shearing time
- gender differences, and
- cultural factors.<sup>13,14,15,16,17</sup>

In addition to improving understanding of mental health and mental health literacy across Australia through community education mechanisms to allay fears and reduce stigma, improving utilisation of mental health services by

rural and remote people will require action to increase access to appropriate and affordable mental health care.

Identifying where mental health service gaps exist and strategies to redressing the shortages and mal-distribution of mental health workforces must be part of an overall strategic rural mental health strategic plan. In the shorter term mental health needs in rural and remote areas should be addressed by

- targeting investment to areas experiencing critical need where medical support is infrequent or absent
- underpinning the devolution of responsibility for mental health services to Primary Health Networks (PHNs) with strong governance and accountability processes to ensure that rural and remote communities receive equitable services and mitigate the risk of any unintended consequences (particularly where the PHN covers both urban and rural areas) and to ensure local solutions are developed with rural and remote GPs and their teams
- investing in prevention and early intervention services provided by rural and remote general practices.

*(b) the higher rate of suicide in rural and remote Australia;*

Although overall suicide rates in rural and remote Australia are significantly higher than in metropolitan areas, with the increase in suicide rates in regional, rural and remote areas being more than 4 times the increase in capital cities over the last 5 years<sup>18</sup>, it must be recognised that suicide has a complex aetiology:

*... there are localities in rural and remote areas where the suicide rate might be very low. A recent study shows that rural suicide is not a homogeneous phenomenon. This heterogeneity suggests that local, place-based factors (social, economic etc.) may be more important drivers of psychological distress, poor social and emotional wellbeing and suicide than mental illness.<sup>19</sup>*

There are also gender differences. For example, multiple factors contribute to increased suicide rates among rural men including *farming under stress, the reluctance of men to utilise health services, the stigma of mental illness, stoicism, threatened masculinity and changing rural practices*<sup>20</sup>. Stoicism is also a factor contributing to mental health issues among rural women. Other stressors may include exposure to domestic violence, isolation,<sup>21</sup> “pressure to keep it all together”, exhaustion, and post-natal depression<sup>22</sup>.

Although recent investment in mental health and suicide prevention programs<sup>23</sup> is welcome, the specific barriers that exist in rural and remote

Australia that compromise the effectiveness of measures must also be addressed. Providing greater support to rural and remote doctors and their teams to provide crisis and continuing care, and increasing the numbers of other trained mental health professionals in rural and remote areas to provide ongoing face-to-face services in the longer term, will be critical to reduce the incidence of mental health issues, self harm and suicide in rural and remote areas. Where resident services cannot be provided there must be significant investment in the provision of innovative outreach and digital health models of care. This should include ensuring access to a combination face-to-face/telehealth cycle of care provided by a person's regular GP as well as mechanisms to support 24-hour access. Support for patient transport and accommodation when needed is also necessary.

Initiatives must also be supported by measures to provide necessary physical, capital and technological infrastructure, including redressing the poorer digital connectivity and data speeds evident in many rural and remote areas as a matter of urgency.

#### *(c) the nature of the mental health workforce;*

The profile of the mental health workforce in rural and remote Australia is far different from that in major cities. The National Rural Health Alliance notes that *the prevalence of mental health professionals decreases rapidly with remoteness, with psychiatrists being roughly 6 times less prevalent in Very remote areas, psychologists roughly 4 times less prevalent and mental health nurses roughly 3 times less prevalent. Prevalences for these professions in regional/rural areas are about a third to two thirds what they are in Major cities (depending on profession)*<sup>24</sup>.

Rural and remote GPs are frequently the first point of contact for those seeking help and may be the only local mental health care provider. They treat not only the individual but also deal with the consequences of poor mental health on families, friends and communities. Rural and remote GPs, together with police, ambulance and Emergency Department staff, also bear the brunt of acute mental disorder crises.

They provide episodic and ongoing treatment and support often with limited referral pathways, as concentrations of psychiatrists and psychologists decreases markedly with increasing remoteness. Gaining access to psychiatrists for GPs seeking specialist guidance on the management of a patient and for patients, particularly for those with complex diagnostic or care needs, is often very difficult.

Fewer numbers of other mental health professionals, distance and under-resourcing also means that models of care in rural and remote areas are very



different to those that can be offered in more urban settings. Patients are reliant on their GP, outreach and telehealth services or have to travel great distances for support.

