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national rural health student network

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National Priorities Paper

May 2015

the future of rural health

rhw
rural health workforce
AUSTRALIA

The NRHSN is managed by Rural Health Workforce Australia with funding from the Australian Government's Department of Health

National Rural Health Student Network

The National Rural Health Student Network (NRHSN) represents the future of rural health in Australia. It has more than 9,000 members who belong to 28 university Rural Health Clubs from all states and territories.

It is Australia's only multi-disciplinary student health network, bringing together people studying medicine, nursing and allied health, encouraging them to pursue rural health careers.

The NRHSN has two aims:

- to provide a voice for students who are interested in improving health outcomes for rural and remote Australians
- to promote rural health careers to students and encourage students who are interested in practising in rural health care.

The NRHSN and its Rural Health Clubs offer rural experience weekends, career information sessions and professional development activities as well as providing a social base for students at university and when on rural placement.

The student network leaders also advocate on behalf of health students of all disciplines - including opportunities for more rural placements and training support.

The NRHSN is managed by Rural Health Workforce Australia (RHWA) with funding from the Federal Department of Health.

Rural Health Workforce Australia

Rural Health Workforce Australia is the national peak body for the seven state and territory Rural Workforce Agencies. Our not-for-profit Network is dedicated to making primary health care more accessible by attracting, recruiting and supporting health professionals needed in rural and remote communities. RHWA is also committed to the future workforce through our support of the National Rural Health Student Network.

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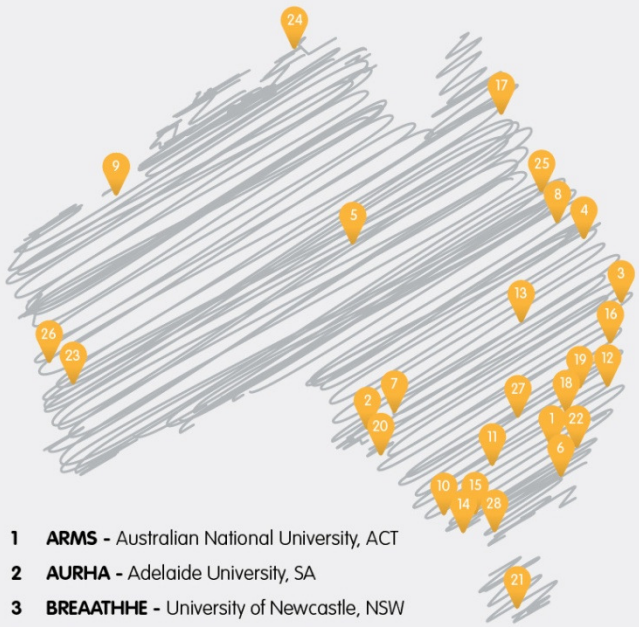
Rural Health Clubs



1 **ARMS -** Australian National University, ACT
2 **AURHA -** Adelaide University, SA
3 **BREAATHHE -** University of Newcastle, NSW
4 **BUSHFIRE -** Bond University, QLD
5 **CARAH -** Charles Darwin University, NT in assoc with Flinders University, SA
6 **CRANC -** University of Canberra, ACT
7 **FURHS -** Flinders University, SA
8 **HOPE4HEALTH -** Griffith University, QLD
9 **KRASH -** Notre Dame University, Broome, WA
10 **LARHC -** La Trobe University, Bendigo, VIC
11 **MARHS -** Charles Sturt University, Albury, NSW including La Trobe University Wodonga campus
12 **MIRAGE -** University of Sydney, NSW
13 **NERCHA -** University of New England, NSW
14 **NOMAD -** Deakin University, VIC
15 **OUTLOOK -** University of Melbourne, VIC
16 **RAHMS -** University of New South Wales, NSW
17 **RHINO -** James Cook University, QLD
18 **RHUUWS -** University of Western Sydney, NSW
19 **ROUNDS -** Notre Dame University, Sydney campus, NSW
20 **ROUSTAH -** University of South Australia, SA
21 **RUSTICA -** University of Tasmania, TAS
22 **SHARP -** University of Wollongong, NSW
23 **SPINRPHEX -** Combined Universities of Western Australia, WA
24 **StARRH -** Charles Darwin University, NT including Flinders University, SA
25 **TROHPIQ -** University of Queensland, QLD
26 **WAALHIIBE -** Combined Universities of Western Australia, WA
27 **WARRIAHS -** Charles Sturt University, Wagga Wagga, NSW
28 **WILDFIRE -** Monash University, VIC

