Dear Pothida,

As discussed at the Community Affairs Committee

a. An academic publication describing the location of Podiatrists, Occupational Therapists and Physiotherapists in South Australia.
b. A commentary paper outlining how access to psychological treatments -Behavioural Activation- for common mental health conditions could be increased.
c. Information about an online program which can prepare non-specialist workers to practice Behavioural Activation. https://study.unisa.edu.au/short-courses/professional-certificate-in-behavioural-activation-for-depression/

If you require further information, please do not hesitate to get in touch

Many thanks

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ORIGINAL RESEARCH

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Geographical distribution of 3 allied health professions in South Australia: A summary of access and disadvantage

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Abstract

Objective: To describe the distribution of 3 allied health professionals—occupational therapists, physiotherapists and podiatrists—in South Australia stratified by the Modified Monash Model and the Index of Relative Socio-Economic Disadvantage.

Design: A descriptive data linkage cross-sectional study.

Setting: The state of South Australia, Australia.

Participants and main outcome measures: Distribution of the 3 registered allied health professional groups stratified by Modified Monash Model and Index of Relative Socio-Economic Disadvantage.

Results: The largest proportion of the 3 allied health professional groups (occupational therapists, physiotherapists and podiatrists) were found in areas classified as Modified Monash 1 and Modified Monash 2 (86.5%). The lowest proportion of allied health professionals were found in Modified Monash 7. The largest number of allied health professionals per 10 000 population was found in areas classified as Modified Monash 1 and Modified Monash 2. The lowest number of allied health professionals per 10 000 population was found in Modified Monash 7 areas. The largest number of allied health professionals per 10 000 population was found in areas with Index of Relative Socio-Economic Disadvantage quintile 2, while the lowest number of allied health professionals per 10 000 population was found in areas with Index of Relative Socio-Economic Disadvantage quintile 1.

Conclusions: The distribution of allied health professionals according to geographical remoteness, socio-economic disadvantage and per 10 000 population varies widely in South Australia. The number of allied health professionals per 10 000 population was lowest in rural and remote/very remote areas, explaining the typically poor access to allied health services for communities in these areas. The number of allied health professionals per 10 000 population according to Index of Relative Socio-Economic Disadvantage was variable within the context of both urban and rural areas.

KEYWORDS
allied health professionals, geographical distribution, health workforce distribution, Modified Monash Model, socio-economic disadvantage, South Australia

1 | INTRODUCTION

Allied health professionals (AHPs), such as occupational therapists, physiotherapists, podiatrists, pharmacists and psychologists, comprised approximately 22.8% of the registered health practitioners in Australia in 2018.[1] AHPs play a significant role in the provision of allied health services in primary care, hospitals, private practice, community health and in-home care. AHPs, alongside nurses and doctors, are the main part of Australia's health system that provides safe and affordable health care for all Australians. The health status of Australians is determined by where they live. Australians living in rural communities have shorter lives and have poorer health than people living in metropolitan centres.[2] This is partly explained by the availability and accessibility of health services. In Australia, allied health services and the number of AHPs vary according to geographical locations. For instance, when compared to metropolitan areas, people living in rural, remote and very remote areas have poorer access to health services.[2] When compared to major cities, the clinical full-time equivalent rate of AHPs is lower in regional, remote and very remote areas.[2]

A comprehensive and adequately skilled allied health workforce is essential to support people living with long-term health conditions. Perhaps more so in rural Australia where residents experience high levels of long-term physical and mental health conditions.[3,4] A shortage of health workforce, including AHPs, can affect health service delivery with implications for the adverse health of the population in Australia.

Several members of the Organisation for Economic Co-operation and Development, including Australia, have introduced policies aimed at recruiting and retaining health workers to live and work in communities that experience health inequalities, particularly in rural areas.[5] In Australia, the Rural Health Multidisciplinary Training (RHMT) program, which is a national program aimed at delivering this objective, has been in place for the past 2 decades.[6] An independent review of the RHMT program conducted in 2020 highlighted the success of the program and recommended continued investment in rural communities.[7] The review emphasised the role of the RHMT in investing in communities experiencing workforce shortages, including AHPs. The review also mentioned the program's role in supporting the social and economic infrastructure in rural Australia.