Providing mental health training for local community nurses, midwives and Aboriginal Health Workers beyond core skill sets could improve prevention and identification of potential mental health conditions, and earlier referral to appropriate treatment.

The infrequency or absence of local medical support also contributes to poorer conversion to specialist psychological or psychiatric treatment in rural areas, increasing the burden on rural and remote GPs who, in providing for the mental health care needs of their patients, face considerable time and other pressures including administrative impost, providing for the safety and security of their staff and themselves, and managing their practice as a business.

RDAAC continues to call for:

- support for team-based models of care and telehealth which would allow flexible support structures within the general practice and the capacity to utilise broader community resources. Many aspects of managed and stepped care can be undertaken by practice staff and community support staff or by mental health professionals via telehealth. It is important that these services be coordinated by the GP to ensure continuity of care
- a nationally consistent approach to clinical privileges to ensure that they are statewide rather than facility based (as is the case in some States/Territories) and transferable to other parts of Australia/ across State/Territory boundaries
- national safety guidelines for the management and transfer of aggressive and violent patients. Current protocols vary between States and Territories.

RDAAC acknowledges that addressing medical training and distribution issues to remedy the workforce maldistribution are a medium to longer-term proposition. Providing opportunities for advanced skill training in mental health through the establishment of the National Rural Generalist Pathway will be a positive step in this regard.

Mental health training which is appropriate to rural circumstances must be made available and accessible for other mental health professionals and for other social and community sector workforces including police, employment and housing workers.



This includes acknowledging that in Aboriginal and Torres Strait Islander communities, Aboriginal and Torres Strait Islander health professionals are best placed to meet those communities' needs. While training more Aboriginal and Torres Strait Islander mental health clinicians and other health professionals should be a priority, providing appropriate training in cultural safety for non-Indigenous health professionals working in these communities, and more generally, is necessary to ensure that the specific needs of Aboriginal and Torres Strait Islander patients and communities are met.

#### *(d) the challenges of delivering mental health services in the regions*

Regional, rural and remote communities are not homogenous. Australia's regional, rural and remote communities are diverse, supported by and supporting activities related to mining, agriculture, forestry, fishing/aquaculture and tourism. This diversity, together with degree of isolation, and other geographic, climatic, socio-economic, demographic and cultural factors create unique sets of circumstances that can have specific implications for mental health care. For example, in mining towns where FIFO or DIDO industrial arrangements have become common workers report high levels of psychological distress associated with stressors such as missing special events, relationship problems with partners, and shift rosters, as well as financial stress, social isolation and fear of stigmatisation for mental health problems<sup>25</sup>.

Other challenges that have been previously identified by RDAA<sup>26</sup> but continue to be problematic include:

- funding and funding cycles

Cyclical, short-term funding arrangements creates uncertainty among mental health service providers impacting on their capacity to engage in long term planning and provide employment certainty for staff. This, in turn, impacts on confidence in the service.

The allocation of funding to deliver mental health services can also be an issue. The Australian Government's commitment to prioritising mental health and to the National Rural Generalist Pathway, which will provide an opportunity for doctors to undertake advance skill training in mental health, in the 2018-19 Federal Budget<sup>27</sup> is welcome. However, increased and ongoing investment at all levels of government will be essential to improve access to and quality of mental health services in rural and remote areas.

- service provision and integration



Inadequate service provision and integration is characteristic of mental health care in rural and remote communities. Not all communities have local mental health and/or social and community services. The increased complexity and high levels of need associated with co- or multi-morbidities, particularly in relation to alcohol and other drugs and violence issues, and the impact of a range of other issues related to homelessness, housing, justice, education and employment are often poorly addressed.

The capacity of existing services to provide high quality care is compromised by poor integration between types of health service, and with other social and community services. Patients are often moved between services without appropriate communication between services increasing the risk of poor patient outcomes. Referral pathways, ongoing psychiatric, psychological and nursing services, timely intra- and inter-professional communication and the provision of affordable access to longer-term care are all problematic. Many mental health issues are time sensitive. For example, for people experiencing suicidal ideation or women experiencing ante natal depression a wait of several months for appropriate support and treatment can only have adverse outcomes.

There are also notable issues with mental health service delivery models in rural and remote communities. Access to care is commonly only obtainable during business hours. After hours service on weekdays and weekends relies on doctors and nurses from local clinics being available. Some assistance may also be accessible via phone or video-conferencing. Care is further limited over Christmas and school holidays when staff shortages are more likely. In addition to strategies to redress service provision and workforce issues in the longer term, investment to allow the systemic mobilisation of mental health resources – as is the case during and immediately following environmental crises – to cover these known high-risk periods is necessary to immediately improve accessibility to mental health care in rural and remote areas.