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Executive Summary

The NRHSN welcomes continued commitment from all sides of politics and levels of government to reform the health system so that it delivers better health for Australian rural and remote communities. As the future workforce for rural health, we believe that it is important that health initiatives at both national and local levels consider the particular needs of rural and remote communities. NRHSN provides direct feedback from students across the disciplines, with insights into how this generation of up and coming health professionals want to train and work.

The NRHSN is pleased to support the National Rural Health Alliance (NRHA) vision for equivalent health and wellbeing in regional, rural and remote Australia by the year 2020. Network members additionally support efforts to close the gap in health inequity between Indigenous and non-Indigenous Australians within a generation. To support achievement of the above, the NRHSN would like to see policymakers and stakeholders take action now in the following national priority areas:

1. Rural and remote training pathways
2. Positive rural experiences
3. Aboriginal and Torres Strait Islander Health
4. Mental health training for all health students.

This National Priorities Paper outlines these key issues from the NRHSN student perspective. In doing so, it offers key recommendations to inform the rural, remote and Indigenous health reform agenda. The National Priorities Paper has been developed in consultation with members of the 28 NRHSN Rural Health Clubs. The NRHSN also has a number of other position papers on specific issues, which can be accessed by contacting the NRHSN Executive Committee or visiting the website www.nrhsn.org.au.

PRIORITY 1: Rural and remote training pathways

The Australian Government's Rural Health Workforce Audit[1] , published in April 2008, demonstrated the gross undersupply of medical practitioners, specialist nurses and allied health professionals in rural and remote areas compared to metropolitan Australia. Health Workforce Australia's Health Workforce 2025 report identified that doctor shortages and significant nursing shortages will continue, adding to these shortages will be health workforce maldistribution in rural and remote Australia[2]. This priority outlines steps recommended by the NRHSN to improve support to health students in Australia, ensuring more move into rural and remote careers.

Develop a national target: 30% of health students from a rural background

There is substantial evidence to support students coming from rural backgrounds are more likely to return to rural areas after they graduate[3][4][5]. The NRHSN encourages the Australian Government to promote policy based around this knowledge and address the differences in rural entry schemes across the country. Rural entry schemes which fail to include high school students who have attended urban boarding schools discriminate against a substantial proportion of potential rural health graduates.

The NRHSN supports current Rural Clinical Training and Support (RCTS) Program guidelines which require Universities to maintain an intake of at least 25% rural origin students for the Commonwealth Supported Places in their medical schools. The NRHSN also supports extending this intake percentage to aim for a target of 30% in line with the current rural and remote population breakdown[6]. The NRHSN would welcome the extension of the RCTS Program at a University level to support active recruitment of a greater number of rural students into all health degrees.

- **Recommendation 1:** 30% of health students should be of rural backgrounds as students from rural backgrounds are likely to return to rural areas.
- **Recommendation 2:** For current rural entry schemes to be expanded to include all health disciplines.
- **Recommendation 3:** For rural entry schemes to more fairly assess Student rurality by considering student's place of residence or where they spent a vast period of their life, not just their secondary school location and that this classification of rurality be consistent across all universities in Australia.
- **Recommendation 4**: For the RCTS Program to be extended to include all health disciplines.

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[1] Australian Government Department of Health and Ageing (2008), Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008. Commonwealth of Australia, Canberra.

[2] Health Workforce Australia (2012), Health Workforce 2025 Vol. 1.