What is already known on this subject:

- Health workforce maldistribution and shortage might lead to poorer health outcomes in socio-economically disadvantaged and rural communities
- Allied health professionals have an important role in providing services to Australian communities within a range of settings, including hospitals, private practice, community health and in-home care
- Despite the public availability of data sources on workforce location and socio-economic status, there are limited insights into the distribution of allied health professionals according to access, population and socioeconomic factors in South Australia

What this study adds:

- The distribution of allied health professionals according to geographical access, socio-economic disadvantage and population varies widely in South Australia
- Although the number of allied health professionals per 10 000 population was lowest in rural and remote/very remote areas, the number of allied health professionals varied according to Index of Relative Socio-Economic Disadvantage quintiles within areas classified as 'metropolitan' and 'regional centres' (Modified Monash 1 and Modified Monash 2), as well as within areas that range from 'large rural towns' (Modified Monash 3) to 'very remote communities' (Modified Monash 7)
- The presence of a higher number of allied health professionals per 10 000 population in 'metropolitan' and 'regional centres' areas might indicate the better employment opportunities available in those communities

The geographical distribution of health workforce has been reported using different data sources in Australia. For instance, a study conducted by Joyce and Wolfe[8] using

census data from 1996 and 2001 described the geographical distribution of medical and non-medical primary health professions. Moreover, 2 reports[9,10] by the Australian Institute of Health and Welfare used the National Health Workforce data set and Geographically Adjusted Index of Relative Supply to describe the proportion of allied health workforce in 2012 and to examine the geographical supply of the clinical health workforce in 2014 in Australia, respectively. However, increasing the understanding of the distribution of the health workforce by socio-economic status could help us better understand whether the workforce is located in communities experiencing the greatest health need. A 2020 review by Gillam et al[11] concluded that data sets are available to help us understand workforce location and better use of these data sources could assist workforce and service planning. In South Australia, there are limited insights into the distribution of AHPs according to access, population distribution and socio-economic factors. In this study, we use linked data from different sources to describe the distribution of 3 allied health disciplines (occupational therapists, physiotherapists and podiatrists) by geographical location, population and socio-economic status in South Australia.

2 | METHODS

2.1 | Data source

We linked data from 3 sources: (a) the public registry data of 3 AHPs (occupational therapists, physiotherapists and podiatrists) obtained from the Australian Health Practitioner Regulation Agency (AHPRA); (b) the Modified Monash Model (MMM) 2019 data from the Australian Department of Health; and (c) the Socio-Economic Indexes for Areas (SEIFA) data obtained from the Australian Bureau of Statistics (ABS) based on the 2016 census. SEIFA ranks areas according to relative socio-economic advantage and disadvantage and consists of 4 indexes. These include the Index of Relative Socio-Economic Disadvantage (IRSD), the Index of Relative Socio-Economic Advantage and Disadvantage, the Index of Education and Occupation and the Index of Economic Resources. The AHPRA data were extracted in April 2021, which was de-identified. The MMM categories and each SEIFA index quintile were combined with AHPRA data based on the practitioners' principal place of practice. Only 3 AHPs were included in this study because of limited funding to obtain the data from AHPRA. The AHPs were chosen because they typically have a key role in the management of long-term physical health conditions such as diabetes, cardiovascular disease and arthritis, which all are common conditions in rural areas.[3]

2.2 | Study variables

The outcome measure of interest was the distribution of AHPs stratified by the MMM and the IRSD. The MMM is a measure of location according to geographical remoteness and town/population size. The model quantifies remoteness and population size on a category scale of MM 1–7, which is based on the Australian Statistical Geography Standard-Remoteness Areas framework. MM 1 indicates the location is a 'metropolitan,' and MM 7 indicates the location is a 'very remote communities.' A detailed description about the MMM can be accessed online.[12]

The IRSD is one of the 4 SEIFA indexes generated by ABS. IRSD summarises several variables (indicators of disadvantage) regarding the economic and social conditions of people and households within an area. IRSD only considers measures of relative disadvantage. A low IRSD score (quintile 1) indicates a relatively greater disadvantage, while a high IRSD score (quintile 5) indicates relatively least disadvantage within an area. We categorised the IRSD deciles into quintiles for the purpose of this study. The details about the SEIFA indexes, including IRSD, can be accessed online.[13]

2.3 | Statistical analysis

We first summarised the proportion of the overall AHPs and each discipline by MM categories and IRSD quintiles. Next, we calculated the proportion of AHPs by IRSD quintiles within the level of 2 MM subcategories, representing 'metropolitan' and 'regional centres' areas (MM 1 and MM 2), as well as rural and remotes areas (MM 3-7) in South Australia. Finally, we calculated the number of AHPs per 10 000 population according to MM categories and IRSD quintiles. Statistical analysis was conducted using Stata/SE version 17 (StataCorp, College Station).

2.4 | Ethics approval

Ethics approval for this study was exempted by the University of South Australia's Human Research Ethics Committee.

3 | RESULTS

3.1 | Proportion of AHPs according to MMM

The majority of AHPs in South Australia registered with AHPRA were found to be practising in MM 1 and MM

2 areas (Table 1). The lowest proportion of AHPs (0.2%) were found in MM 7. The proportion of AHPs varies widely in areas classified from MM 3-7.