Access disparities also exist between states and territories. People living in cross-border towns can have better access to health professionals and services on one side of the same town. This is generally not an issue with respect to acute medical services, but is problematic for all other levels of mental health care.

- lack of appropriate physical, capital and technological infrastructure

Enhancing or expanding physical and technological infrastructure to



facilitate the recruitment and retention of the necessary number of health practitioners, accommodating them and providing telehealth equipment and facilities will be a necessary adjunct to strategies to address rural and remote mental health workforce shortages. Re-establishing an infrastructure grants program and innovative options for funding and better utilising existing rural health infrastructure should be considered.

Australia's tiered healthcare funding means that emergency facilities and services are located within hospitals and funded by State and Territory government. It is essential that rural hospitals have the facilities and resources, including a safe room with telehealth facilities, to provide people experiencing an acute mental health episode with appropriate care and provide ongoing treatment and support for those experiencing sub- or non-acute disorders. This is an area which requires urgent investment.

*(e) attitudes towards mental health services;*

It is well recognised that there is generally poor understanding of, and significant levels of stigma associated with, mental health disorders among the Australian population. Understanding of mental health and mental health literacy can be improved by delivery of population-wide and targeted community education and prevention programs through a range of online and social media platforms as well as through more traditional media outlets. Australia's progress in tobacco control is indicative of how successful such strategies can be.

Rural and remote GPs and their teams often already play an educative role with patients and their families/carers and within their communities. Providing quality online resources to support this role would be useful in this regard.

*(f) opportunities that technology presents for improved service delivery*

RDAA supports the use of technology to improve access to psychological, psychiatric and mental health support services. However increasing the availability and accessibility of local face-to-face and combination face-to-face/telehealth mental health services targeted across the age spectrum to provide intensive and ongoing support will be critical to reducing the incidence of mental illness, self harm and suicide in rural and remote areas.

Organisations such as Lifeline and beyondblue do an extraordinary job in providing mental health and crisis support nationally using available technologies, but continued support is best provided by wrap-around local services. Where there is limited access online services are an important complementary delivery mechanism. Ensuring rural and remote GPs are supported through the MBS to offer telehealth consultations as part of a



cycle of care that includes face-to-face contact is an immediately achievable strategy.

*(g) other related matters*

The shortcomings of already poor service provision generally become even more evident with respect to child and adolescent mental health and are extremely concerning. Distant services are much more difficult to use as a child or adolescent for a number of reasons including lack of transport, the need for parental or carer permission and supervision and the greater associated travel and accommodation costs.

There is an immediate need to provide dedicated child and adolescent mental health services. This should include establishing a 24-hour emergency telehealth advice and support service at State/Territory or national levels that is delivered by child and adolescent mental health specialists both directly to patients and their families/carers and to GPs seeking advice on the management of a patient. This must be underpinned at the local level by flexible service models that allow fast tracking of child and adolescent patients into care and minimise the impact of geographical isolation. Options include combining regular video-conferencing with a distant psychiatrist or psychologist with ongoing face-to-face support from the patient's regular GP and other local health professionals they know and trust.

The indicators of the underlying issues of access and quality that beset mental health care in rural and remote Australia are well documented. Addressing these issues will require bipartisan leadership to develop strategic and operative plans underpinned by significant investment to

## CONCLUSION

redress the inequities that exist and improve outcomes.

Rural and remote GPs already play a pivotal, but often undervalued, role in mental health care in their communities. They must be supported in this role to improve access to and quality of mental health services in rural and remote areas.

<sup>1</sup> National Mental Health Commission (2014) Report of the National Review of Mental Health Programmes and Services: Summary. Sydney: NMHC. p8.

<sup>2</sup> Bishop L, Ransom A, Lavery, M, & Gale, L (2017). *Mental health in remote and rural communities*. Canberra: Royal Flying Doctor Service of Australia.

<sup>3</sup> Rural Doctors Association of Australia. (2016). *Mental health care in rural Australia: A RDAA background paper*. Canberra: RDAA.

## ENDNOTES

<sup>4</sup> In 2016, the number of suicides per 100,000 people in rural and remote Australia was 50% higher than in cities. This rate gets higher as areas become more remote and has been growing more rapidly than in the cities. The rate for Aboriginal and Torres Strait Islander people is twice that for non-Indigenous people.