[3] Australian Medical Workforce Advisory Committee (2002). Career decision making by doctors in their postgraduate years: A literature review. AMWAC report 2002.1, Sydney.

[4] World Health Organisation (2010), Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations. Geneva: World Health Organisation.

[5] Rabinowitz, J. Diamond, Markham F and Paynter N (2001), Critical Factors for Designing Programs to Increase the Supply and Retention of Rural Primary Care Physicians, JAMA Vol. 286, No. 9. pp. 1041-1048.

[6] Australian Bureau of Statistics (2013), Regional Population Growth, Australia 2011-2012, cat. no. 3218.0.

Ensure adequate supply of rural and remote graduate opportunities

There are currently record numbers of medical students graduating from medical schools across the country, a short-term undersupply of graduate nursing positions and an anticipated oversupply (but maldistribution) of allied health graduates[7] . There are also low numbers of allied health professionals working in rural or remote Australia with the majority working in private practice in metropolitan areas[8], limiting the number of graduate training positions outside metropolitan centres. The NRHSN acknowledges the current lack of data and research into the supply and demand of allied health practitioners in rural Australia[6] and encourages improvement in this field, so issues surrounding appropriate health care and the health workforce in rural Australia can be adequately addressed.

Vast amounts of money, energy and resources have been invested in increasing the number of medical schools and medical students across the country along with initiatives aiming to increase the positive perception and aspiration of rural careers among medical students eg. rural-focused medical schools, Rural Clinical Schools, University Departments of Rural Health, HECS-Reimbursement Schemes, John Flynn Placement Program, Rural Australian Medical Undergraduate Scholarship, Bonded Support Program, Medical Rural Bonded Scholarship and Rural Health Clubs.

Consequently more medical students are graduating with an interest in working in a rural or remote area. However, more internship, junior doctor training or specialist training positions have not been made available in these areas. This gap in the training pipeline must be rectified to prevent a significant waste of money and a continued loss of potential rural doctors back to metropolitan areas.

The NRHSN recognises that quality clinical teaching and training in public hospitals and general practice underpins medical education in Australia. Core rotations of medicine, surgery and emergency medicine must be maintained as part of the intern year with a minimum duration of 8-weeks each[9]. Providing intern training opportunities in rural and remote locations is vital in addressing the workforce shortage and encouraging rural practice long term6. In this process, it is essential that quality educational support and supervision is maintained for interns who choose to undertake these rotations ensuring they meet the 'National Training and Assessment Guidelines for Junior Medical Doctors PGY 1 and 2[10] and 'Standards for the Supervision of Prevocational Doctors in General Practice[11]. Additionally, it is vital for appropriate graduate positions for allied health and nursing students to be created and supported in rural and regional areas.

- **Recommendation 5**: For internship training options to be diversified to offer placements in general practice, Aboriginal Community Controlled Health Organisations and smaller public and private rural hospitals to provide opportunities to experience greater variety of medical practice and alleviate pressure on current teaching hospitals.
- **Recommendation 6**: For the undersupply of nursing graduate positions to be addressed by incorporating and promoting an optional rotation at a rural area into graduate program positions to allow nurses to

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[7] Mason, J (2013), Review of Australian government health workforce programs, Commonwealth of Australia: Department of Health and Ageing, Canberra.

[8] Australian Government Department of Health and Ageing (2008), Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008. Commonwealth of Australia, Canberra.

[9] Australian Medical Association (2011), Prevocational Medical Education and Training – 2011, Australian Medical Association, Canberra.

[10] Australian Government Department of Health and Ageing (2003), National Training and Assessment Guidelines for Junior Medical Doctors PGY 1and 2. Commonwealth of Australia, Canberra.

[11] The Royal Australian College of General Practitioners (2007). Standards for the Supervision of Prevocational Doctors in General Practice, South Melbourne, The Royal Australian College of General Practitioners.

experience greater variety in their training and enable extra graduates to be accommodated into graduate programs.