3.2 | Number of AHPs per 10 000 and MMM

The number of AHPs per 10 000 population within MMM categories is presented in Figure 1. The largest number of AHPs per 10 000 population was found in areas classified as MM 1 and MM 2 (34.8), while the lowest number of AHPs per 10 000 population (5.1) was in MM 7 areas. In terms of the distribution of the specific AHPs per 10 000 population, MM 1 and MM 2 had the largest number of occupational therapists (12.4), physiotherapists (19.0) and podiatrists (3.4), while MM 7 had the smallest number of occupational therapists (2.2), physiotherapists (2.2) and podiatrists (0.6) per 10 000 population (Figure 1).

3.3 | Number of AHPs per 10 000 and IRSD

The number of AHPs per 10 000 population stratified by IRSD quintiles is presented in Figure 2. The largest number of overall AHPs per 10 000 population was found in areas with IRSD quintile 2 (38.0), while the IRSD quintiles 3, 4 and 5 had similar number of overall AHPs per 10 000 population (Figure 2).

3.4 | Number of AHPs per 10 000 population stratified by IRSD and MMM

Figure 3 shows the number of AHPs per 10 000 population stratified by IRSD quintiles in areas classified as MM 1 and MM 2. IRSD quintile 2 had the highest number of overall AHPs per 10 000 population (46.5) within areas classified as MM 1 and MM 2 in South Australia.

On the contrary, for areas classified from MM 3-7, IRSD quintile 1 had the highest number of overall AHPs per 10 000 population, while IRSD quintiles 4 and 5 had the lowest number of AHPs per 10 000 population (Figure 4).

4 | DISCUSSION

We used data from the public registry data of 3 AHPs (occupational therapists, physiotherapists and podiatrists) from AHPRA, linked with the MMM and IRSD data from the ABS at the level of principal place of practice, to describe the distribution of AHPs in South Australia. To the best of our knowledge, this is the first study in South Australia, which has linked the available data sources to describe the distribution of occupational therapists, physiotherapists and podiatrists according to MM categories and IRSD quintiles. The findings of our study provide the first contribution to ongoing scientific discourse regarding the distribution of AHPs in South Australia.

The distribution of AHPs, according to geographical access and area-level socio-economic position and per 10 000 population, varied widely in South Australia. The number of AHPs per 10 000 population was lowest in areas that range from 'large rural towns' (MM 3) to 'very remote communities' (MM 7). This might explain the generally poor access to allied health services for communities in these areas. The number of AHPs per 10 000 population was highest in 'metropolitan areas' and 'regional centres' (MM 1 and MM 2), and this might reflect employment opportunities in these areas.

The number of AHPs per 10 000 population varied widely according to IRSD quintiles within areas classified as both 'metropolitan' and 'regional centres' (MM 1 and MM 2), as well as within areas that range from 'large rural towns' (MM 3) to 'very remote communities' (MM

TABLE 1 Proportion of total population and allied health professionals (AHPs) by Modified Monash (MM) categories in South Australia

	Profession				
MM categories	Occupational therapist N (%)	Physiotherapist N (%)	Podiatrist N (%)	Overall AHPs N (%)	Total population in SA N (%)
MM 1 and 2	1566 (86.5)	2395 (86.7)	424 (84.1)	4385 (86.3)	1 259 742 (75.5)
MM 3	115 (6.4)	153 (5.5)	32 (6.4)	300 (5.9)	133 040 (8.0)
MM 4	47 (2.6)	74 (2.7)	19 (3.8)	140 (2.8)	57 315 (3.4)
MM 5	58 (3.2)	97 (3.5)	24 (4.8)	179 (3.5)	161 152 (9.7)
MM 6	20 (1.1)	40 (1.4)	4 (0.8)	64 (1.3)	38 254 (2.3)
MM 7	4 (0.2)	4 (0.1)	1 (0.2)	9 (0.2)	17 786 (1.1)
Total	1810 (100.0)	2763 (100.0)	504 (100.0)	5077 (100.0)	1 667 289 (100.0)