Hazell T, Dalton H, Caton T, Perkins D (2017) *Rural Suicide and its Prevention: a CRRMH position paper*. Centre for Rural and Remote Mental Health, University of Newcastle, Australia.

<sup>5</sup> Rural Doctors Association of Australia. Op cit.

<sup>6</sup> National Rural Health Alliance. (2016). *Mental health in rural and remote Australia*. Canberra: National Rural Health Alliance Inc.

<sup>7</sup> Australian Unity, & Deakin University. (2015). *What makes us happy?* Third edition. Melbourne: Australian Unity cited in Bishop, L., Ransom, A., Laverty, M., & Gale, L. (2017). *Mental health in remote and rural communities*. Canberra: Royal Flying Doctor Service of Australia.

<sup>8</sup> Australian Institute of Health and Welfare 2016. *Australia's health 2016*. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW. pp248-251.

<sup>9</sup> Rural Doctors Association of Australia. Op cit.

<sup>10</sup> Australian Institute of Health and Welfare. Op cit.

<sup>11</sup> National Mental Health Commission. (2014b). *The national review of mental health programmes and services. Vol. 4, Paper 2*. Sydney: National Mental Health Commission.

<sup>12</sup> The Royal Australian College of General Practitioners (2017). *General Practice: Health of the Nation*. East Melbourne, Vic: RACGP. p1.

<sup>13</sup> Bishop, L et al. Op cit.

<sup>14</sup> Alston M. *Rural male suicide in Australia*. *Social Science & Medicine* 2012; 74(4): 515-522. <https://doi.org/10.1016/j.socscimed.2010.04.036> cited in Crnek-Georgeson KT, Wilson LA, Page A Factors influencing suicide in older rural males: a review of Australian studies *Rural and Remote Health* 17: 4020. (Online) 2017. Available: <http://www.rrh.org.au>

<sup>15</sup> Vines, R. (2011) *Equity in health and wellbeing: Why does regional, rural and remote Australia matter?* *InPsych* 2011, Vol. 33 Issue 5.

<sup>16</sup> Australian Institute of Family Studies (2008). *Prevention and early intervention in strengthening families and relationships: Challenges and implications*. AFRC Issues No. 2 – February 2008 <https://aifs.gov.au/cfca/publications/prevention-and-early-intervention-strengthening-families/help-seeking-behaviour> Accessed 10 May 2018

<sup>17</sup> Pierce D, Brewer C (2012) Factors Promoting Use of Mental Health Services in a Rural Area of Australia. *J Community Med Health Educ* 2:190. doi: 10.4172/2161-0711.1000190

<sup>18</sup> Centre for Rural and Remote Mental Health (2017). *Rural Suicide and its Prevention: a CRRMH Prevention Paper – Summary*.

[https://www.crrmh.com.au/content/uploads/Summary\\_CRRMH-Position-Paper\\_26112017\\_FINAL.pdf](https://www.crrmh.com.au/content/uploads/Summary_CRRMH-Position-Paper_26112017_FINAL.pdf) Accessed 10 May 2018

<sup>19</sup> Hazell T et al (2017). Op cit.

<sup>20</sup> Alston M. Op cit.

<sup>21</sup> Vines, R. (2011) *Equity in health and wellbeing: Why does regional, rural and remote Australia matter?* *InPsych* 2011, Vol. 33 Issue 5

<sup>22</sup> Australian Broadcasting Corporation (2014) *Depression, anxiety and suicide in rural areas is not confined to males*

<http://www.abc.net.au/radionational/programs/archived/busstelegraph/rural-women-depression/5798586>



Accessed 10 May 2018.

<sup>23</sup> Commonwealth of Australia (2018). *Budget 2018-19 Portfolio Budget Statements 2018-19 Budget Related Paper No. 1.9 Health Portfolio*. Canberra: Commonwealth of Australia. pp 21-23

<sup>24</sup> National Rural Health Alliance. *The little book of rural health numbers: Special topic – Rural Mental Health* <http://ruralhealth.org.au/book/workforce> Accessed 10 May 2018.

<sup>25</sup> Bowers J, Lo J, Miller P, Mawren D, Jones B (2018) *Psychological distress in remote mining and construction workers in Australia*. *The Medical Journal of Australia* 2018 May 14. [Epub ahead of print]

<sup>26</sup> Rural Doctors Association of Australia. Op cit.

<sup>27</sup> Commonwealth of Australia. Op cit.