- **Recommendation 7:** Attracting more nursing, midwifery and allied health graduates to rural areas with positive rural incentives such as expansion of the HECS reimbursement scheme or HECS forgiveness scheme for health professionals working in an undersupplied area for a specific term.
- **Recommendation 8:** For initiation of data collection and analysis of the current allied health workforce in Australia, identifying areas of workforce shortage, training and infrastructure requirements and current distribution of services in order to better understand and support future workforce and training needs.
- **Recommendation 9:** Funding for rurally based intern training opportunities to be considered, and an increase in funding for graduate nursing and allied health roles in areas of need.
- **Recommendation 10:** For quality regional and rural training facilities to be developed that support graduates wanting to specialise and work in rural or remote areas, particularly in specialties that are most beneficial for rural and remote areas.

Rural and remote training opportunities

The NRHSN recommends that more be done to ensure continuity and clarity for health students to pursue training and careers in rural and remote Australia.

The NRHSN believes that Primary Health Networks, Rural Workforce Agencies, rural training providers, medical colleges and Local Hospital Networks play an important role in providing a smooth, easily navigable rural health career pathway. These bodies have an essential role in identifying gaps in local workforce needs including capacity within regional, rural and remote Australia to train and retain a sustainable health workforce.

One example of how agencies have worked together to meet training needs is the Queensland Rural Generalist Pathway and the proposed National Rural Advanced Training Pathway[12] which has merit in similar regards. These programs are clearly articulated, well supported and backed by competitive remuneration, which is crucial in ensuring an attractive training pathway for graduates. While these programs currently only include medical graduates, there is scope for application of similar models across disciplines to provide a complete rural health workforce.

Primary Health Networks have a key role to encourage local and regional partnerships to enhance their regions' ability to support seamless pathways for training the next generation of health professionals. The need for a more integrated approach to the employment of allied health professionals is of particular importance[7].

The NRHSN also encourages these bodies to seek feedback from health students about local training issues, to ensure initiatives that impact students have current trainee input.

- **Recommendation 11:** That rural career pathways are clearly articulated and promoted to students.
- **Recommendation 12:** That Primary Health Networks, Rural Workforce Agencies, rural training providers, medical colleges and Local Hospital Networks work together to ensure clarity, continuity and ease of navigation for health graduates wanting to pursue a rural or remote health career.
- **Recommendation 13:** That Primary Health Networks ensure partnerships and collaborations between health services, tertiary referral centres and training providers with regard to the provision of rural health workforce training.

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[12] Rural Doctors Association of Australia (2011) http://www.rdaa.com.au/Uploads/Documents/Policy%20position%20-%20RGP%20_20110408011607.pdf.

- **Recommendation 14:** That workforce planning bodies, such as Primary Health Networks, Local Hospital Networks and training providers covering rural and remote areas seek feedback from health students training in their region to ensure local training needs are met.

PRIORITY 2: Positive rural experiences

Positive rural experiences, such as placements, are integral for recruitment of health practitioners to rural practice and are among the leading factors in determining eventual rural practice[13][14]. The less time students spend in the city for their training, the greater likelihood they will pursue rural and remote practice[7].

The NRHSN recognises the importance of well-supported and positive rural placement experiences to attracting and supporting a future rural and remote health workforce. Rural and remote placements offer the opportunity for health students to further their professional development in an environment that offers many new experiences. For an individual student, a positive rural placement can stimulate an interest in rural and remote Australia as a place to practice their profession. Alternatively – a poorly supported placement can turn people away from that. Additionally, requiring students who have no interest in rural health to undertake a rural placement is counterproductive and only serves to place unnecessary strain on rural clinical training capacity.

Further information to enable optimal rural placements for health students can be found in the NRHSN's Optimising Rural Placement Guidelines. The guidelines have been developed by the NRHSN to offer a student perspective to placement providers in an effort to provide a consistently high standard of placements and can be obtained by contacting executivecommittee@nrhsn.org.au.

This section will outline key considerations with regard to ensuring students receive a positive rural experience.