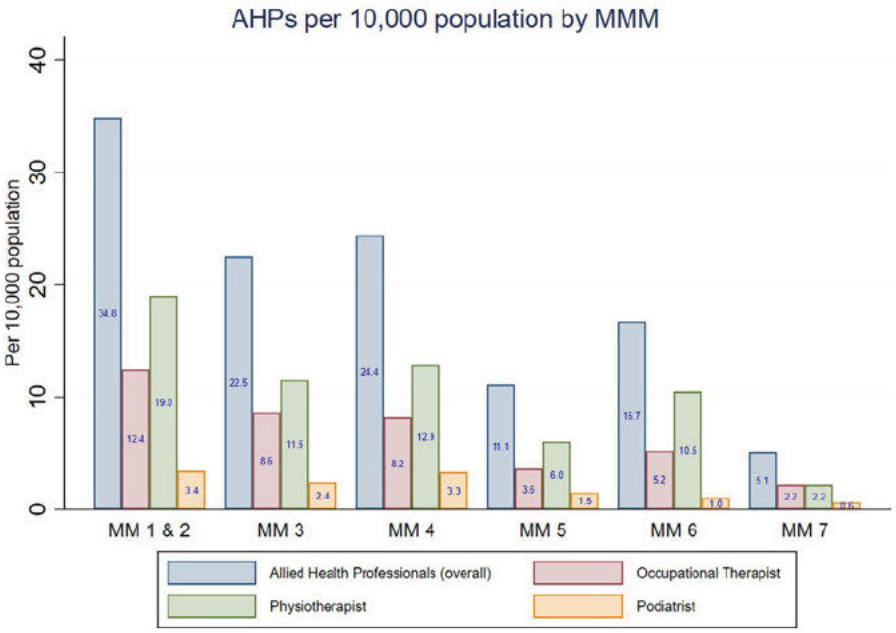

FIGURE 1 Distribution of allied health professionals (AHPs) stratified by per 10 000 population and Modified Monash (MM) in South Australia

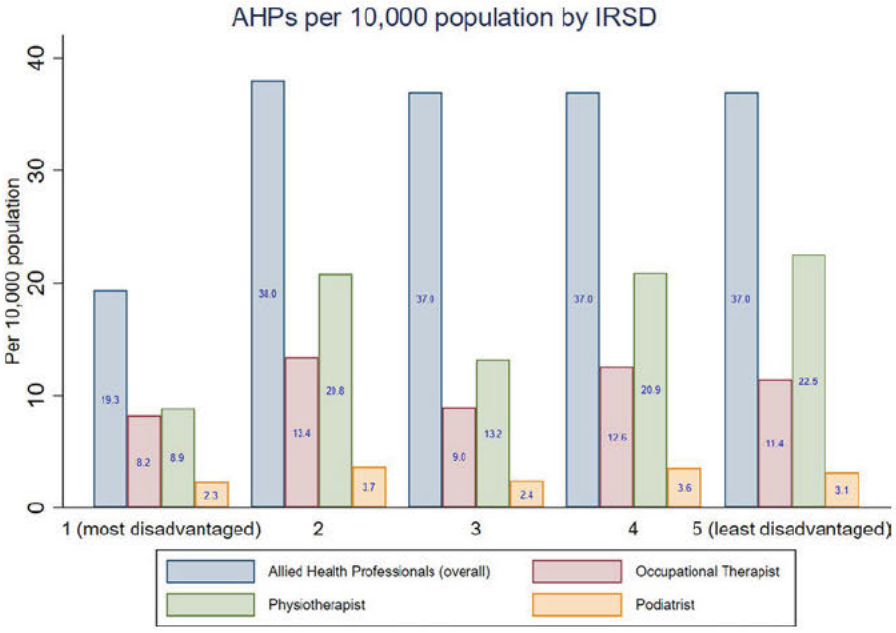

FIGURE 2 Distribution of allied health professionals (AHPs) stratified by per 10 000 population and Index of Relative Socio-Economic Disadvantage in South Australia

7). These findings might indicate the presence of maldistribution of AHPs based on socio-economic disadvantage irrespective of geographical remoteness and town size. In MM 1 and MM 2 areas, the AHP density was lowest in the areas with the most disadvantaged quintile, whereas in MM 3-7 areas, the AHP density was highest in areas with the most disadvantaged quintile. These findings show the presence of a different pattern in the distribution of the AHPs stratified by IRSD quintiles among areas classified as MM 1-2 and MM 3-7. The high AHP density in areas with most disadvantaged quintile in MM 3-7 might be due to that these disadvantaged areas such as Whyalla and Port Augusta act as rural health hub in South Australia.

A previous comprehensive review conducted in developed countries by Smith et al[14] found that intra-rural health differentials can be as noticeable as those between rural and urban areas, and rurality by itself does not always explain health disadvantage. Moreover, the review indicated that the health status of a community is related to other factors than just geographical location. Poorer health conditions can be due to a combination of different factors such as higher level of socio-economic disadvantage, ethnicity and poorer access to health services.[14] A 2013 study conducted by Tideman et al[15] compared cardiovascular (CVD) risk and mortality in the Greater Green Triangle of South-Western Victoria and North-West Adelaide, representing rural and metropolitan areas, respectively. They found that lower measures of socio-economic status were associated with worse CVD outcomes regardless of geographical location. This might suggest that policies

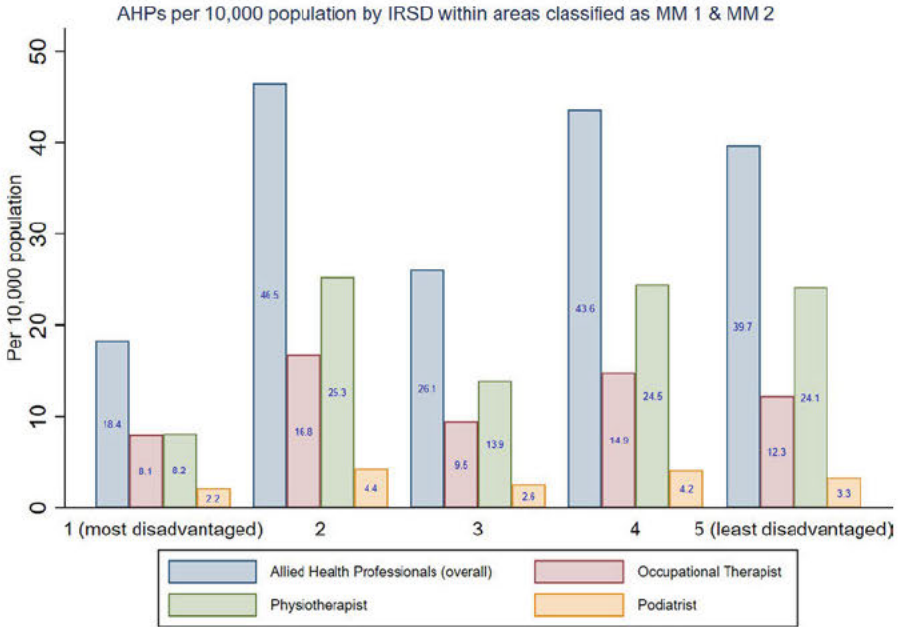

FIGURE 3 Distribution of allied health professionals (AHPs) stratified by per 10 000 population and Index of Relative Socio-Economic Disadvantage (IRSD) in the areas classified as Modified Monash (MM) 1 and MM 2 (metropolitan areas and regional centres) in South Australia

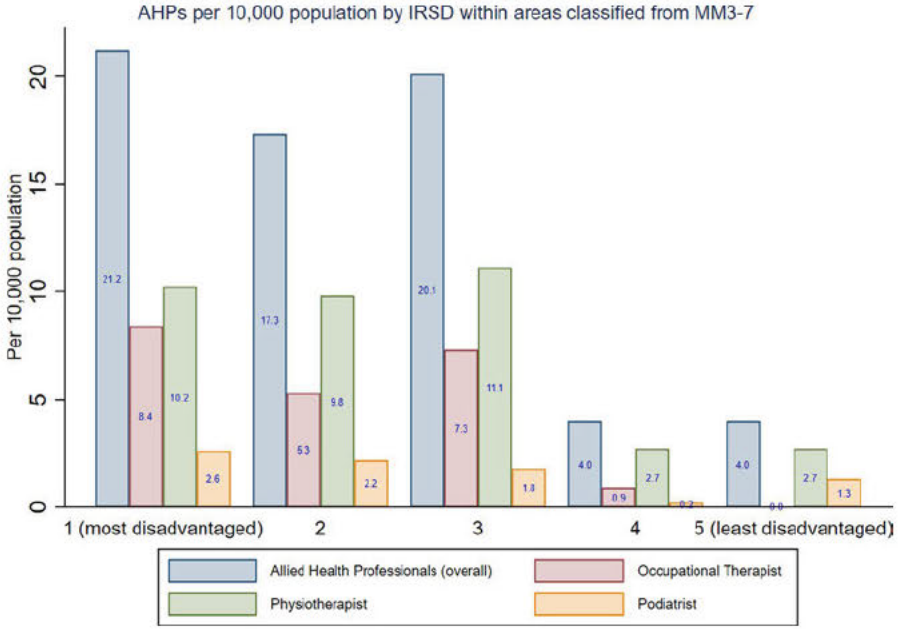

FIGURE 4 Distribution of allied health professionals (AHPs) stratified by per 10 000 population and Index of Relative Socio-Economic Disadvantage (IRSD) in the areas classified from Modified Monash (MM) 3-7 (rural and very remote areas) in South Australia

designed to improve health inequality in rural Australia need to address both social disadvantage and workforce shortages in those communities.

Several reviews[16,17] that focus on examining factors affecting recruitment and retention of the rural health workforce, as a strategy to address workforce maldistribution, have been conducted. A 2020 scoping review conducted by Walsh et al[5] examined the effectiveness of national policies to address rural allied health, nursing and dentistry workforce maldistributions. They reported that the effectiveness of such policies was unclear with evaluations of such policies time-limited and not completed at scale.