Improve placements for nursing, midwifery and allied health

Nursing and allied health students continue to lack access to quality, well-supported rural placement opportunities both as part of their degree and extra-curricular opportunities. It is inequitable that these students are more likely to be required to personally organise their placements and receive less financial support for the costs of accommodation and travel.

- **Recommendation 15**: For additional rural placement programs to be established (or the guidelines for the current ones expanded) to include nursing and allied health students ensuring students across all health disciplines have equal access to placements in rural and remote communities.
- **Recommendation 16:** For rural placements to be well supported; all health students need equitable access to supervisors and clinical teachers, transport, and financial assistance.

Support rural healthcare settings to develop appropriate capacity to train students in two tiers

Capacity needs to be built to enable regional and rural centres to accommodate different length and tiered placements during health student training. The NRHSN recommends that all health degrees include a rural health curriculum that provides rural/remote exposure in two tiers. Firstly, an early (first or second year) rural placement to facilitate the breakdown of stigmas associated with rural practice. Secondly, a longer-term rural placement that affords interested students the opportunity to become integral members in a rural community.

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[13] Australian Medical Workforce Advisory Committee (1998), Influences On Participation In The Australian Medical Workforce, AMWAC Report 1998.4, Sydney, p9.

[14] Eley D and Baker P (2006), Does recruitment lead to retention? – Rural Clinical School training experiences and subsequent intern choices, Rural and Remote Health 6:511.

It is essential that rural health services have an understanding of the type of placements it wishes to support when designing clinical training infrastructure.

It is becoming more evident that the longer students are supervised in rural settings, the better it is for postgraduate rural choices. A consistent theme in recent literature is the suggestion that longer placements generate better outcomes[15][16]. Infrastructure to support longer rural student placements should build on successful models such as University Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS). Given many UDRH and RCS placements are becoming oversubscribed and some regions lack a connection with a UDRH, the NRHSN sees opportunity for expansion of the UDRH and RCS programs.

- **Recommendation 17:** Increase the number of longitudinal health student placements available through both the establishment of new sites and the extension of existing sites within the UDRH and RCS programs. Increases must be accompanied by a proportional increase in funding to enable the program to service more students and more sites.

Ensure provision of appropriate accommodation and educational resources at rural training sites

Health services in rural and remote communities which currently or are looking to accommodate health students during their training must be equipped with the necessary infrastructure to ensure students have access to a quality, well-supported educational experience. Students training in such areas will need access to tutorials, lectures and other learning opportunities just like their metropolitan counterparts. It is vital that the infrastructure is there to support them so they do not feel educationally disadvantaged on their placements.

As outlined in the Mason Review[7] there is a continuing need for multidisciplinary student accommodation to support rural placements. It is essential that accommodation be close to the practice/hospital where the student will be undertaking their clinical placement and is provided free of charge or at a minimal/subsidised cost.

- **Recommendation 18:** For rural and remote health settings to be supported to provide secure computing facilities with fast, reliable broadband internet access, and quality IT and videoconferencing facilities to interact with tertiary education institutions.
- **Recommendation 19:** For quality accommodation to be provided for all health students undertaking rural placements free of charge or at a minimal/subsidised cost. Ensure accommodation is close to the hospital or practice location.

Inter-professional education and co-placements

There are significant benefits in inter-professional education as a method for training and preparing current health students for future practice, as well as creating a broader support network for health students during their placement in rural areas. Research overseas and in Australia suggests that inter-professional education

[15] Playford, D. E., and Cheong, E. (2012). Rural Undergraduate Support and Coordination, Rural Clinical School, and Rural Australian Medical Undergraduate Scholarship: rural undergraduate initiatives and subsequent rural medical workforce. Australian Health Review, 36(3), 301-307.

[16] Smedts, A. M., and Lowe, M. P. (2008). Efficiency of clinical training at the Northern Territory Clinical School: placement length and rate of return for internship. Medical Journal of Australia, 189(3), 166-168.

can have an impact on effective team work, career attitudes and intent to work in rural locations[17][18]. It is important that any new development of health infrastructure in rural communities considers inter-professional training. Local accommodation, educational infrastructure, teaching spaces, and resources can be designed and shared in such a way to promote interaction and interdisciplinary collegiality among students across the health disciplines when placed in the same community. Inter-professional education should be encouraged across institutions including universities, TAFE and other organisations which train health workers.

- **Recommendation 20:** Create a national inter-professional learning (IPL) policy to drive change within educational institutions for IPL to become a larger part of the training of health professionals.
- **Recommendation 21:** Promote greater collaboration between health services and institutions involved in placing medical, nursing and allied health students and graduates to improve student access to infrastructure supporting interdisciplinary learning. This should be encouraged when applying for rural health infrastructure grants.

[17] Shannon, C. K., Baker, H., Jackson, J., Roy, A., Heady, H., and Gunel, E. (2005). Evaluation of a required statewide interdisciplinary rural health education program: student attitudes, career intents and perceived quality. Rural Remote Health, 5(4), 405.

[18] McNair, R., Stone, N., Sims, J., and Curtis, C. (2005). Australian evidence for interprofessional education contributing to effective teamwork preparation and interest in rural practice. Journal of Interprofessional Care, 19(6), 579-594.

PRIORITY 3: Aboriginal and Torres Strait Islander workforce

NRHSN policy states that all Australians have a right to access appropriate and high quality health care[19]. This includes Indigenous Australians and therefore eliminating the disparities between Aboriginal and Torres Strait Islander peoples and the general population should be a key national priority[20]. Comprehensive training of health students from all disciplines must provide opportunities that facilitate the development of clinically and culturally competent professionals, who are confident in all aspects of Aboriginal and Torres Strait Islander health.

Addressing health inequalities between Indigenous and non-Indigenous Australians is a generational issue[21]. It requires a change in the culture of learning for the next generation of health professionals, to foster health professionals who are critical thinkers and informed with regards to the social, historical, environmental, political and cultural determinants of Aboriginal and Torres Strait Islander health[22]. This vision should be a core objective to all individuals involved with 'closing the gap' and is a crucial element to Aboriginal and Torres Strait Islander health reform.

A significant investment of time and effort into the development of the future health workforce[23] is required. A health workforce that truly addresses the needs of Aboriginal and Torres Strait Islander peoples will provide significant benefits and opportunities for Indigenous and non-Indigenous patients, students and health professionals.

This section will focus on the changes needed to drive the development of the Indigenous regional, rural and remote health workforce.

Recruitment, retention and graduation of Aboriginal and Torres Strait Islander students

Whilst an increasing number of institutions provide opportunities for Aboriginal and Torres Strait Islander peoples studying health programs, the number of Indigenous students in these courses is still minimal compared to non-Indigenous Australians[24]. Approximately 2.5% of the Australian population identifies as Aboriginal and Torres Strait Islander[25] yet they represent only 1.8% of the national health workforce as of 20117. This gap is even more severe in many disciplines. For example, only 0.2% of medical practitioners, 0.8% of registered nurses and 0.2% of dental practitioners are Indigenous, indicating an urgent need for increased training of Aboriginal and Torres Strait Islander health professionals7. Increasing the Indigenous health workforce is a key element in achieving better health outcomes in the Aboriginal and Torres Strait Islander population[7].

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[19] NRHSN Indigenous Health Policy (2010), Melbourne VIC.

[20] Minniecon D, Kong K (2005) Healthy Futures: Defining best practice in the recruitment and retention of Indigenous medical students, Canberra ACT, Australian Indigenous Doctors Association.

[21] Calma T (2010) 2010 Chalmers Oration – What's needed to close the gap? Rural and Remote Health 10, 1586

[22] Carson B, Dunbar T, Chenhall R and Bailie R (2007) Social determinants of Indigenous Health, Sydney NSW, Menzies School of Health Research.