We found a larger number of AHPs per 10 000 population in 'metropolitan' and 'regional centres' areas with IRSD quintile 2, while IRSD quintiles 4 and 5 in these areas had also a relatively high number of AHPs per 10 000 population in South Australia. Although the absolute number of the AHPs is relatively low, the number of AHPs per 10 000 population according to IRSD quintile 1 (most disadvantaged) was high within areas that range from 'large rural towns' (MM 3) to 'very remote communities' (MM 7). It is unclear whether this is due to AHPs spending a significant proportion of their time providing outreach services and reporting this as their principal place of practice or whether they are living in these areas. Access to allied health services for people living in some areas classified from MM 3-7 is problematic due to remoteness. Moreover, the socio-economic disadvantage in MM 1-2 and MM 3-7 is different. For instance, compared with 'metropolitan' areas, there are higher rates of

unemployment in some areas classified from MM 3-7. Policies aimed at addressing health inequalities in rural areas should also address the socio-economic disadvantages. Moreover, AHPs who based their practice location in MM 3-7 should receive professional and infrastructural support to enable them to better serve communities where they are practising. In areas where AHPs' principal place of practice are not based, provision of professional support, fly-in/fly-out model-based practice and televideo support might help to provide clinical services to communities. However, this approach would not necessarily strengthen the social capital of those communities.

The strengths of this study include the use of public registry data of AHPs (occupational therapists, physiotherapists and podiatrists) from AHPRA, linked with publicly available national data from the Australian Department of Health and the Australian Bureau of Statistics. As it is a requirement for all APHRA-registered professions to annually update their registration status, we are confident that the data are contemporary. The use of these linked data obtained from different sources allowed us to provide a new insight into the distribution of AHPs stratified by MMM and IRSD in South Australia. A 2021 study by Versace et al[18] used a similar approach to describe the population distribution and socio-economic position of residents across Australia, stratified by MMM classifications. Our combined use of the MMM and IRSD index system to describe the distribution of AHPs in South Australia likely strengthens the findings of our study to better inform public health policy.

This study has some limitations. First, we only described the distribution of 3 disciplines (occupational therapists, physiotherapists and podiatrists). It would be useful to include other registered allied health professionals, such as pharmacists, clinical psychologists and social workers in future studies. While psychologist data can be extracted from AHPRA, extracting social workers' data would need a different approach to access the primary place of practice since they are not registered with AHPRA. As our study did not include the data for psychologists and pharmacists, we missed important information about the distribution of these groups of health workers in South Australia. Future work in this area needs to include all AHPRA-registered health workforce to provide comprehensive information regarding the distribution of health workforce according to geographical remoteness and socio-economic disadvantage in South Australia. Second, there might be several AHPs who practise in rural and remote areas but live in metropolitan areas. As the data of AHPs, in this study, are based on principal place of practice, we did not capture the distribution of AHPs practising in areas other than their principal place of practice. It would be important to explore and use potential data sources that include both AHPs' place of practice and place of residence when describing the distribution of health workforce by MMM and IRSD in future research. Third, as our study only focused on describing the distribution of AHPs, further work is needed to understand other factors associated with the distribution of AHPs, and why they vary according to socio-economic disadvantage, population distribution and geographical locations. Finally, as areas in other states could be classified differently by both MMM and IRSD, it is important to conduct similar studies for the whole of Australia to examine the pattern of allied health workforce distribution in rural and urban areas.

5 | CONCLUSIONS

The distribution of AHPs according to geographical access, socio-economic disadvantage and per 10 000 population varies widely in South Australia. The number of AHPs per 10 000 population was lowest in rural and remote/very remote areas, which might explain poor access to allied health services for communities living in these areas. The number of AHPs per 10 000 was highest in 'metropolitan' areas, perhaps reflecting better employment opportunities. There was a high disparity in the number of AHPs according to IRSD quintiles within areas classified as both 'metropolitan' and 'regional centres' (MM 1 and MM 2), as well as within areas that range from 'large rural towns' (MM 3) to 'very remote communities' (MM 7). Policies aimed at improving health inequalities in rural communities should address health workforce maldistribution and social disadvantage. Implementing the recommendations highlighted in the 2020 evaluation[7] of the RHMT program could be part of the solution.

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CONFLICT OF INTEREST

None to declare.

AUTHOR CONTRIBUTIONS

EY: Conceptualization; Formal analysis; Methodology; Visualization;Writing-originaldraft.**MG:**Conceptualization; Data curation; Methodology; Supervision; Writing-review & editing. **VLV:** Conceptualization; Data curation; Methodology; Supervision; Writing-review & editing. **SJ:** Writing-review & editing. **SW:** Writing-review & editing. **EM:** Resources; Writing-review & editing. **MJ:** Conceptualization; Data curation; Methodology; Supervision; Writing-review & editing.

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COMMENTARY

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Behavioural activation for depression in rural Australia: Challenges and opportunities

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The commentary considers opportunities that may exist in rural Australia to prepare lay workers to support people living with depression. Depression will become the leading cause of disability by 2030.[1] In rural Australia, the prevalence of depression is likely to be increased due to the psychological pressures and environmental challenges linked to climate change. Drought and bushfires, and the economic pressures and entrenched inequities associated with living in rural and remote communities can impact people's mental health.[2-5] While there is conflicting evidence regarding the prevalence of depression for people living in rural areas, the outcomes may be worse than people who live in metropolitan centres. For example, death by suicide may be up to 30% higher.[6] In rural and remote Australia, some groups may be disproportionally affected by mood disorders. For example, people who are working in rural heavy industry, Aboriginal peoples and young people have a substantial burden of mental disorder in comparison with their counterparts in metropolitan Australia.[7] This may partly explain the higher rates of suicide in this population.[8] In rural school-age children and young people, there is an increasing recognition that depression is prevalent, but access to services in some rural communities is limited.[9]

Around 6 in 10 people with depression prefer psychological approaches over antidepressant medication as a treatment of depression.[10] Access to psychological therapies is a challenge in rural Australia because of a lack of appropriately qualified mental health professionals, including psychologists, nurses, social workers and psychiatrists.[11] Policymakers have focused on encouraging the migration and training of more mental health workers to practice in rural and remote communities. Despite this policy operating for 20 years, there is little tangible evidence of the success of recruiting and retaining mental health professionals in the bush. Perhaps alternative approaches to meeting the mental health needs of rural communities need to be considered which explore the opportunities for other groups of workers to deliver psychological care for people with depression.

There is good evidence reported in systematic reviews that some psychological treatments, notably cognitive behavioural therapy (CBT), are as effective as antidepressant medication and may be better tolerated.[12] CBT is a complex treatment, helping patients to appraise and change their schema (thinking patterns), and takes a high level of clinical skill and training to deliver effectively.[13] The results of recent trials indicate that alternate psychological treatments may be as effective as CBT but are simpler to deliver. Richards et al[14] reported an equivalence trial, testing CBT with a comparable dose of behavioural activation (BA) in 221 people with moderate-to-severe depression. The authors reported that both treatments were equally effective in treating depression symptoms. BA is not a new treatment; the first trials date back to the 1970s; perhaps it may be best categorised as a rediscovered treatment. A systematic review and meta-analysis of 26 randomised controlled trials involving 1524 people with depression symptoms favoured BA over treatment as usual with a standard mean deviation (SMD) of −0.74 a large effect size.[15] In the same review, 3 trials involving 283 participants tested BA against antidepressant medication. BA was favoured over antidepressants. The SMD at post-treatment was −0.42 a moderate effect size.[15]

The focus of BA is on the person's behaviour, not their thinking (cognition). Underpinning BA is the theory that people who are depressed are less active, which negatively

impacts their mood and results in further inactivity. Breaking this 'depression cycle' is a crucial feature of BA as a treatment. The aim is to get an individual to engage in activities that will break this cycle. The two active components of BA are mood monitoring and activity schedule.

Mood monitoring involves the person rating their mood during the day to notice a relationship between mood and activity, while activity scheduling requires the person to do more of the better mood activities, balancing pleasant and achievement-based activities, such as exercise.[16] In most of the clinical trials of BA, the intervention was delivered by a mental health clinician.[17] Returning to the Richards et al[15] trial, in this study BA was provided by non-clinicians. Most workers held a baccalaureate degree and had no previous clinical experience working in mental health services. Workers received 5 days of training in BA and were deemed competent in delivering the intervention before they started to see patients as part of the trial.[15] While in Australia, an innovation referred to as new Access members of the community was prepared to deliver low-intensity CBT as a coach.[18] An independent evaluation of the new Access program which supported young people has demonstrated meaningful improvements in young people's mental health. However, the preparation time to conduct the training was 12 months. We are wondering, if non-clinicians outside of a mental health service can be effectively trained to deliver BA. If so, might it be possible to extend this model of delivery to enhance access to treatment, particularly in rural and remote Australia?

1 | WHO MIGHT DELIVER BA IN RURAL AND REMOTE COMMUNITIES?