[23] Calma T (2005) Social Justice Report, Aboriginal and Torres Strait Islander Social Justice Commission, Sydney NSW

[24] Drysdale M, Faulkner S and Chesters J (2006) Footprints forwards: Better strategies for the recruitment, retention and support of Indigenous medical students, Moe VIC, Monash University of Rural Health.

[25] Australian Bureau of Statistics, 2075.0 – Census of Population and Housing – Counts of Aboriginal and Torres Strait Islander Australians, ABS, 2011.

- **Recommendation 22:** For there to be an increased focus on attracting and retaining Aboriginal and Torres Strait Islander students into and through health courses to graduation; so that the representation of Aboriginal and Torres Strait Islander students across health disciplines reaches parity with the representation of Aboriginal and Torres Strait Islander people in the Australian population.
- **Recommendation 23:** For there to be continued support for programs that promote early engagement with health careers in both primary and secondary education such as through high school visits and mentoring.
- **Recommendation 24:** For development and implementation of national guidelines for flexible entry schemes in to medical and health courses.

Cultural training and competency throughout all levels of health education

The paucity and inconsistency of curriculum and training opportunities in Aboriginal and Torres Strait Islander health, along with lack of community and clinical placements in this area are major barriers precluding the motivation of health students to work in Indigenous health settings. Vertical integration of curriculum and professional development of health students in Aboriginal and Torres Strait Islander health needs to be considered[26].

- **Recommendation 25:** For an integrated Indigenous health curriculum (as per the Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Curriculum Framework) to be facilitated by all health education providers, applying these principles across all health disciplines.
- **Recommendation 26:** For tertiary education institutions to ensure training in culturally appropriate and safe practices for all health students entering the workforce. Subsequent long-term evaluation should be carried out by the tertiary institute to assess sustainability of culturally competent practices[27].
- **Recommendation 27:** For there to be increased clinical placement opportunities in Aboriginal and Torres Strait Islander health across primary, secondary and tertiary health services in regional, rural and remote contexts that are beneficial, educational and safe for the community and the student.
- **Recommendation 28:** For universities and graduate training providers to engage with professional peak bodies to ensure vertical integration of Indigenous health content throughout health professional training pathways.

Indigenous leadership, community relationships and infrastructure

Commitment to Indigenous health must be implemented at an institutional level. Lack of institutional and faculty commitment to Indigenous health, along with limited Aboriginal and Torres Strait Islander academic and administrative positions within institutions has been noted as a major contributor to the lack of motivation of health students to work in Indigenous settings[20]. In addition, strong networks and relationships between institutions and local Aboriginal medical services and other key community organisations are needed in order to improve the future health workforce[28]. These will provide opportunities for better Aboriginal and Torres Strait Islander teaching resources, clinical placements and student support.

- **Recommendation 29:** Promote institutional commitment to Aboriginal and Torres Strait Islander health and social priorities (eg. Reconciliation Action Plan)

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[26] Personal Interview, Associate Professor Ngiare Brown, June 4th 2011.

[27] Durey A. Reducing racism in Aboriginal health care in Australia: where does cultural education fit? Australian and New Zealand Journal of Public Health. 2010 Jul;34 Suppl 1:S87-92.

[28] Eckemann A, Dowd T, Chong E, Nixon L, Gray R, Johnson S (2010) Binan Goonj: Bridging cultures in Aboriginal health, Sydney NSW, Elsevier Australia.

- **Recommendation:** Training bodies should ensure a clear commitment to addressing issues pertaining to recruitment and education (as outlined in 3.1.1).
- **Recommendation 30:** Universities and other health training organisations should ensure the appointment and support of qualified, competent and motivated Aboriginal and Torres Strait Islander academic positions. Such academic positions should be supported by the Indigenous community and aim to address the recruitment of Indigenous students, Indigenous curriculum and teaching.
- **Recommendation 31:** For there to be a co-ordinated and equitable approach to financial support for Aboriginal and Torres Strait Islander students across all health disciplines.
- **Recommendation 32:** Universities and other health training organisations should prioritise the development and maintenance of relationships with the local Indigenous communities, including Aboriginal medical services and other relevant Indigenous health organisations. This will provide students with the opportunity to experience Indigenous health settings with confidence and institutional support via these partnerships.