There are, perhaps, 3 groups of people who are well placed to deliver BA in rural and remote communities. The first are members of the community—that may have personal experience of mental health problems—who are motivated to work with people with depression. The second are people—such as miners—who share common characteristics with a group of people at increased risk of mental health problems. The third are people who work in a professional capacity with groups at risk of depression, for example financial counsellors or drought workers who work with people who may be at risk of depression.

2 | CAN PEOPLE WITH PERSONAL EXPERIENCE OF DEPRESSION EXPERIENCE DELIVER BA?

One of the key benefits of people, with personal experience, delivering psychological interventions is that they may be better able to build a positive working relationship with the people they work with by drawing on their own experiences.[19] There is some evidence to suggest that people with lived experience can safely deliver psychological care and treatment.[19] White et al[20] conducted a systematic review of 23 studies evaluating the impact of people with a lived experience supporting people with mental health problems. The study involved 3329 participants. The review described improvements in patients reporting feeling empowered and in which they also reported self-recovery. However, no improved clinical outcomes were reported. The types of training were heterogeneous, perhaps suggesting it was the quality of the lived experience delivery which resulted in the reported positive therapeutic outcomes. We are wondering if peer workers were prepared to practice BA, whether the clinical gains expected for people with depression could be replicated.

3 | WHAT ABOUT OTHER GROUPS OF LAY WORKERS?

Are there other particular groups of individuals in the community that could deliver BA? The strength of rural communities in Australia is their interconnectedness.[21] People are willing to give their time alongside their occupational and family roles. There are many different groups of lay workers who could be prepared to deliver BA. There is some evidence to suggest that rural communities experience internal barriers to accessing mental health services. A survey of Australian farmers identified that they found it challenging to engage with mental health professionals and expressed a desire to be in control of their care and treatment.[22] There is an argument that people who share common characteristics delivering BA might work well in rural communities. A final group that might be well placed to deliver BA are workers who come into contact with people who are at risk of depression who share common occupational characteristics, for example financial counsellors. Mental health issues are common in people who experience financial stress. As financial counsellors are already engaged with this group, an extended role to support psychological treatment makes sense. Of course, it could be argued financial counsellors already have more than enough on their plate to keep them fully occupied. Might it be possible to blend aspects of BA—such as teaching people to monitor and notice fluctuation's in mood—into the financial counsellor's role?

This raises the possibility of other evidenced-based approaches being incorporated into lay workers' repertoire such as Mental Health First Aid as an activity to increase workers' knowledge and improve attitudes when caring for people experiencing mental distress.

4 | WHAT HAPPENS IF THINGS GO WRONG?

Several safety and quality issues need to be considered that relate to members of a rural and remote community delivering BA. The first, and perhaps most important question to ask, is whether lay workers can be expected to deliver a BA as a treatment. Other issues to consider, are community workers employed or voluntary, who trains and supervises workers, how is confidentiality maintained in a rural community, how do people make a complaint, and what about developing early warning systems to capture if things are going wrong? These are areas in which traditional health services are experienced in providing. These pose important governance questions that primarily relate to how to deal with something going wrong. Psychologists, psychiatrists, occupational therapists and mental health nurses are regulated professionals; community workers are not. Lay workers will need training, and ideally certification, so they are competent to deliver BA. They will need to have a good understanding of issues regarding patient confidentiality. Supervision by an appropriately trained mental health professional is also essential. Alongside this, is the importance of robust systems and process to capture the quality and safety of BA delivered by lay workers. Ensuring good governance around community working is not insurmountable, but careful consideration of the issues is required. Services such as new Access and other providers in rural Australia which have experience in employing lay workers may have an important supervisory role to this group of lay workers.

5 | CONCLUSION

We have presented an argument for BA to be delivered by lay workers to meet the mental health needs of rural Australians and complement existing rural mental health services. If communities were to adopt these approaches, implementation could be tailored to the community. By reframing mental health as an issue for the community to solve itself, it becomes a shared responsibility. It could be argued the model we have presented 'shortchanges' rural communities by not focusing on encouraging suitably qualified mental health professionals to live and work in the bush. However, the current policy approach has yet to adequately address the availability of mental health workers in rural communities. Several safeguards will need to be put in place to ensure safety and quality, should this approach be developed. We want to emphasise that our approach does not allow governments to abdicate their responsibilities for the provision of qualified mental health professionals. However, a lay worker model builds on the self-reliance rural communities is so well-known for. A model perhaps may have an important contribution to improve access to evidence-based approaches for depression in rural communities.

CONFLICT OF INTEREST

Richard Gray and Martin Jones in partnership with the National Centre for Farmer Health have been awarded a grant from Western Victoria Primary Health Network to work with farmers to co-design a model of farmer peer-led BA, then train farmers to deliver BA and seek feedback from the farming community as to the advantages and disadvantages of the BA training.

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