PRIORITY 4: Mental health training for all health students

Mental health research, awareness, individual resilience and training for health students are key areas which the NRHSN recognises as requiring immediate attention. It must be ensured that health Student who desire to work in rural or remote areas are equipped with the appropriate knowledge and skills to effectively manage mental health issues (their own and their patients). This is imperative to developing a competent and sustainable future rural health workforce.

The NRHSN, in partnership with Beyond Blue, produced 'When the Cowpat Hits the Windmill' a mental health guide by students for students. Further, Mental Health nights, Mental Health First Aid and Applied Suicide Intervention Skills Training have become more regular and popular features of Rural Health Club events. This section will outline what the NRHSN believes should be done to help make mental health for health students a national priority.

Better understand mental health issues affecting all health students

In addition to demands associated with balancing study with relevant family, work, social, and financial commitments, our experience indicates that students in health degrees can be at particular risk of mental health issues[29]. The significant number of contact hours, volume of learning materials and clinical placement requirements attached to many health courses challenge the life management skills of students undertaking them and place these young Australians at increased risk of reduced mental health and wellbeing9. Feelings of isolation that may accompany rural placements involving a move away from family, friends and other regular support structures may add further stress9. In addition, certain personality traits common among health students have been found to place them at increased risk of mental health problems[30].

Rural origin students may also be at increased risk as they must often additionally cope with the pressures associated with relocation in order to attend tertiary studies9.

While there is emerging evidence supporting the prevalence of depression and anxiety among medical students and junior doctors[31], there is a considerable lack of understanding of the extent of mental health challenges experienced by students and professionals of the other health disciplines.

- **Recommendation 33:** Research is required into the mental health challenges experienced by health students during tertiary study and rural placements.

Prioritise mental health first aid training for all health students

Promotion and training in mental health must occur at the university level as it is integral to the development of resilient, healthy and confident practitioners. Students equipped with practical knowledge and basic skills to manage their own mental health and those around them will be valuable assets to the future health workforce. Greater confidence in handling mental health issues is especially significant for students who will later work in

[29] Frazer S, Johnson S (2011) Investing in the future – promoting mental wellbeing for students, by students: Proceedings of the 11th National Rural Health Conference, Perth, Australia, March 2011, accessed 30/6/2011, http://nrha.org.au/11nrhc/papers/11th%20NRHC%20Frazer_Stephanie_B1.pdf.

[30] Henning K, Ey S, Shaw D (1998) Perfectionism, the imposter phenomenon and psychological adjustment in medical, dental, nursing and pharmacy students. Medical Education 32: 456-464.

[31] Elliot L, Tan J, Norris S (2010) The mental health of doctors: A systematic literature review, *beyondblue*.

rural and remote Australia. They will be more likely to take roles as mental health champions and advocates in their communities, areas that are traditionally underserviced in the realm of mental health[32].

The NRHSN sees an urgent need for mental health training to be made more widespread and accessible to all health students, as it may help reduce the stigma of mental illness and encourage future health professionals to actively pursue greater mental health literacy.

Mental Health First Aid is an internationally recognised course, which increases mental health literacy through improving participant understanding of common mental health problems and confidence to recognise and respond to various mental health scenarios. Investment in Mental Health First Aid and similar training for health students will support greater levels of mental wellbeing among health students on placement and in their future careers, preventing the likelihood of experiencing professional burnout.

- **Recommendation 34:** Ensure all health students undertake mental health training during their degree to stimulate resilience and increase awareness of challenges experienced by healthcare professionals whilst developing skills to support self and colleagues

[32] Australian Government Department of Health and Ageing (2009).Fourth National Metal Health Plan-An agenda for collaborative government action in mental health 2009-2014. Commonwealth of Australia, Canberra.